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Sincerely,

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An Analysis of Socialized Medicine Advocacy Across Time: Fighting the "Long Defeat" for Universal Health Care

Thesis Title and Semester Completed

An Analysis of Socialized Medicine Advocacy Across Time: Fighting the "Long Defeat" for Universal Health Care

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Note from the Author

This thesis represents the view of the author and not those of Carnegie Mellon University.

Abstract

This thesis is based upon the premise that access to health care is a fundamental human right and should never be dictated by profit, class, gender, or national identity. Given the quixotism of this objective for universal health care coverage, I am studying the works of the most prominent proponents of socialized healthcare—Rudolf Virchow, Henry E. Sigerist, and Paul Farmer. According to the White House, approximately 18% of our GDP is currently spent on healthcare—a cost that is only expected to rise if we cannot change our fee-for-service healthcare system today that prioritizes medical costs for treating disease over preventative services that maintain public health. Given this status quo, assuming a socialized healthcare system—which would incentivize the maintenance of health—was desirable, how could its implementation even be possible? I am trying to answer this question by exploring the reasoning upon which Virchow, Sigerist, and Farmer based their beliefs. Although each of these physicians lived in different time periods, they all agreed that healthcare is a public good that should not be excluded from those who cannot afford it.

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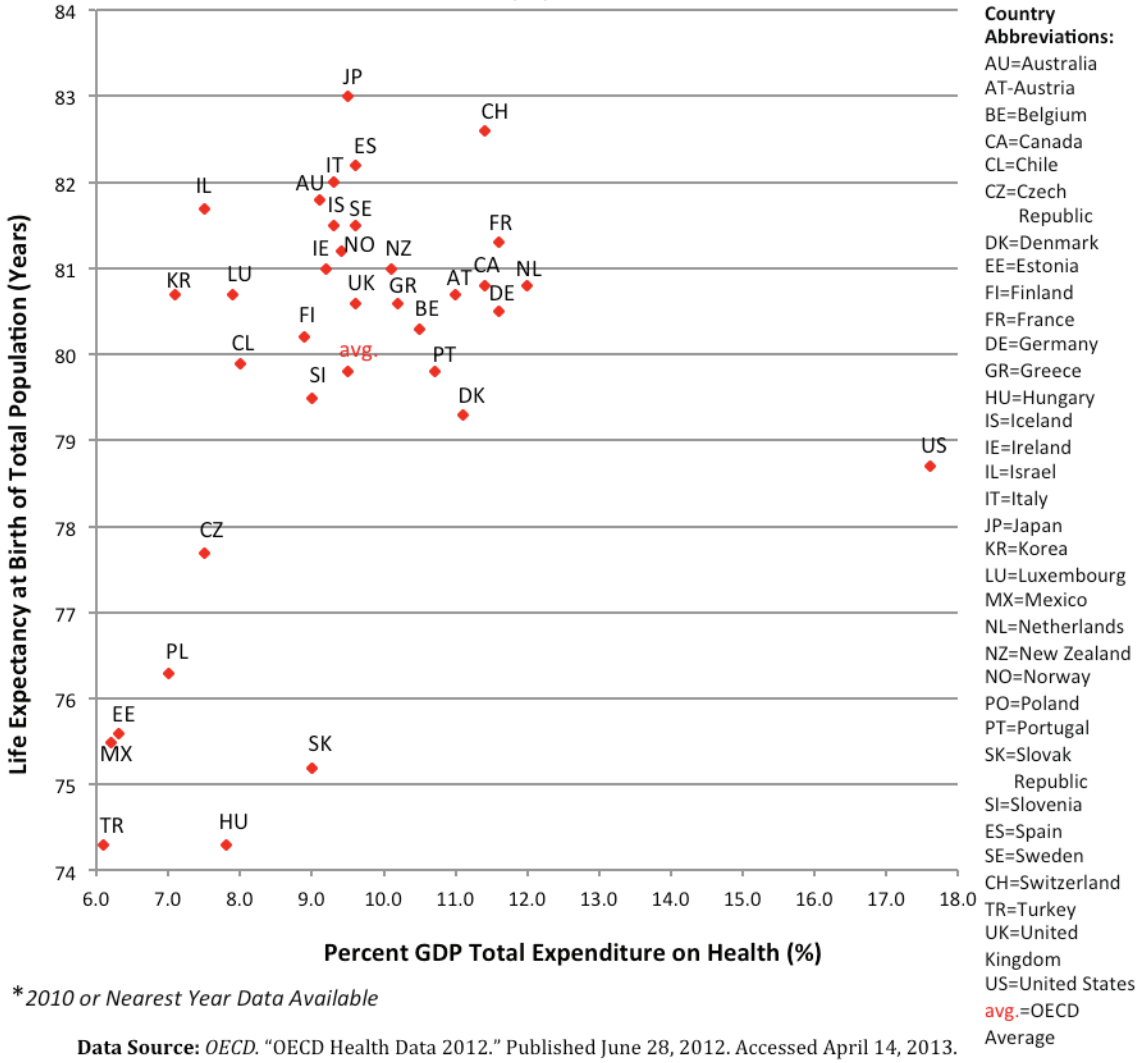
Introduction

More than twenty years ago, the headline of *Los Angeles Times* editorial boldly declared, "Our healthcare is sick." (*Los Angeles Times* 1989.) This is not an original revelation, and worse, little has changed since its realization. Any quantitative assay of the current overall performance of U.S. healthcare in the international arena efficiently demonstrates our healthcare's sickness. For an honest comparison between the United States and other countries that share similar economic and political values, let us examine the data provided by the Organization of Economic Co-operation and Development (OECD) of its constituent countries. Chart 1 shown below conveys the relationship between the life expectancy at birth and the percent GDP spent on health of each of the thirty-four countries in the OECD in the year 2010.

