Chapter 5

Health, Healing, and Social Justice

Insights from Liberation Theology

> If I define my neighbor as the one I must go out to look for, on the highways and byways, in the factories and slums, on the farms and in the mines—then my world changes. This is what is happening with the "option for the poor," for in the gospel it is the poor person who is the neighbor par excellence. . . .
>
> But the poor person does not exist as an inescapable fact of destiny. His or her existence is not politically neutral, and it is not ethically innocent. The poor are a by-product of the system in which we live and for which we are responsible. They are marginalized by our social and cultural world. They are the oppressed, exploited proletariat, robbed of the fruit of their labor and despoiled of their humanity. Hence the poverty of the poor is not a call to generous relief action, but a demand that we go and build a different kind of social order.
>
> Gustavo Gutiérrez, *The Power of the Poor in History*

> Not everything that the poor are and do is gospel. But a great deal of it is.
>
> Jon Sobrino, *Spirituality of Liberation*

Making a Preferential Option for the Poor

For decades now, proponents of liberation theology have argued that people of faith must make a "preferential option for the poor." As discussed by Brazil's Leonardo Boff, a leading contributor to the movement, "the Church's option is a preferential option *for the poor, against their*

poverty." The poor, Boff adds, "are those who suffer injustice. Their poverty is produced by mechanisms of impoverishment and exploitation. Their poverty is therefore an evil and an injustice."[1] To those concerned with health, a preferential option for the poor offers both a challenge and an insight. It challenges doctors and other health providers to make an option—a choice—for the poor, to work on their behalf.

The insight is, in a sense, an epidemiological one: most often, diseases themselves make a preferential option for the poor. Every careful survey, across boundaries of time and space, shows us that the poor are sicker than the nonpoor. They're at increased risk of dying prematurely, whether from increased exposure to pathogens (including pathogenic situations) or from decreased access to services—or, as is most often the case, from both of these "risk factors" working together.[2] Given this indisputable association, medicine has a clear—if not always observed—mandate to devote itself to populations struggling against poverty.

It's also clear that many health professionals feel paralyzed by the magnitude of the challenge. Where on earth does one start? We have received endless, detailed prescriptions from experts, many of them manifestly dismissive of initiatives coming from afflicted communities themselves. But those who formulate health policy in Geneva, Washington, New York, or Paris do not really labor to transform the social conditions of the wretched of the earth. Instead, the actions of technocrats—and what physician is not a technocrat?—are most often tantamount to managing social inequality, to keeping the problem under control. The limitations of such tinkering are sharp, as Peruvian theologian Gustavo Gutiérrez warns:

> Latin American misery and injustice go too deep to be responsive to palliatives. Hence we speak of social revolution, not reform; of liberation, not development; of socialism, not modernization of the prevailing system. "Realists" call these statements romantic and utopian. And they should, for the reality of these statements is of a kind quite unfamiliar to them.[3]

Liberation theology, in contrast to officialdom, argues that genuine change will be most

often rooted in small communities of poor people; and it advances a simple methodology—*observe, judge, act*.[4] Throughout Latin America, such base-community movements have worked to take stock of their situations and devise strategies for change.[5] The approach is straightforward. Although it has been termed "simplistic" by technocrats and experts, this methodology has proven useful for promoting health in settings as diverse as Brazil, Guatemala, El Salvador, rural Mexico, and urban Peru. Insights from liberation theology have proven useful in rural Haiti too, perhaps the sickest region of the hemisphere and the one I know best. With all due respect for health policy expertise, then, this chapter explores the implications—so far, almost completely overlooked—of liberation theology for medicine and health policy.[6]

