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. . . .
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> 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*

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

invariably begins with the notion that health is a desirable outcome to be attained through the purchase of the right goods and services. Socialized medicine in industrialized countries is no doubt a step up from a situation in which market forces determine who has access to care. But a perspective based in liberation theology highlights the fundamental weakness of this and other strategies of the affluent: if the governments of Scandinavian countries and that of France, for example, then spend a great deal of effort barring noncitizens from access to health care services, they will find few critics within their borders. (Indeed, the social democracies share a mania for border control.) But we will critique them, and bitterly, because access to the fruits of science and medicine should not be determined by passports, but rather by need. The "health care for all" movement in the United States will never be morally robust until it truly means "all."

Liberation theology's first lesson for medicine is similar to that usually confronting healers: There is something terribly wrong. Things are not the way they should be. But the problem, in this view, is with the world, even though it may be manifest in the patient. Truth—and liberation theology, in contrast to much postmodern attitudinizing, believes in historical accuracy—is to be found in the perspective of those who suffer unjust privation.[30] Cornel West argues that "the condition of truth is to allow the suffering to speak. It doesn't mean that those who suffer have a monopoly on truth, but it means that the condition of truth to emerge must be in tune with those who are undergoing social misery—socially induced forms of suffering."[31]

The second lesson is that medicine has much to learn by reflecting on the lives and struggles of poor or otherwise oppressed people. How is suffering, including that caused by sickness, best explained? How is it to be addressed? These questions are, of course, as old as humankind. We've had millennia in which to address—societally, in an organized fashion—the suffering that surrounds us. In looking at approaches to such problems, one can easily discern three main trends: *charity, development*, and *social justice*.

Each of these might have much to recommend it, but it is my belief that the first two approaches are deeply flawed. Those who believe that charity is the answer to the world's problems often have a tendency—sometimes striking, sometimes subtle, and surely lurking in all

of us—to regard those needing charity as intrinsically inferior. This is different from regarding the poor as powerless or impoverished because of historical processes and events (slavery, say, or unjust economic policies propped up by powerful parties). There is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as the victims of structural violence. Indeed, it is likely that the struggle for rights is undermined whenever the history of unequal chances, and of oppression, is erased or distorted.

The approach of charity further presupposes that there will always be those who have and those who have not. This may or may not be true, but, again, there are costs to viewing the problem in this light. In *Pedagogy of the Oppressed,* Paulo Freire writes: "In order to have the continued opportunity to express their 'generosity,' the oppressors must perpetuate injustice as well. An unjust social order is the permanent fount of this 'generosity,' which is nourished by death, despair, and poverty." Freire's conclusion follows naturally enough: "True generosity consists precisely in fighting to destroy the causes which nourish false charity."[32] Given the twentieth century's marked tendency toward increasing economic inequity in the face of economic growth, the future holds plenty of false charity. All the recent chatter about "personal responsibility" from "compassionate conservatives" erases history in a manner embarrassingly expedient for themselves. In a study of food aid in the United States, Janet Poppendieck links a rise in "kindness" to a decline in justice:

> The resurgence of charity is at once a *symptom* and a *cause* of our society's failure to face up to and deal with the erosion of equality. It is a symptom in that it stems, in part at least, from an abandonment of our hopes for the elimination of poverty; it signifies a retreat from the goals as well as the means that characterized the Great Society. It is symptomatic of a pervasive despair about actually solving problems that has turned us toward ways of managing them: damage control, rather than prevention. More significantly, and more controversially, the proliferation of charity *contributes* to our society's failure to grapple in meaningful ways with poverty.[33]

It is possible, however, to overstate the case against charity—it is, after all, one of the four cardinal virtues, in many traditions. Sometimes holier-than-thou progressives dismiss charity when it is precisely the virtue demanded. In medicine, charity underpins the often laudable goal of addressing the needs of "underserved populations." To the extent that medicine responds to, rather than creates, underserved populations, charity will always have its place in medicine.

Unfortunately, a preferential option for the poor is all too often absent from charity medicine. First, charity medicine should avoid, at all costs, the temptation to ignore or hide the causes of excess suffering among the poor. Meredeth Turshen gives a jarring example from apartheid South Africa:

> South African paediatricians may have developed an expertise in the understanding and treatment of malnutrition and its complications, but medical expertise does not change the system that gives rise to malnutrition nor the environment to which treated children return, an environment in which half of the children die before their fifth birthday. Malnutrition, in this context, is a direct result of the government's policies, which perpetuate the apartheid system and promote the poor health conditions and human rights violations.[34]

Second, charity medicine too frequently consists of second-hand, castoff services—leftover medicine—doled out in piecemeal fashion. How can we tell the difference between the proper place of charity in medicine and the doling out of leftovers? Many of us have been involved in these sorts of good works and have often heard a motto such as this: "the homeless poor are every bit as deserving of good medical care as the rest of us." The notion of a preferential option for the poor challenges us by reframing the motto: the homeless poor are *more* deserving of good medical care than the rest of us.[35] Whenever medicine seeks to reserve its finest services for the destitute sick, you can be sure that it is option-for-the-poor medicine.