Chart 1: Life Expectancy vs. Total Health Expenditure as Percent GDP in 2010*



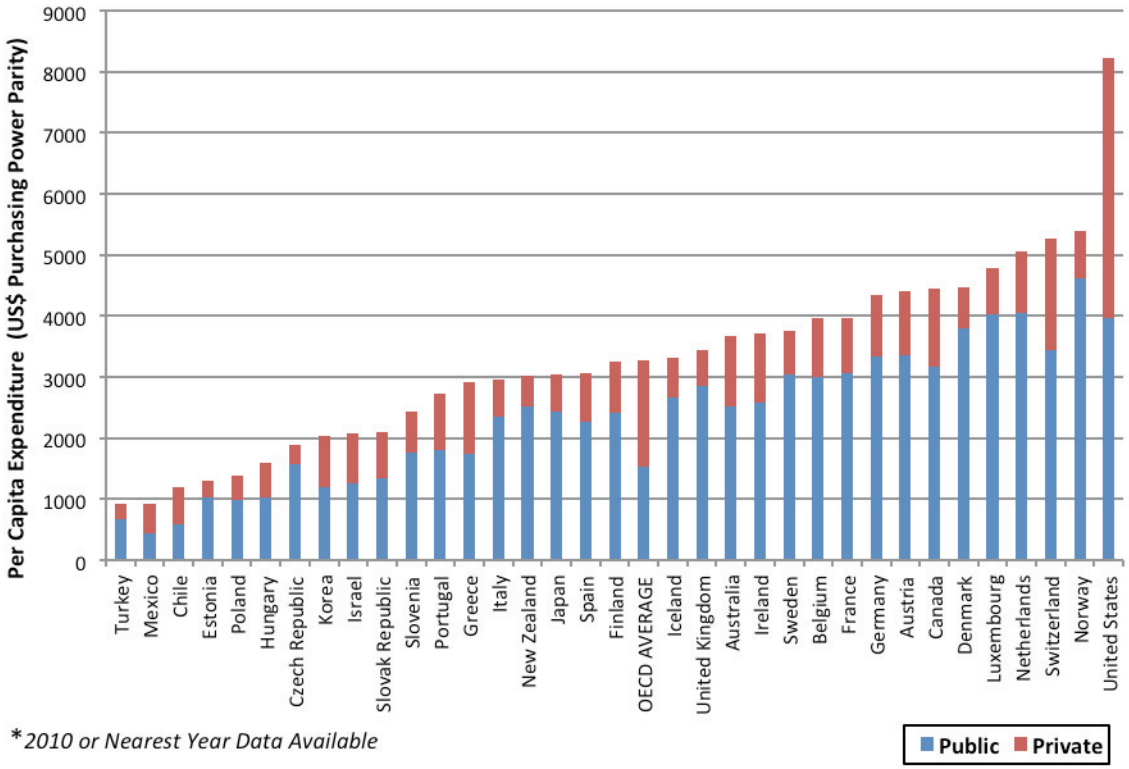
Data Source: *OECD.* "OECD Health Data 2012." Published June 28, 2012. Accessed April 14, 2013. <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>.

**2010 or Nearest Year Data Available*

With 17.6% of its GDP spent on healthcare in 2010, the United States had the highest percent GDP health expenditure in the world and yet was ranked 49th in life expectancy by the CIA for that same year ("The World Factbook" 2010.) Dr. Otis Brawley, who is the chief medical officer and executive vice president of the American Cancer Society as well as a practicing oncologist and epidemiologist, sums up the meaning of this discrepancy best in his book *How We Do Harm: A Doctor*

Breaks Ranks About Being Sick in America. Straightforwardly, he says that as "the biggest spender by far, we aren't getting what we pay for" (Brawley 2012: 22.) But on what kind of healthcare, exactly, are we spending? To break down this spending further, the total per capita health expenditure for each of these countries in 2010 is divided between the public and private expenditures as depicted in Chart 2 below.

Chart 2: Per Capita Private and Public Expenditure on Health in 2010*



**2010 or Nearest Year Data Available*

Data Source: *OECD.* "OECD Health Data 2012." Published June 28, 2012. Accessed April 14, 2013. <http://stats.oecd.org/Index.aspx?DataSetCode=SHA>.

The exorbitant amount the average American spends on private healthcare in comparison to the lower amounts other countries' citizens spend on healthcare—both public and private—as conveyed by this chart is an indication of how healthcare has yet to be considered a non-excludable public good in America. David

Zilberman, an agricultural and resource economist from the University of California at Berkeley, defines public goods in the following:

> Public goods are goods or services that can be consumed by several individuals simultaneously without diminishing the value of consumption to any one of the individuals. This key characteristic of public goods, that multiple individuals can consume the same good without diminishing its value, is termed non-rivalry. Non-rivalry is what most strongly distinguishes public goods from private goods. A pure public good also has the characteristic of non-excludability, that is, an individual cannot be prevented from consuming the good whether or not the individual pays for it. For example, fresh air, a public park, a beautiful view, national defense. (Zilberman: 1)

By Zilberman's definition, healthcare is not a public good in the United states because, as shown in Chart 1, the value, or quality, of healthcare as measured by life expectancy in the United States decreases with its consumption. Furthermore, the private healthcare sector creates rivalry not only between competing private healthcare providers, but also between these providers and public ones as well.

The consequence of this is clear: Americans incur a large cost both in dollars and in years of life expectancy because we do not collectively invest in public healthcare. This collective investment in healthcare, specifically in the form of taxes, is better known as socialized, or universal, healthcare, and is distinguished from other healthcare systems by its recognition of healthcare as a public good whose accessibility to all is to the benefit of all. In spite of all of its spending on public health, the prioritization of private over public healthcare in the United States negates any recognition of healthcare as a public good, and in so doing denies many of its citizens the access to healthcare—public or private. And until Americans do,

healthcare in the United States, and all of the lives that depend upon it, will suffer still.

Thus the time has come for Americans to collectively recognize healthcare as the public good it truly is. Many have already done so, and others still have gone on so far as to fight upon its behalf. Yet still, the question remains: How? How does an entire country come together to redefine healthcare as a non-excludable public good and embrace the model of socialized healthcare still haunted in many of our eyes by the ghosts of McCarthyism? My answer: the dualism of etic and emic awareness.

These terms are best defined in the paper "Views from Inside and Outside: Integrating Emic and Etic Insights on Culture and Justice Judgment" by the social psychologists Michael Morris from Stanford University, Kwok Leung from the Chinese University of Hong Kong, Daniel Ames from the University of California at Berkeley, and Brian Lickel from the University of California at Santa Barbara. In this paper, these authors define "emic" to be "the inside perspective of ethnographers, who strive to describe a particular culture in its own terms," differentiating this from the "etic," which they defined as "the outside perspective of comparativist researchers, who attempt to describe differences across cultures in terms of a general, external standard" (Morris et al 1999: 781.) To apply these sociological terms to healthcare analysis, the "etic" is an outsiders' panoramic, bird's-eye view of healthcare—as distinct from the integrated, multilateral view afforded by holism—while the "emic" is an insider's, ground-level microcosmic view of the healthcare from the individual's perspective. I argue that both of these perspectives—the etic

as well as the emic—are imperative to the establishment of health care as a public good in the United States. I will accomplish this by analyzing the advocacy of socialized medicine championed by the physicians Rudolf Ernst Virchow, Henry Ernst Sigerist, and Paul Farmer across time in order to establish that it was their unique ability to perceive healthcare both emically and etically that allowed them to recognize it as a public good.