Observe, judge, act. The "observe" part of the formula implies analysis. There has been no shortage of analysis from the self-appointed apostles of international health policy, who insist that their latest recipes become the cornerstones of health policy in all of Latin America's nations.[7] Within ministries of health, one quickly learns not to question these fads, since failure to acknowledge the primacy of the regnant health ideology can stop many projects from ever getting off the ground. But other, less conventional sources of analysis are relevant to our understanding of health and illness. It's surprising that many Catholic bishops of Latin America, for centuries allied with the elites of their countries, have in more recent decades chosen to favor tough-minded social analysis of their societies. Many would argue that liberation theology's key documents were hammered out at the bishops' conventions in Medellín in 1968 and in Puebla in 1978. In both instances, progressive bishops, working with like-minded theologians, denounced the political and economic forces that immiserate so many Latin Americans. Regarding causality, the bishops did not mince words:

> Let us recall once again that the present moment in the history of our peoples is characterized in the social order, and from an objective point of view, by a situation of underdevelopment. Certain phenomena point an accusing finger at it: marginalized existence, alienation, and poverty. In the last analysis it is conditioned by structures of economic, political, and cultural dependence on the

> great industrialized metropolises, the latter enjoying a monopoly on technology and science (neocolonialism).[8]

What began timidly in the preparation for the Medellín meeting in 1968 was by 1978 a strong current. "The Puebla document," remarks Boff, "moves immediately to the structural analysis of these forces and denounces the systems, structures, and mechanisms that 'create a situation where the rich get richer at the expense of the poor, who get even poorer.'{hrs}"[9] In both of these meetings, the bishops were at pains to argue that "this reality calls for personal conversion and profound structural changes that will meet the legitimate aspirations of the people for authentic social justice."[10]

As Chapter 1 noted, liberation theology has always been about the struggle for social and economic rights. The injunction to "observe" leads to descriptions of the conditions of the Latin American poor, and also to claims regarding the origins of these conditions. These causal claims have obvious implications for a rethinking of human rights, as Gutiérrez explains:

> A structural analysis better suited to Latin American reality has led certain Christians to speak of the "rights of the poor" and to interpret the defense of human rights under this new formality. The adjustment is not merely a matter of words. This alternative language represents a critical approach to the laissez-faire, liberal doctrine to the effect that our society enjoys an equality that in fact does not exist. This new formulation likewise seeks constantly to remind us of what is really at stake in the defense of human rights: the misery and spoliation of the poorest of the poor, the conflictive character of Latin American life and society, and the biblical roots of the defense of the poor.[11]

Liberation theologians are among the few who have dared to underline, from the left, the deficiencies of the liberal human rights movement. The most glaring of these deficiencies emerges from intimate acquaintance with the suffering of the poor in countries that are signatory to all modern human rights agreements. When children living in poverty die of measles, gastroenteritis, and malnutrition, and yet no party is judged guilty of a human rights violation,

liberation theology finds fault with the entire notion of human rights as defined within liberal democracies. Thus, even before judgment is rendered, the "observe" part of the formula reveals atrocious conditions as atrocious.

The "judge" part of the equation is nonetheless important even if it is, in a sense, pre-judged. We look at the lives of the poor and are sure, just as they are, that *something is terribly wrong*. They are targets of structural violence. (Some of the bishops termed this "structural sin.")[12] This is, granted, an a priori judgment—but it is seldom incorrect, for analysis of social suffering invariably reveals its social origins. It is not primarily cataclysms of nature that wreak havoc in the lives of the Latin American poor:

> All these aspects which make up the overall picture of the state of humanity in the late twentieth century have one common name: oppression. They all, including the hunger suffered by millions of human beings, result from the oppression of some human beings by others. The impotence of international bodies in the face of generally recognized problems, their inability to effect solutions, stems from the self-interest of those who stand to benefit from their oppression of other human beings. In each major problem there is broad recognition of both the moral intolerableness and the political non-viability of the existing situation, coupled with a lack of capacity to respond. If the problem is (or the problems are) a conflict of interests, then the energy to find the solution can come only from the oppressed themselves.[13]