What about development approaches?[36] Often, this perspective seems to regard progress and development as almost natural processes. The technocrats who design development

projects—including a certain Péligre dam, which three decades ago displaced the population we seek to serve in central Haiti—plead for patience. In due time, the technocrats tell the poor, if they speak to them at all, you too will share our standard of living. (After a generation, the reassurance may be changed to "if not you, your children.") And certainly, looking around us, we see everywhere the tangible benefits of scientific development. So who but a Luddite would object to development as touted by the technocrats?

According to liberation theology, progress for the poor is not likely to ensue from development approaches, which are based on a "liberal" view of poverty. Liberal views place the problem with the poor themselves: these people are backward and reject the technological fruits of modernity. With assistance from others, they too will, after a while, reach a higher level of development. Thus does the victim-blaming noted in the earlier discussion of tuberculosis recur in discussions of underdevelopment.

For many liberation theologians, developmentalism or reformism cannot be rehabilitated. Jorge Pixley and Clodovis Boff use these terms to describe what they consider an "erroneous" view of poverty, in contrast to the "dialectical" explanation, in which the growth of poverty is dependent on the growth of wealth. Poverty today, they note, "is mainly the result of a contradictory development, in which the rich become steadily richer, and the poor become steadily poorer." Such a poverty is "internal to the system and a natural product of it."[37] Developmentalism not only erases the historical creation of poverty but also implies that development is necessarily a linear process: progress will inevitably occur if the right steps are followed. Yet any critical assessment of the impact of such approaches must acknowledge their failure to help the poor, as Leonardo and Clodovis Boff argue:

> "Reformism" seeks to improve the situation of the poor, but always within existing social relationships and the basic structuring of society, which rules out greater participation by all and diminution in the privileges enjoyed by the ruling classes. Reformism can lead to great feats of development in the poorer nations, but this development is nearly always at the expense of the oppressed poor and

> very rarely in their favor. For example, in 1964 the Brazilian economy ranked 46th in the world; in 1984 it ranked 8th. The last twenty years have seen undeniable technological and industrial progress, but at the same time there has been a considerable worsening of social conditions for the poor, with exploitation, destitution, and hunger on a scale previously unknown in Brazilian history. This has been the price paid by the poor for this type of elitist, exploitative, and exclusivist development.[38]

In his introduction to *A Theology of Liberation,* Gustavo Gutiérrez concurs: we assert our humanity, he argues, in "the struggle to construct a just and fraternal society, where persons can live with dignity and be the agents of their own destiny. It is my opinion that the term *development* does not well express these profound aspirations."[39] Gutiérrez continues by noting that the term "liberation" expresses the hopes of the poor much more succinctly. Philip Berryman puts it even more sharply: "{hrs}'Liberation' entails a break with the present order in which Latin American countries could establish sufficient autonomy to reshape their economies to serve the needs of that poor majority. The term 'liberation' is understood in contradistinction to 'development.'{hrs}"[40]

In examining medicine, one sees the impact of "developmental" thinking not only in the planned obsolescence of medical technology, essential to the process of commodification, but also in influential analytic constructs such as the "health transition model."[41] In this view, societies as they develop are making their way toward that great transition, when deaths will no longer be caused by infections such as tuberculosis but will occur much later and be caused by heart disease and cancer. But this model masks interclass differences *within* a particular country. For the poor, wherever they live, there is, often enough, no health transition. In other words, wealthy citizens of "underdeveloped" nations (those countries that have not yet experienced their health transition) do not die young from infectious diseases; they die later and from the same diseases that claim similar populations in wealthy countries. In parts of Harlem, in contrast, death rates in certain age groups are as high as those in Bangladesh; in both places, the leading causes of death in young adults are infections and violence.[42]

The powerful, including heads of state and influential policymakers, are of course impatient with such observations and respond, if they deign to respond, with sharp reminders that the overall trends are the results that count. But if we focus exclusively on aggregate data, why not declare public health in Latin America a resounding success? After all, life expectancies have climbed; infant and maternal mortality have dropped. But if you work in the service of the poor, what's happening to that particular class, whether in Harlem or in Haiti, always counts a great deal. In fact, it counts most. And from this vantage point—the one demanded by liberation theology—neither medicine nor development looks nearly so successful. In fact, the outcome gap between rich and poor has continued to grow.