Rudolf Virchow's Advocacy of Socialized Medicine: Expanding the Academically Emic Biological Analysis of Disease to Observe its Etic Social Origins

In his 1848 "Report on the Typhus Epidemic in Upper Silesia," the young Prussian physician by the name of Rudolf Virchow expanded the academically emic, biological analysis of disease to include its etic, social origins by conveying that the derivation of disease from conditions on the biological level is a consequence of macroscopic social inequalities on the social level. And while Virchow distinguished himself in this report as a man of great scientific insight, he more importantly set himself apart as "one of the first to make the case for the social origins of illness and the multifactorial etiology of epidemics" (Brown and Fee 2012.) Alternatively put, while Virchow agreed with his scientist peers the squalid conditions cultivate disease, he broadened his focus to argue that socioeconomic conditions are what facilitate both its incidence and prevalence. In addition to geographic and climatic factors, the socioeconomic conditions Virchow pointed to in the 1848 "Report on the

Typhus Epidemic in Upper Silesia" include Upper Silesia's exclusion from the German culture, the Catholic hierarchy, neglect of the Prussian government, the legacy of indentured servitude in the region, the high person to domicile ratio, and other living conditions. However, as much as this report was a herald of public health, several aspects of it definitively sets it within the context of its time, including Virchow's intermittent racism and patronizing attitude toward the Silesian people.

Virchow began the report by setting the scene of Upper Silesia—what is now the southwestern region of current day Poland describing in detail its topography and climatic (*Encyclopædia Britannica.)* He described the region as a "torn and deeply-cut high tableland" surrounded by mountains, which, when assailed by air masses, gave rise to large amounts of precipitation due to the region's high humidity (Virchow 1848: 12-3.) This humidity was in part due to the clay soil composition, which prevented the rain from permeating the soil and thereby led to stagnant waters and marsh areas—cultivators of malaria. But in contrast to the contemporaneous German "law of exclusivity" stating that typhus and malaria cannot be concurrent, Virchow argued that the socially derived conditions that foster both typhus and malaria existed in Upper Silesia, and therefore allowed both diseases to occur simultaneously within the Upper Silesian population and even within an Upper Silesian individual (Virchow 1848: 23.) An apt metaphor for the Northern Germans' ignorance of such conditions was the omnipresent lakes in Upper Silesia. Describing them, Virchow says, "Lakes, even large ones, are not rare;

their beaches are mostly flat, so that they appear to the eye of the North German used to higher hilly slopes rather than like ephemeral water collections in shallow depressions of the ground." (Virchow 1848: 13) Here Virchow's description of Northern Germans' perception of the Upper Silesian lakes as "ephemeral" and "shallow" may be covertly castigating their "untrained eye"—their ignorance—of the conditions there that were, like the lakes, extensive and unfathomable in both the figurative and literal sense.

And while Virchow acknowledged these geographic and climatic factors' significant contribution to the typhus epidemic, what made this report so revolutionary for this time was his holistic consideration of socioeconomic factors, and even more importantly, how all of these factors came together to create the typhus epidemic in Upper Silesia. As a scientist, Virchow did not dismiss how frequent flooding, which creates the malarial stagnant waters, and the Upper Silesians' daily contact with infected animal products or rotting vegetables, typhus cultivators, created the necessary environments for the pathogens of such endemic diseases to proliferate. However, unlike his predecessors had before him, he did not stop there, but rather scientifically probed more deeply into the complexities that created such an environment. Yes, the Upper Silesian territory's humidity, impermeable clay soil, and frequent flooding promoted the spread of disease, but why were Silesians building houses in such flood-prone areas? Yes, coming in contact with infected animals and rotting vegetables increased the incidence of typhus, but why were so many Silesians in contact with infected animals and rotting

vegetables? As a scientist, Virchow asked these questions, but it was as a historian, anthropologist, statistical analyst, political scientist, and economist—all constituents of a public healthcare worker—that he sought their answers.

Virchow discovered that the Silesians who were building houses in the flood plains were the middle and lower class people who did not have the status to build their houses on higher grounds. In Upper Silesia, he observed, "The church occupies the highest and most favorable spot; then follow the houses of the wealthy, the city proper, or in the country, the farmsteads; deepest down, sometimes in the middle of the pasture land, stand the hovels of the cottagers, and from the towns the suburbs extend far down into the valleys. At every flooding, whenever the waters rise, these houses in the lower locations are most affected" (Virchow 1848: 20-1.) In this way, the architectural topography reflected the social hierarchy of Upper Silesia, which, as Virchow pointed out, placed the church at its apex. Specifically, this was the Catholic Church, whose theocratic oppression of the Upper Silesian people was another factor Virchow listed as a contributor to the typhus epidemic. On this topic, he said, without reservation, "Be it clear that I do not wish to accuse individual members of the clergy of having made a cruel and inhuman use of their spiritual powers, but no one can deny that so powerful a hierarchy, which the people obeyed so blindly, could have fostered a certain mental development in the people, had it so wished. But it lies in the interest of the mother church to keep the people bigoted, stupid and dependent" (Virchow 1848: 16.) How did these characteristics of the Silesians being "bigoted, stupid and dependent" lead to a typhus epidemic? Virchow

contemplated, “Many trustworthy persons have assured me that the people had been facing death with certain confidence, as death would relieve them of this miserable life and assure them of compensation by heavenly joys. When someone became ill he did not look to the physician but to the priest. For if the holy sacraments would not help, what could these miserable medicines achieve?” (Virchow 1848: 15.) The “compensation by heavenly joys” poor Silesians were expecting upon death was in reference to the beatitudes, particularly, “*‘Blessed are you who are poor, for yours is the kingdom of God’*” (Luke 6:21-3, 2001: 107 New Testament.) The beatitudes were, and still are today, commonplace dicta of Catholic sermons, and Virchow observed that for people whose lives were as “miserable” as the Upper Silesians’, the spiritual comfort of splendor after death that priests promised them was preferable to any physical comfort doctors could offer them that would only sustain their impoverished condition in life.

But how did so many Upper Silesians come to such poverty? To answer this, Virchow explored both concurrent and historical processes. Shortly before the epidemic outbreak, there was a rapid increase in the number of dwelling occupants between 1843 and 1847 followed by a series of unyielding potato harvests (Virchow 1848: 15.) Therefore, not only were Silesian houses overcrowded, but also there was not enough *“zur*,” the common dish of Silesia consisting of sauerkraut, buttermilk, potatoes, and flour, to feed their occupants (Virchow 1848: 21.) Virchow described the cramped living conditions of the dwellings in detail, depicting them as “blockhouses” whose “living space is usually small, about 6 or 8-

12 feet square, mostly 5-6 feet high" with a floor made of loam (Virchow 1848: 21.) To make matters worse, only the wealthy Silesians could afford "separate stables and barns," forcing the families that were "prosperous enough" to own livestock to have to share most of their house with them (Virchow 1848: 15.) Considering all of these factors: the location of overcrowded houses in the floodplain, famine, and the constant exposure to animal products and waste, typhus and malaria quickly became endemic. But Virchow didn't stop there, and instead went even further by asking, where was assistance from the Prussian governmental authorities?