Rendering judgment based on careful observation can be a powerful experience. The Brazilian sociologist Paulo Freire coined the term *conscientization*, or "consciousness raising," to explain the process of coming to understand how social structures cause injustice.[14] This "involves discovering that evil not only is present in the hearts of powerful individuals who muck things up for the rest of us but is embedded in the very structures of society, so that those structures, and not just individuals who work within them, must be changed if the world is to change."[15] Liberation theology uses the primary tools of social analysis to reveal the mechanisms by which social structures cause social misery. Such analysis, unlike many

fraudulently dispassionate academic treatises, is meant to challenge the observer to judge. It requires a very different approach than that most often used by, say, global health bureaucrats. It requires an approach that implicates the observer, as Jon Sobrino notes:

> The reality posed by the poor, then, is no rhetorical question. Precisely as sin, this reality tends to conceal itself, to be relativized, to pass itself off as something secondary and provisional in the larger picture of human achievements. It is a reality that calls men and women not only to recognize and acknowledge it, but to take a primary, basic position regarding it. Outwardly, this reality demands that it be stated for what it is, and denounced. . . . But inwardly, this same reality is a question for human beings as themselves participants in the sin of humankind. . . . the poor of the world are not the causal products of human history. No, poverty results from the actions of other human beings.[16]

How is all of this relevant to medicine? It is more realistic, surely, to ask how this could be considered irrelevant to medicine. In the wealthy countries of the Northern hemisphere, the relatively poor often travel far and wait long for health care inferior to that available to the wealthy. In the Third World, where conservative estimates suggest that one billion souls live in dire poverty, the plight of the poor is even worse. How do they cope? They don't, often enough. The poor there have short life expectancies, often dying of preventable or treatable diseases or from accidents. Few have access to modern medical care. In fact, most of the Third World poor receive no effective biomedical care at all. For some people, there is no such thing as a measles vaccine. For many, tuberculosis is as lethal as AIDS. Childbirth involves mortal risk. In an age of explosive development in the realm of medical technology, it is unnerving to find that the discoveries of Salk, Sabin, and even Pasteur remain irrelevant to much of humanity.

Many physicians are uncomfortable acknowledging these harsh facts of life and death. To do so, one must admit that the majority of premature deaths are, as the Haitians would say, "stupid deaths." They are completely preventable with the tools already available to the fortunate few. By the criteria of liberation theology, these deaths are a great injustice and a stain on the

conscience of modern medicine and science. Why, then, are these premature deaths not the primary object of discussion and debate within our professional circles? Again, liberation theology helps to answer this question. First, acknowledging the scandalous conditions of those living in poverty often requires a rejection of comforting relativism. Sobrino is addressing fellow theologians, but what he writes is of relevance to physicians, too:

> In order to recognize the truth of creation today, one must take another tack in this first, basic moment, a moment of honesty. The data, the statistics, may seem cold. They may seem to have precious little to do with theology. But we must take account of them. This is where we have to start. "Humanity" today is the victim of poverty and institutionalized violence. Often enough this means death, slow or sudden.[17]

A second reason that premature deaths are not the primary topic of our professional discussion is that the viewpoints of poor people will inevitably be suppressed or neglected as long as elites control most means of communication. Thus the steps of observation and judgment are usually difficult, because vested interests, including those controlling "development" and even international health policy, have an obvious stake in shaping observations about causality and in attenuating harsh judgments of harsh conditions. (This is, of course, another reason that people living in poverty are cited in this book as experts on structural violence and human rights.)

Finally, the liberation theologians and the communities from which they draw their inspiration agree that it is necessary to *act* on these reflections. The "act" part of the formula implies much more than reporting one's findings. The goal of this judging is not producing more publications or securing tenure in a university: "in order to *understand* the world, Latin American Christians are taking seriously the insights of social scientists, sociologists, and economists, in order to learn how to *change* the world."[18] Sobrino puts it this way: "There is no doubt that the only correct way to love the poor will be to struggle for their liberation. This liberation will consist, first and foremost, in their liberation at the most elementary level—that of

their simple, physical life, which is what is at stake in the present situation."[19] I could confirm his assessment with my own experiences in Haiti and elsewhere, including the streets of some of the cities of the hemisphere's most affluent country. What's at stake, for many of the poor, is physical survival.