In summary, then, the charity and development models, though perhaps useful at times, are found wanting in rigorous and soul-searching examination. That leaves the social justice model. In my experience, people who work for social justice, regardless of their own station in life, tend to see the world as deeply flawed. They see the conditions of the poor not only as unacceptable but as the result of structural violence that is human-made. As Robert McAfee Brown, paraphrasing the Uruguayan Jesuit Juan Segundo, observes, "unless we agree that the world should not be the way it is . . . there is no point of contact, because the world that is satisfying to us is the same world that is utterly devastating to them."[43] Often, if these individuals are privileged people like me, they understand that they have been implicated, whether directly or indirectly, in the creation or maintenance of this structural violence. They then feel indignation, but also humility and penitence. Where I work, this is easy: I see the Péligre dam almost every week.

This posture—of penitence and indignation—is critical to effective social justice work. Alas, it is all too often absent or, worse, transformed from posture into posturing. And unless the posture is linked to much more pragmatic interventions, it usually fizzles out.

Fortunately, embracing these concepts and this posture do have very concrete implications. Making an option for the poor inevitably implies working for social justice, working with poor people as they struggle to change their situations. In a world riven by

inequity, medicine could be viewed as social justice work. In fact, doctors are far more fortunate than most modern professionals: we still have a sliver of hope for meaningful, dignified service to the oppressed. Few other disciplines can make this claim with any honesty. We have a lot to offer right now. In Haiti and Peru and Chiapas, we have found that it is often less a question of "development" and more one of redistribution of goods and services, of simply sharing the fruits of science and technology. The majority of our efforts in the transfer of technology—medications, laboratory supplies, computers, and training—are conceived in just this way. They end up being innovative for other reasons: it is almost unheard of to insist that the destitute sick receive high quality care as a right.

Treating poor Peruvians who suffer from multidrug-resistant tuberculosis according to the highest standard of care, rather than according to whatever happens to be deemed "cost-effective," is not only social justice work but also, ironically enough, innovative. Introducing antiretroviral medications, and the health systems necessary to use them wisely, to AIDS-afflicted rural Haiti is, again, viewed as pie-in-the-sky by international health specialists but as only fitting by liberation theology. For example, operating rooms (and cesarean sections) must be part of any "minimum package" of health services wherever the majority of maternal deaths are caused by cephalopelvic disproportion. This is obvious from the perspective of social justice but controversial in international health circles. And the list goes on.

A preferential option for the poor also implies a mode of analyzing health systems. In examining tuberculosis in Haiti, for example, our analysis must be *historically deep*—not merely deep enough to recall an event such as that which deprived most of my patients of their land, but deep enough to remember that modern-day Haitians are the descendants of a people enslaved in order to provide our ancestors with cheap sugar, coffee, and cotton.

Our analysis must be *geographically broad*. In this increasingly interconnected world ("the world that is satisfying to us is the same world that is utterly devastating to them"), we must understand that what happens to poor people is never divorced from the actions of the powerful. Certainly, people who define themselves as poor may control their own destinies to

some extent. But control of lives is related to control of land, systems of production, and the formal political and legal structures in which lives are enmeshed. With time, both wealth and control have become increasingly concentrated in the hands of a few. The opposite trend is desired by those working for social justice.

For those who work in Latin America, the role of the United States looms large. Father James Guadalupe Carney, a Jesuit priest, put his life on the line in order to serve the poor of Honduras. As far as we can tell, he was killed by U.S.-trained Honduran security forces in 1983.[44] In an introduction to his posthumously published autobiography, his sister and brother-in-law asked starkly: "Do we North Americans eat well because the poor in the third world do not eat at all? Are we North Americans powerful, because we help keep the poor in the third world weak? Are we North Americans free, because we help keep the poor in the third world oppressed?"[45]

Granted, it is difficult enough to "think globally and act locally." But perhaps what we are really called to do, in efforts to make common cause with the poor, is to think locally *and* globally and to act in response to both levels of analysis. If we fail in this task, we may never be able to contend with the structures that create and maintain poverty, structures that make people sick. Although physicians and nurses, even those who serve the poor, have not followed liberation theology, its insights have never been more relevant to our vocation. As international health experts come under the sway of the bankers and their curiously bounded utilitarianism, we can expect more and more of our services to be declared "cost-ineffective" and more of our patients to be erased. In declaring health and health care to be a human right, we join forces with those who have long labored to protect the rights and dignity of the poor.