Upon further inquiry, he placed the blame for Silesians' current impoverished conditions upon the Prussian government's neglect of Upper Silesia, which he attributed to either its "reprehensible ignorance of local conditions," or, worse, to its "intentional" dereliction of responsibility to this province whose Polish descent was held in contempt (Virchow 1848: 15.) When governmental authorities finally did provide assistance to the most impoverished Silesians—who amounted to 20,000 or 1/3 of the entire Upper Silesian population—it was in the form of a daily pound of flour per person (Virchow 1848: 21.) For people who had been subsisting—and not even that—on only "green clover, couch-grass, diseased and rotten potatoes, etc.," this was a futile gesture as they had nothing but water with which to mix the flour (Virchow 1848: 21.) What is more, Virchow contended that the "administrative hierarchy knew well how to use" the Silesians' ardent Catholicism, and that "the government medical councilor in Oppeln, Mr. Lorinser, did everything calculated to encourage these tendencies by operating under the

official line that [physicians] were not needed and that the [Silesian] people did not want them" (Virchow 1848: 15.) In this way, Virchow equated the Prussian government encouraging the Silesians' preference of priests to doctors with the medical malpractice of conscientious negligence.

Historically, Virchow placed the blame for the origin of the Silesians' impoverished conditions upon the "villeinage," or feudal serfdom to the wealthy Silesian landowners that Prussian legislation had not protected Upper Silesians from until 1846 (Virchow 1848: 18.) Recounting the conditions of servitude, Virchow said, "These unfortunate people had to render compulsory service to the landlord proprietors as house servants for 5-6 days a week, and there barely remained one day in which they could take care of their small field and family" (Virchow 1848: 18.) When legislation was finally passed that prevented them from being exploited so, however, Silesians were still unable to improve their livelihoods because villeinage had engrained in them a "learned" behavior "not to care for the morrow, but only for the day" (Virchow 1848: 18.) Previously in the report, Virchow conveyed German contempt for the Polish people, specifically Upper Silesians, by stating:

> The Upper Silesian in general does not wash himself at all, but leaves it to celestial providence to free his body occasionally by a heavy shower of rain from the crusts of dirt accumulated on it. Vermin of all kinds, especially lice, are permanent guests on his body. As great as this squalor is for the sloth of the people, their antipathy for mental and physical exertion, their overwhelming penchant for idleness or rather for lying around, which, coupled with a completely canine subservience, is so repulsive to any free man accustomed

> to work that he feels disgust rather than pity. (Virchow 1848, 14)

The fact that Virchow observed that vermin, "especially lice," plagued the Upper Silesians suffering from the typhus epidemic sixty-one years before the physician and microbiologist Charles-Jules-Henri Nicolle would even discover that the louse was the vector of typhus in 1909 lends credit to Virchow's precociousness relative to other scientists and physicians of his time (Schultz and Moren 2009: 1520.) Nonetheless, Virchow's condescension toward the Upper Silesians definitively placed him within the context of his period. The strong, negative connotations of the words "vermin," "squalor," "sloth," "idleness," "canine subservience," "repulsive," and "disgust," acutely relayed the disdain Germans displayed toward the Upper Silesians in the mid-nineteenth century.

However, after discussing the historical process of villeinage and how most Silesians were, until 1846, "downtrodden and subjugated for centuries" and "imprisoned" by this "inimical power," Virchow *excused* such "repulsive" behavior with the rhetorical question, "After so many days of work spent only for the benefit of others, what was more natural than to spend the one day that was their own for resting in idleness and slumbering on their beloved oven?" (Virchow 1848: 18.) Furthermore, he patronizingly explained their continuation of this behavior after liberation from this indentured servitude by saying that there was "no one there to act as their friend, their teacher, or their guardian and to support, instruct, and guide them in their firsts steps on the new road" (Virchow 1848: 18.)

In hindsight, this patronization seems erroneous and marks Virchow as a man of the nineteenth century era of imperialism. However, Virchow's decision against allotting "the filth and sloth of Upper Silesians are Polish" as "national traits" marks him instead as a revolutionary man because he chose patronization over racism. More importantly, this same ability to look past the Upper Silesians' racial differences allowed him to also look beyond the immediate, scientific conditions of the typhus epidemic and analyze also the historical, cultural, economic, social processes that could have created those conditions. In this way, this report stands as a manifestation of Virchow's contribution to both medical science and public health that has accredited him as "At one and the same time father of pathology and father of social medicine" (Eisenberg 1986: 243.) Virchow's ability to both focus in on the scientific, emic causes of disease as well as step back and use this same deductive reasoning to observe the socioeconomic, etic causes allowed him to perceive that the derivation of disease from squalid conditions on the biological level is a consequence of etic, macroscopic social inequalities on the social level. Thus, in order to ameliorate the incidence and prevalence of diseases, Virchow's dual emic and etic perspectives in 1848 supports the establishment of healthcare as a public good that is needed to eliminate the social inequalities that facilitate their spread today.

Henry E. Sigerist's Advocacy for Socialized Medicine: Expanding the Temporally Emic Analysis of Public Health to Observe its Etic, Historical Trends

More than half a century after Virchow, Henry E. Sigerist expanded the temporally emic analysis of healthcare by observing and extrapolating its etic, historical trends to advance the implementation of socialized healthcare systems. As gathered from *Making Medical History: The Life and Times of Henry E. Sigerist*, edited by Elizabeth Fee and Theodore M. Brown, Sigerists' advocacy for socialized medicine distinguished him as a man before his times; as such a man, the waves he made only started to be felt years after his passing and, arguably, are still just being felt today. Having obtained his medical degree before making his name in medical history, Sigerist grounded his arguments for healthcare reform by contextualizing historical trends. In the same vein of Sigerist's approach, to understand the immediate impact of Sigerist's ideas, his Marxist interpretation of history must be placed within the framework of the growing anti-communist trends of American society after WWII. However, during the metamorphic state of the U.S. legislation in the years surrounding the New Deal of the Roosevelt administration prior to WWII, Sigerist became the "chief advocate" of both compulsory national health insurance and socialized medicine (Fee 1997: 197.) But for what, exactly, did he advocate? Sigerist's vision of socialized medicine consisted of three parts: salary incomes for physicians, national healthcare insurance for all, and the prioritization of health over disease.