The results of following this "simple" methodology can be quiet and yet effective, as in the small-scale project described in the next section. But careful reflection on the inhuman conditions endured by so many in this time of great affluence can of course also lead to more explosive actions. Retrospective analysis of these explosions—the one described in Chapter 3 of this volume, for example—often reveals them to be last-ditch efforts to escape untenable situations. That is, the explosions follow innumerable peaceful attempts to attenuate structural violence and the lies that help sustain it. The Zapatistas, who refer often to early death from treatable illnesses, explain it this way in an early communiqué:

> Some ask why we decided to begin now, if we were prepared before. The answer is that before this we tried other peaceful and legal roads to change, but without success. During these last ten years more than 150,000 of our indigenous brothers and sisters have died from curable diseases. The federal, state, and municipal governments' economic and social plans do not even consider any real solution to our problems, and consist of giving us handouts at election times. But these crumbs of charity solve our problems for no more than a moment, and then, death returns to our houses. That is why we think no, no more, enough of this dying useless deaths, it would be better to fight for change. If we die now, we will not die with shame, but with the dignity of our ancestors. Another 150,000 of us are ready to die if that is what is needed to waken our people from their deceit-induced stupor.[20]

Applying Principles of Liberation Theology to Medicine

To act as a physician in the service of poor or otherwise oppressed people is to prevent, whenever possible, the diseases that afflict them—but also to treat and, if possible, to cure. So where's the innovation in that? How would a health intervention inspired by liberation theology be different from one with more conventional underpinnings? Over the past decade, Partners In Health has joined local community health activists to provide basic primary care and preventive services to poor communities in Mexico, Peru, the United States, and, especially, Haiti—offering what we have termed "pragmatic solidarity." Pragmatic solidarity is different from but nourished by solidarity per se, the desire to make common cause with those in need. Solidarity is a precious thing: people enduring great hardship often remark that they are grateful for the prayers and good wishes of fellow human beings. But when sentiment is accompanied by the goods and services that might diminish unjust hardship, surely it is enriched. To those in great need, solidarity without the pragmatic component can seem like so much abstract piety.

Lest all this talk of structural violence and explosive responses to it seem vague and far-removed from the everyday obligations of medicine, allow me to give examples from my own clinical experience. How does liberation theology inform medical practice in, say, rural Haiti? Take tuberculosis, along with HIV the leading infectious cause of preventable adult deaths in the world. How might one observe, judge, and act in pragmatic solidarity with those most likely to acquire tuberculosis or already suffering from it?

The "observation" part of the formula is key, for it involves careful review of a large body of literature that seeks to explain the distribution of the disease within populations, to explore its clinical characteristics, and to evaluate tuberculosis treatment regimens. This sort of review is standard in all responsible health planning, but liberation theology would push analysis in two directions: first, to seek the root causes of the problem; second, *to elicit the experiences and views of poor people* and to incorporate these views into all observations, judgments, and

actions.

Ironically enough, some who understand, quite correctly, that the underlying causes of tuberculosis are poverty and social inequality make a terrible error by failing to honor the experience and views of the poor in designing strategies to respond to the disease. What happens if, after analysis reveals poverty as the root cause of tuberculosis, tuberculosis control strategies ignore the sick and focus solely on eradicating poverty? Elsewhere, I have called this the "Luddite trap," since this ostensibly progressive view would have us ignore both current distress and the tools of modern medicine that might relieve it, thereby committing a new and grave injustice.[21] The destitute sick ardently desire the eradication of poverty, but their tuberculosis can be readily cured by drugs such as isoniazid and rifampin. The prescription for poverty is not so clear.

Careful review of the biomedical and epidemiological literature on tuberculosis does permit certain conclusions. One of the clearest is that the incidence of the disease is not at all random. Certainly, tuberculosis has claimed victims among the great (Frederic Chopin, Fyodor Dostoyevsky, George Orwell, Eleanor Roosevelt), but historically it is a disease that has ravaged the economically disadvantaged.[22] This is especially true in recent decades: with the development of effective therapy in the mid-twentieth century came high cure rates—over 95 percent—for those with access to the right drugs for the right amount of time. Thus tuberculosis *deaths* now—which each year number in the millions—occur almost exclusively among the poor, whether they reside in the inner cities of the United States or in the poor countries of the Southern hemisphere.[23]

The latest twists to the story—the resurgence of tuberculosis in the United States, the advent of HIV-related tuberculosis, and the development of strains of tuberculosis resistant to the first-line therapies developed in recent decades—serve to reinforce the thesis that *Mycobacterium tuberculosis,* the causative organism, makes its own preferential option for the poor.[24]

What "judgment" might be offered on these epidemiological and clinical facts? Many

would find it scandalous that one of the world's leading causes of preventable adult deaths is a disease that, with the possible exception of emerging resistant strains, is more than 95 percent curable, with inexpensive therapies developed decades ago. Those inspired by liberation theology would certainly express distaste for a disease so partial to poor and debilitated hosts and would judge unacceptable the lack of therapy for those most likely to become ill with tuberculosis: poverty puts people at risk of tuberculosis and then bars them from access to effective treatment. An option-for-the-poor approach to tuberculosis would make the disease a top priority for research and development of new drugs and vaccines and at the same time would make programs to detect and cure all cases a global priority.

Contrast this reading to the received wisdom—and the current agenda—concerning tuberculosis. Authorities rarely blame the recrudescence of tuberculosis on the inequalities that structure our society. Instead, we hear mostly about biological factors (the advent of HIV, the mutations that lead to drug resistance) or about cultural and psychological barriers that result in "noncompliance." Through these two sets of explanatory mechanisms, one can expediently attribute high rates of treatment failure either to the organism or to uncooperative patients.

There are costs to seeing the problem in this way. If we see the resurgence or persistence of tuberculosis as an exclusively biological phenomenon, then we will shunt available resources to basic biological research, which, though needed, is not the primary solution, since almost all tuberculosis deaths result from lack of access to existing effective therapy. If we see the problem primarily as one of patient noncompliance, then we must necessarily ground our strategies in plans to change the patients rather than to change the weak tuberculosis control programs that fail to detect and cure the majority of cases. In either event, weak analysis produces the sort of dithering that characterizes current global tuberculosis policy, which must accept as its primary rebuke the shameful death toll that continues unabated.

How about the "act" part of the formula advocated by liberation theology? In a sense, it's simple: heal the sick. Prompt diagnosis and cure of tuberculosis are also the means to prevent new infections, so prevention and treatment are intimately linked. Most studies of tuberculosis in

Haiti reveal that the vast majority of patients do not complete treatment—which explains why, until very recently, tuberculosis remained the leading cause of adult death in rural regions of Haiti. (It has now been surpassed by HIV.) But it does not need to be so. In the country's Central Plateau, Partners In Health worked with our sister organization, Zanmi Lasante, to devise a tuberculosis treatment effort that borrows a number of ideas—and also some passion—from liberation theology.

Although the Zanmi Lasante staff had, from the outset, identified and referred patients with pulmonary tuberculosis to its clinic, it gradually became clear that detection of new cases did not always lead to cure, even though all tuberculosis care, including medication, was free of charge. In December 1988, following the deaths from tuberculosis of three HIV-negative patients, all adults in their forties, the staff met to reconsider the care these individuals had received. How had the staff failed to prevent these deaths? How could we better observe, judge, and act as a community making common cause with the destitute sick?