First, Sigerist asserted the need for physicians to have a salary income in order to "emancipat[e] medicine from the cash-nexus of the *laissez faire* market economy" (Porter and Porter 1988: 93.) In Sigerist's own words, "'It is unworthy of his professional standing for the physician to be forced to express the value of each individual service in terms of money, as if he were a storekeeper….It is an insult to their profession….Are physicians really supposed to be inferior to professors, judges, or clergymen? Those whose minds are on riches had better join the stock exchange'" (Fee 1997: 201.) By placing the "profession" of the physician alongside those of "professors," "judges," and "clergymen," Sigerist is evoking the etymology of the word "profession," originating from the Latin word "professio" meaning "to publically declare" which had encompassed the three realms of medicine, law, and the church—the three main fields of public service ("Profession.") The significance in this correlation lies within the premise of public service's morality, which is upheld by its public avowal to accountability. Sigerist contended that the fee-for-service system of healthcare is an "insult" to the profession of a physician because, when the morality of all physicians' professional services has been publically declared through their unanimous M.D. title, any monetary value assignment made privately to a individual physician's service undermines the ethicality of the entire profession by holding them unequal. This distinction, while slight in rhetoric, is all but slight in practice: it is the difference between a private physician earning a living based on individuals' diseases and the public physician earning a living based on the health of society as a whole.

Ironically, while Sigerist claims that a salaried national healthcare system is progressive, his evocation of the initial usage of the word "profession" suggests a return to the times when physicians, like lawyers, judges, and clergymen, avowed themselves to the good of the public rather than to that of the individual. To be more specific, Sigerist claimed that a salary-based income would make it so that "'there is nothing to interfere with the relationship between them and their patients,'" whereas the capitalist's preference for the "'free choice of physicians'" only "permits the patient to consult incompetent doctors if he so desires" (Fee 1997: 214.) By privately assigning monetary values to medical services, even if there is a freedom of choice in the provider of those services, the value of the medical service is less because the worth of the medical profession is undermined.

Secondly, Sigerist's vision of socialized medicine included a compulsory national health insurance plan that covered all Americans regardless of class. He simply states his stance in the 1938 *Yale Review* article "Socialized Medicine," in which "he asserted that people had a right to healthcare and that society had a responsibility to take care of its members" (Fee 1997: 209.) Such an "ideal medical care system" would include large focal points consisting of hospitals and public health departments, supported by surrounding, smaller local clinics, in turn supported by surrounding community organizations on which they could depend to collect health data and dispense health education (Fee 1997: 209.) Under this system, all health workers would receive a tax-paid salary income, ensuring not only optimal care for each patient for free, but also the integrity of the medical profession

Sigerist so highly valued. Furthermore, this system would resolve the dilemma of "over-specialization" Sigerist found in the American medical system because healthcare workers would all be working together to the overarching goal—improving the overall wellbeing of the public—instead of seeking to solve individual ailments independently, ineffectively, and inefficiently (Fee 1997: 202.)

This holistic approach, transgressing the rigid boundaries of federal and state jurisdictions, is based on the interdependency of medical treatment and preventative public health measures. This leads to the third component of Sigerist's vision of socialized medicine—the prioritization of health over disease in the American medical system. Alternatively put, America's exclusive focus on treating disease has restricted the physician's role to restoring people to health as opposed to also maintaining their health. This lends support to the projection that, if the emphasis of the American healthcare system were shifted to the preventative measures of public health over the treatment of disease, the American population would be overall healthier. Furthermore, in a fee-per-service healthcare system that focuses on the medical treatment of disease, the more patients with diseases that need treatment, the more services physicians must provide, and thus the more fees the patients pay. In such a system, the doctor profits from the ill health of the public and the public pays for their ill health. Conversely, if the public paid taxes to have a national healthcare system that paid the salaries of healthcare workers, the incentive to have an unhealthy disease-riddled public would be removed and the public would be investing in their health instead of paying for their illness. Sigerist

reached this understanding by comparing the healthcare systems of the Soviet Union and the United States. In 1937 he defended his book *Socialized Medicine* in a letter by saying that healthcare in Russia was based on "the idea to supervise man medically from the moment of conception to the moment of death and to concentrate all efforts on prevention of disease (Hutchinson 1997: 249). Four years prior, he wrote in his diary that healthcare under the "capitalist system" of the United States was simply "barbaric" because "preventative medicine is not possible" (Hutchinson 1997: 231.)

Sigerist grounded his tripartite vision of healthcare in his Marxist interpretation of historical trends, arguing that socialized medicine was progressive and thus was inevitable. Having first obtained his medical degree in 1917, Sigerist elected to pursue medical history under the guidance of the first medical historian, Karl Sudhoff, at the Leipzig Institute of the History of Medicine in Germany. And while Sigerist distinguished between the academic fields of medicine and medical history, he did not view their application as mutually exclusive, but rather placed the latter's significance within the context of the former's contemporary issues (Falk 1958: 214.) Thus, by juxtaposing the trends of medical history with the topical problems of healthcare, Sigerist was a pioneer of the mostly unexplored realm of medical sociology. As Theodore M. Brown notes, Sigerist's published works make "abundantly clear that much of his interest in medical history had shifted to exploring the social context of health status and health services. Historical analysis could reveal the social determinants of health and disease in the past, just as

comparative contemporary study could reveal those determinants in the present" (Brown 1997: 321.) Just as an individual patient's medical history is critical to the diagnosis and treatment of his current condition, so too is a society's medical history essential to the identification of public healthcare issues and the policy needed to ameliorate them (Tempkin 1997: 129; Staden 1997: 136.)

In this way, Sigerist, a man who studied medicine in times past, could also be a man before his time. To show, in his own words, how Sigerist's new approach of contextualizing medical history was distinct from those of previous historians, is a diary entry Sigerist made on August 20, 1943, "They [Cushing, Welch, Klebs, Fulton, et. al.] all belong to the Osler school of *historia amabilis*. They 'had a good time' studying history. Their subjects were limited and never offensive….My history is anything but *amabilis*, but is meant to be stirring, to drive people to action" (Brown and Fee 1997: 333.) A derivative of the Latin word, "amare," meaning "to love," the *historia amabilis* academics studied the past for the pure enjoyment of the richness of its narrative (*MyEtymology.*) Alternatively, while Sigerist's "love" for the past was equal to his those in the "Osler school of *historia amabilis*," his was based upon its ability to predict the future in order to improve the state of current affairs. In other words, Sigerist was dissatisfied with the present, and so he used his love of the past to shape the future. He did not study history to merely have "'a good time'" as an individual academic, but rather to make times better for society as a whole. But how did he do this, exactly? As he says in his book *Forschungsinstitute*, Sigerist groups himself together with the clinicians of his time, August Bier, Ferdinand Sauerbruch,

and Ludolf von Krehl, as the creators of at the Leipzig Institute when he says, "We approached history from a point of view that had shifted 180 degrees. The fundamental questions did not arise from the past or from individual cultural epochs but from living medicine. The point at issue was to form from a specialized research institute a general medical institute which dealt with the history of medicine not as an end in itself but as a method of inquiry" (Kästner 1997: 46.) The "180 degree" is a reference to the change in the objective of medical history that Sigerist signified: instead of trying to answer questions about the past using the hindsight of the present, Sigerist tried to answer questions about the present using the foresight of the past.