Initially, we responded to these questions in differing ways. In fact, the early discussions were heated, with a fairly sharp divide between community health workers, who shared the social conditions of the patients, and the doctors and nurses, who did not. Some community health workers believed that tuberculosis patients with poor outcomes were the most economically impoverished and thus the sickest; others hypothesized that patients lost interest in chemotherapy after ridding themselves of the symptoms that had caused them to seek medical advice. Feeling better, they returned as quickly as possible to the herculean task of providing for their families. Still others, including the physicians and nurses, attributed poor compliance to widespread beliefs that tuberculosis was a disorder inflicted through sorcery, beliefs that led patients to abandon biomedical therapy. A desire to focus blame on the patients' ignorance or misunderstanding was palpable, even though the physicians and nurses sought to cure the disease as ardently as anyone else involved in the program.

The caregivers' ideas about the causes of poor outcomes tended to coalesce in two directions: a *cognitivist-personalistic* pole that emphasized individual patient agency (curiously,

"cultural" explanations fit best under this rubric, since beliefs about sorcery allegedly led patients to abandon therapy), and a *structural* pole that emphasized the patients' poverty. And this poverty, though generic to outsiders like the physicians from Port-au-Prince, had a vivid history to those from the region. Most of our tuberculosis patients were landless peasants living in the most dire poverty. They had lost their land a generation before when the Péligre dam, part of an internationally funded development project, flooded their fertile valley.[25]

More meetings followed. Over the next several months, we devised a plan to improve services to patients with tuberculosis—and to test these discrepant hypotheses. Briefly, the new program set goals of detecting cases, supplying adequate chemotherapy, and providing close follow-up. Although they also continued contact screening and vaccination for infants, the staff of Zanmi Lasante was then most concerned with caring for smear-positive and coughing patients—whom many believed to be the most important source of community exposure. The new program was aggressive and community-based, relying heavily on community health workers for close follow-up. It also responded to patients' appeals for nutritional assistance. The patients argued, often with some vehemence and always with eloquence, that to give medicines without food was tantamount to *lave men, siye atè* (washing one's hands and then wiping them dry in the dirt).

Those diagnosed with tuberculosis who participated in the new treatment program were to receive daily visits from their village health worker during the first month following diagnosis. They would also receive financial aid of thirty dollars per month for the first three months; would be eligible for nutritional supplements; would receive regular reminders from their village health worker to attend the clinic; and would receive a five-dollar honorarium to defray "travel expenses" (for example, renting a donkey) for attending the clinic. If a patient did not attend, someone from the clinic—often a physician or an auxiliary nurse—would make a visit to the no-show's house. A series of forms, including a detailed initial interview schedule and home visit reports, regularized these arrangements and replaced the relatively limited forms used for other clinic patients.

Between February 1989 and September 1990, fifty patients were enrolled in the program. During the same period, the clinical staff diagnosed pulmonary tuberculosis in 213 patients from outside our catchment area. The first fifty of these patients to be diagnosed formed the comparison group that would be used to judge the efficacy of the new intervention. They were a "control group" only in the sense that they did not benefit from the community-based services and financial aid; all tuberculosis patients continued to receive free care.

The difference in the outcomes of the two groups was little short of startling. By June 1991, forty-six of the patients receiving the "enhanced package" were free of all symptoms, and none of those with symptoms met radiologic or clinical diagnostic criteria for persistent tuberculosis. Therefore, the medical staff concluded that none had active pulmonary tuberculosis, giving the participants a cure rate of 100 percent. We could not locate all fifty of the patients from outside the catchment area, but for the forty patients examined more than one year after diagnosis, the cure rate was barely half that of the first group, based on clinical, laboratory, and radiographic evaluation. It should be noted that this dismal cure rate was nonetheless higher than that reported in most studies of tuberculosis outcomes in Haiti.[26]