But this new approach was not unilateral; almost immediately upon overtaking Sudhoff as the head of the Leipzig Institute in 1925, Sigerist "opened the Leipzig Institute to interdisciplinary debate on the burning issues in medical science, turning it into an open forum for discussion" (Kästner 1997: 46.) Thus, Sigerist transformed the Leipzig Institute of the History of Medicine into a hub among other universities, such as the Institute of Social and Universal History, Egyptological Institute, and the Leipzig Medical Society (Kästner 1997: 51.) An example of such academic solidarity is the *Kyklos* symbol under which Sigerist had the institutes' research findings published. Sigerist explains the symbol's significance in "Erinnerungen an meine Leipziger Tätigkeit" when he says:

> The triangle symbolized the working program of the institute, the connection between medicine, history, and philosophy. Above it was the elongated Omega, leading to a circle.

> This was to express the thought that when medicine, conscious of its historical position and permeated by philosophy, is guided by the intellect, then the pathway to a better and more perfect medicine results, expressed by the circle. (Kästner 1997: 48)

Figure 1. Kyklos Symbol of the Leipzig Institute of the History of Medicine

Herein lies the revolutionary vision of Sigerist's work: the holism of his historiographical approach to contemporary medical issues. However, just like all revolutionary concepts, Sigerist's ideas were often criticized and their manifestation as changes in policy was widely resisted, especially by the American Medical Association.

Sigerist's beliefs were first truly resisted in the 1930s as the Weimer Republic began to decline and the Nazi party's influence grew throughout Germany (Käster 1997: 56.) A social democrat, Sigerist had officially declared his support for the Weimar Republic in 1926, and had even thrown two students out of his classroom at the Leipzig Institute for wearing Nazi uniforms (Käster 1997: 56.) Furthermore, while Germany was suffering from exorbitant inflation, the Social Democratic Party's platform of "community health care, uniform social insurance, planned distributions in both town and country, and the creation of a central board

of health" no longer were economically feasible (Käster 1997: 54.) Consequently, when Sigerist was offered the deanship at Johns Hopkins Institute of the History of Medicine after he had taken a "lecture and study tour in the United States," he accepted the position and immediately moved to Baltimore.

In the United States, Sigerist became a prominent figure in the promotion of socialized medicine, specifically advocating the inclusion of compulsory health insurance into the New Deal, and in so doing became the "spokesman for the left wing of the medical profession" (Fee 1997: 199.) However, to his own detriment, Sigerist also publicly admired the healthcare system in the Soviet Union, most notably with his book *Socialized Medicine in the Soviet Union*, which was published in 1937, two years before the Nazi-Soviet pact was formed and the Soviet Union invaded Finland (Fee 1997: 199.) Advocating for the implementation of socialized medicine in America, Sigerist contended that such reform was progressive because "historical trends supported moves in the direction of more structured and rational forms of medical care" (Fee 1997: 204.) However, Sigerist's predilection for the realization of such "historical trends" to be the Soviet medical system blinded him from seeing its many faults until only the last years of Stalin's reign (Hutchinson 1997: 251.) As the historian John Hutchinson observed, "Sigerist's belief in the necessity for state control over all aspects of medicine ultimately made him an apologist for state control over more aspects of human life, as his Stalinist hosts were the first to appreciate" (Hutchinson 1997: 252.) But many others, including the American Medical Association (AMA) and the FBI, were much quicker to see faults

in the Soviet medical system, and by association, in the reasoning on which Sigerist's support for it was based (Beeson 1997: 114.)

Sigerist faced the opposition of the AMA first in 1934 when he became part of the Technical Committee on Medical Care, which was to advise President Roosevelt on the inclusion of health insurance with Social Security in the New Deal (Fee 1997: 202-3.) Yielding to the massive resistance to its inclusion led by the AMA, Roosevelt withdrew health insurance from the New Deal, but that did not prevent medical cooperatives from forming with the help of Sigerist's approbation (Fee 1997: 205.) The AMA, however, made the perpetuation of such medical cooperatives extremely difficult because it wielded the power "to control hospital appointments, deny rebellious physicians admitting privileges, and therefore deprive their patients of hospital care" (Fee 1997: 205-6.) Sigerist's battle with the AMA and empathetic pharmaceutical and drug companies continued into 1943, with the first introduction of the Wagner-Murray-Dingell Bill, which proposed including national health insurance again with Social Security, but in a more compromised form by strictly limiting the number of days per year health care would be covered (Fee 1997: 215.) Such compromises proved futile, however: the bill did not pass, and although it was repeatedly proposed in subsequent years, Sigerist was no longer in an official position to support it (Palmer.)

In the months immediately following his induction into the Committee for the Nation's Health, the Civil Service Commission accused Sigerist "of belonging to

'Communist front' organizations and of displaying too much interest in the political and economic theories of Communism" and thus his government employment was terminated because "he did not 'measure up to the general standards of suitability and fitness maintained for government employees'" (Fee 1997: 216.) Although acquitted at his hearing, Sigerist was disenchanted with America and its politics, and retreated into reclusion to write the *History of Medicine* before retiring to Switzerland in 1947 before he could be further maligned by the "witch-hunts" of McCarthyism in the 1950s (Fee 1997: 217.) Although he was a "self-proclaimed Marxist," Sigerist was never a member of the Communist party (Brown 1997: 288.) And while he "he positively reveled in the combative rhetoric of class warfare," as John Hutchinson puts it, Sigerist was only guilty of siding with the losers in the struggle for healthcare equality. "'Our place,' he once wrote—referring to the fellow academics—'is with the coal miners and stevedores, not with the bankers and industrialists'" (Hutchinson 1997: 252.)

And so, just as Sigerist studied contemporary issues within the context of historic trends, so too must the appraisal of his influence today be placed within the context of the increasing alignment toward the McCarthyian anti-Communist—specifically anti-Soviet—prejudice in American politics, and society as a whole, after WWII. Furthermore, Sigerist was an academic and never in a political position to effect change himself, but played purely advisory roles to those who could. And yet, in spite of the limits of his political authority, Sigerist optimized the little faculty he did possess through the prolificacy of his published works and public statements.