Could this striking difference in outcome be attributed to patients' ideas and beliefs about tuberculosis? Previous ethnographic research had revealed extremely complex and changing ways of understanding and speaking about tuberculosis among rural Haitians.[27] Because most physicians and nurses (and a few community health workers) had hypothesized that patients who "believed in sorcery" as a cause of tuberculosis would have higher rates of noncompliance with their medical regimens, we took some pains to address this issue with each patient. As the resident medical anthropologist, I conducted long—often very long—and open-ended interviews with all patients in both groups, trying to delineate the dominant explanatory models that shaped their views of the disease. I learned that few from either group would deny the possibility of sorcery as an etiologic factor in their own illness, but I could discern no relationship between avowal of such beliefs and compliance with a biomedical regimen. That is, the outcomes were related to the quality of the program rather than the quality of the patients' ideas about the

disease. Suffice it to say, this was not the outcome envisioned by many of my colleagues in anthropology.

Although anthropologists are expected to underline the importance of *culture* in determining the efficacy of efforts to combat disease, in Haiti we learned that many of the most important variables—initial exposure to infection, reactivation of quiescent tuberculosis, transmission to household members, access to diagnosis and therapy, length of convalescence, development of drug resistance, degree of lung destruction, and, most of all, mortality—are all strongly influenced by *economic* factors. We concluded that removing structural barriers to "compliance," when coupled with financial aid, dramatically improved outcomes in poor Haitians with tuberculosis. This conclusion proved that the community health workers, and not the doctors, had been correct.

This insight forever altered approaches to tuberculosis within our program. It cut straight to the heart of the compliance question. Certainly, patients may be noncompliant, but how relevant is the notion of compliance in rural Haiti? Doctors may instruct their patients to eat well. But the patients will "refuse" if they have no food. They may be told to sleep in an open room and away from others, and here again they will be "noncompliant" if they do not expand and remodel their miserable huts. They may be instructed to go to a hospital. But if hospital care must be paid for in cash, as is the case throughout Haiti, and the patients have no cash, they will be deemed "grossly negligent." In a study published in collaboration with the Zanmi Lasante team, we concluded that "the hoary truth that poverty and tuberculosis are greater than the sum of their parts is once again supported by data, this time coming from rural Haiti and reminding us that such deadly synergism, formerly linked chiefly to crowded cities, is in fact most closely associated with deep poverty."[28]

Similar scenarios could be offered for diseases ranging from typhoid to AIDS. In each case, poor people are at higher risk of contracting the disease and are also less likely to have access to care. And in each case, analysis of the problem can lead researchers to focus on the patients' shortcomings (for example, failure to drink pure water, failure to use condoms,

ignorance about public health and hygiene) or, instead, to focus on the conditions that structure people's risk (for example, lack of access to potable water, lack of economic opportunities for women, unfair distribution of the world's resources). In many current discussions of these plagues of the poor, one can discern a cognitivist-personalistic pole and a structural pole. Although focus on the former is the current fashion, one of the chief benefits of the latter mode of analysis is that it encourages physicians (and others concerned to protect or promote health) to make common cause with people who are both poor and sick.

A Social Justice Approach to Addressing Disease and Suffering

Tuberculosis aside, what follows next from a perspective on medicine that is based in liberation theology? Does recourse to these ideas demand loyalty to any specific ideology? For me, applying an option for the poor has never implied advancing a particular strategy for a national economy. It does not imply preferring one form of development, or social system, over another—although some economic systems are patently more pathogenic than others and should be denounced as such by physicians. Recourse to the central ideas of liberation theology does not necessarily imply subscription to a specific body of religious beliefs; Partners In Health and its sister organizations in Haiti and Peru are completely ecumenical.[29] At the same time, the flabby moral relativism of our times would have us believe that we may now choose from a broad menu of approaches to delivering effective health care services to the poor. This is simply not true. Whether you are sitting in a clinic in rural Haiti, and thus a witness to stupid deaths from infection, or sitting in an emergency room in a U.S. city, and thus the provider of first resort for forty million uninsured, you must acknowledge that the commodification of medicine invariably punishes the vulnerable.

A truly committed quest for high-quality care for the destitute sick starts from the perspective that health is a fundamental human right. In contrast, commodified medicine