For example, Sigerist gave multiple radio talks throughout his lifetime at a time when radio was the most common conveyer of news to the largest number of people. Such a talk took place in January of 1940, when Sigerist professed the wide range of socialized medical reform in the United States on the radio broadcasting to millions of American listeners (Fee 1997: 212.) And while not all who heard Sigerist speak listened to what he said, the innumerable students of his who were deeply influenced by his lectures and his countless colleagues, many of whom he maintained correspondence with in Switzerland, did listen, and were moved to action. Many of these students and colleagues did rise to positions where they could effect medical reform, including Andrija Štampar—the first director of the World Health Organization, and the prominent medical Historians Leslie Falk, George Rosen, and René Sand (Fee 1997: 217.) So, by the measurable standard of comparing the number of books and articles he published while at Johns Hopkins—472—to the number of his ideas that manifested as ratified national policy reform in the United States during his lifetime—0, Henry Sigerist was a failure (Miller 1997: 78.) He bet "on the wrong horse" by applauding the socialized medical system of the Soviet Union, and for this the U.S. Civil Service Commission discredited his ability to advise the American government (Worthington.) Moreover, toward the end of his tenure at Johns Hopkins, his political activism had estranged him from many members of the academic community, especially those of his own administration who were made "uncomfortable" by the "letters arrived from conservative medical alumni, deeply offended that their alma mater was sheltering a 'radical communist' who might poison the minds of young physicians" (Fee 1997: 215.)

But such a parochial assessment of the influence of such broad-minded man would not only be unjust, but it would also be unjustifiable. Henry E. Sigerist was not a failure because he successfully inspired others to action both during his time and still today. This success is not tangible, and is by no means quantifiable, but it is still legitimate. He set processes of change in motion, whether directly through his own work or indirectly through those he inspired or the organizations he influenced, like the American Association for the History of Medicine—which he transformed into a national, professional organization—and the *Bulletin of the History of Medicine*, which he founded in 1933 (Fee and Brown 1997: 343 and 337.) Sigerist's tripartite vision of socialized medicine, consisting of salary incomes for physicians, national healthcare insurance for all, and the prioritization of health over disease, was brilliant for its holistic historiographical approach to healthcare, but it was before it's time. As Henry Sigerist himself once said, "'The optional subject of the history of medicine is also meant to install an idealism into the young students of medicine, an idealism more desirable than ever and without which life would not be worth living'" (Bickel 1997: 32.) Although he may have failed to make his own ideals manifest because of the anti-socialist prejudice of his time, he did share his idealism with countless others. His farsighted, temporally etic analysis of the historical trends of healthcare in juxtaposition to his emic analysis of its concurrent state allowed him to foresee its vast potential fulfilled by the implementation of socialized healthcare systems. In this way, Henry Sigerist was a man before his times—not because his ideal of establishing healthcare as a public

good failed to take form in policy change during his times, but because the times in which his ideals take form is still to come.

Paul Farmer's Vision of Socialized Healthcare: Expanding Reductionist, Emic Analyses to Observe Multifaceted, Etic forms of Structural Violence

Like his predecessors Rudolf Virchow and Henry Sigerist, Paul Farmer—a man of our times—carries on the torch of socialized medicine by expanding the reductionist, "bacterio-centric" emic analyses of new antidrug resistant strains to observe how they are manifestations of etic forms of structural violence (Roswell 1889: 9.) Born in 1959, Paul Farmer has since made his name in the field of global health by starting the nonprofit organization Partners In Health, or PIH (Kidder 2004: 47). Farmer and his associates founded PIH in 1988 with the mission to redistribute the medicine and medical technology of affluent countries to the impoverished ones that lack them, starting with Haiti and spreading to others such as Peru, Rwanda, and Russia, among others ("Global Health" 2012.) Inspired by Rudolf Virchow—the father of public health who said the "physician is the natural attorney of the poor" (Farmer et al. 2006: 378) and Gustavo Gutierrez—the father of liberation theology who propagated the phrase "preferential option for the poor" (Gutiérrez 1988: xxv), Farmer presents a new argument for the establishment of healthcare that is grounded in social justice. In this way, Farmer combines the

biosocial analysis of Virchow with the historical one of Sigerist to contend current biological phenomena—particularly the diseases of tuberculosis and AIDS—are not merely caused by historical "structural violence," but rather they are also manifestations of them (Farmer, Nizeye, Stulac, Keshavjee 2006: 376.) And because the pathologies of these diseases transverse all geographic and disciplinary realms, they in turn require international transdisciplinary analyses and solutions—manifestations of structural justice.

But what exactly is "structural violence"? Quoting sociologist John Galtung, Farmer denotes structural violence to be "'avoidable impairment of fundamental human needs,' embedded in longstanding 'ubiquitous social structures, normalized by stable institutions and regular experience'" such as unequal "access to resources, political power, education, and health care" and other hyper-macroscopic "social forces beyond the control" of the people they oppress (Farmer et al. 2006: 378.) What is more, Farmer says that because such structures are "embedded in the economic organization of the world," they are "invisible," hidden in plain sight by habituation to inequality. And these forces are not novel, but rather, as Farmer puts it, "historically given and economically driven," and they will remain in place so long as "Racism of one form or another, gender inequality, and, above all, brute poverty in the face of affluence are linked to social plans and programs ranging from slavery to the current quest for unbridled growth" (Farmer 2001, 2004: 373.) These were the same forces, although described differently, to which Virchow attributed the typhus epidemic in his 1848 "Report on the Typhus Epidemic in Upper Silesia" and

Sigerist combated with his 1943 proposal of the Wagner-Murray-Dingell Bill. And yet, there is one major distinction between the contexts of the structural violence in the times of Sigerist and Virchow as compared to now: the advent of antibiotics in the mid-twentieth century and of antiretrovirals since.

Structural violence has not only unequally distributed diseases to the poor, but also has unequally allocated their treatments to the wealthy. In other words, structural violence not only inflicts diseases upon the poor, but also denies them the medicine needed to treat these diseases. A comparison between the prevalence amongst demographic populations of "social" diseases such as tuberculosis, which Farmer abbreviates as "TB," before and after effective treatment was developed shows that processes of structural violence have exacerbated inequalities (Farmer, Nizeye, Stulac, Keshavjee 2006: 376.) Quoting the observations of René and Jean Dubos who described tuberculosis in 1952 after antibiotics were first prescribed for tuberculosis on a mass scale, Farmer says that while tuberculosis was "'a minor problem in certain parts of the United States, extremely high rates still prevail[ed] in the colored population'" (Farmer 2000: 224.) Here, the structural violence form of racism segregated those who received antibiotic treatment—the white population—from those who didn't—the black population.

However, the continued prevalence of tuberculosis not "distributed merely by race" within American poor populations suggests that additional forms of structural violence have contributed to its unequal prevalence amongst other

demographic populations (Farmer 2000: 224.) Again in reference to the writings of René and Jean Dubos, Farmer states that, "Within racial categories, differential risk remained the rule. Among whites, these authors noted, the case-fatality rate was 'almost seven times higher among unskilled laborers than among professional persons.' Ironically, then, the advent of effective therapy seems to have further entrenched this striking variation in disease distribution and outcomes. Inequalities operated both locally and globally: the 'TB outcome gap' between rich and poor grew, and so too did the outcome gap between rich countries and poor countries" (Farmer 2000: 224.) The significantly higher distribution of tuberculosis amongst the "unskilled laborers" in comparison to the skilled ones within the white population in the United States shows that the structural violence form of prerogative had denied poorer populations the access to antibiotics just as the structural violence form of racism had denied colored populations access to them as well.

Furthermore, Farmer argues that the "'TB outcome gap'" observed between the wealthy and poor within the United States was amplified on an international level so much so that, while tuberculosis was almost eliminated from the wealthy, white populations of affluent countries, it was being anything but eliminated in the impoverished and colored populations of poorer ones. In this way, the "'TB outcome gap'" has not only become wider, but it has also become deeper and thus more difficult to amend. As opposed to using the term structural violence to categorize the widening of inequality differences, Farmer uses the term "structural sin" to

characterize our inability to rectify medical injustices. For example, in a recorded conversation between Paul Farmer and Gustavo Gutierrez, Farmer says, "As science and technology advance, our structural sin deepens…. Another way of putting this is that, as the effectiveness of medical interventions increases, our failure to use such interventions justly, our failure to make preferential option for the poor in medicine, compounds the problem by widening the outcome gap" ("Global Health" 2012.) In other words, as the healthcare of wealthy countries progresses forward, it leaves the poor countries farther behind.

This stark contrast between the tuberculosis prevalence in wealthy and poor countries is reflected in the language used to described tuberculosis. Recently, antibiotic resistant forms of it returned to the affluent countries all the while remaining the "world's leading infectious cause of preventable deaths" in poor countries, tuberculosis has been characterized as an "emerging social disease" (Farmer 1997: 189.) Farmer observes this ethnocentric rhetoric when he says, "It is therefore very interesting, from the perspective of a sociologist of science, to hear tuberculosis termed an 'emerging' infectious disease or a 'reemerging' disease. Tuberculosis never went away. Some people escaped it, that is all. The mortality rates globally have not shifted that significantly, although of course there have been massive local shifts. Only from a highly particularistic point of view—that of the wealthy nations—could one speak of tuberculosis as a disease that disappeared and then came back" (Farmer 2000: 250.) The terms "emerging" and "reemerging" convey affluent nation's ethnocentrism, but more so, their negligence for the

tuberculosis prevalence in poor countries. The negligence may not be intended, but it is present nonetheless, and is of significance. “One of the implications” of this negligence, as Farmer says, “clearly, is that one place for disease to ‘hide’ is among poor people, especially when the poor are socially and medically segregated from those whose deaths might be considered more significant” (Farmer 1997: 189.) Tuberculosis is able to remain hidden in plain sight because the structures of violence that facilitate its spread are hidden in plain sight as well. What is more, tuberculosis is so well hidden amongst the poor because the affluent countries are not looking for it there. Why? Just as Virchow argued that the high prevalence of typhus amongst the Upper Silesian populations was because they were held in contempt by Prussian principals, Farmer argues that tuberculosis remains prevalent in poor populations around the world because of the affluent countries’ belief that their deaths are not as “significant” as their wealthier counterparts.

In spite of the advent of effective medical treatment, because this social contempt for other demographic populations—both within and separated by national boundaries—has never gone away, the social diseases tuberculosis and typhus have never gone away either. But because of the unequal distribution of medicine that excluded the poor, antibiotic resistant forms of these diseases, such as of multi-drug resistant tuberculosis (MDRTB) have emerged since the invention of these treatments. As Farmer puts it, “The emerging phenomenon of acquired resistance to antibiotics—including antibacterial, antiviral, and antiparasitic agents—is perforce a biosocial process, one that began less than a century ago as

novel treatments were introduced" (Farmer, Nizeye, Stulac, Keshavjee 2006: 376.) Thus, antibiotic resistance is not merely caused by structural violence; it is also a manifestation of structural violence.

This distinction is small, but it is of the greatest importance. To offer a fitting analogy that emphasizes this, the distinction between thinking of structural violence as the cause for antibiotic resistance and thinking of it as also a the manifestation of antibiotic resistance is the same distinction that separates thinking of symptoms as caused by diseases and thinking of symptoms as manifestations of them as well. From the former perspective, the symptom is viewed as separate from the disease and thus may be treated, but not remedied, separately, whereas from the latter perspective, the symptom is a sign of disease, and cannot be remedied without treating the disease instead of the symptom alone. And just as a disease usually presents itself through more than one symptom, so too does structural violence manifest itself in more than one form. Racism and prerogative forms of structural violence are not its only two forms, but rather are just two heads of this many-headed Hydra beast which takes the form of scientific, social, economic, philosophic, and historical manifestations. Without a thorough comprehension of each of these forms, any unilateral attempt to eliminate one of these structures of violence will only yield more forms of structural violence to be combated.

First I will analyze the scientific form of structural violence, which presents itself in many facets. But before a better understanding scientific structural violence

may be gleaned, the science's ability to even be a form of structural violence must be established. According to Farmer, science can substantialize structural violence because it, in itself, is a social construct. On this he says, "The sociology of science often shows us how knowledge held to be scientific arises from unacknowledged ideological frameworks. Like other forms of knowledge, science is socially constructed: everything from research problem choice to the interpretation of data is influenced by the factors that influence other human affairs" (Farmer 2000: 262.) Although a signature trait of scientific reasoning is its standardization by removing all signs of human influence, this trait—the absence of human influence—is human influenced. Because of this, science is as much a social construction as religion, and with this socially engrained foundation, science can serve as a form of structural violence. Such an instance of scientific structural violence in medicine is the reduction of whole individuals, shaped by past and present experiences, to a series of molecular interactions.

Again, while this reductionism allows a physician the composure he or she needs to fully assess and understand the disease of an individual patient without emotional bias or distraction, the application of such microscopic measures on a macroscopic social scale results in a "gap" of knowledge due to the oversimplification of complex social derivations of disease. Farmer explains the cause of this "gap" when he says, "One reason for this gap is that the holy grail of modern medicine remains the search for the molecular basis of disease. While the practical yield of such circumscribed inquiry has been enormous, it has led to the

increasing 'desocialization' of scientific inquiry: a tendency to ask only biological questions about what are in fact biosocial phenomena" (Farmer, Nizeye, Stulac, Keshavjee 2006: 376.) Molecular analysis of diseases is necessary to understand the disease's pathology within the individual, but social analysis is also necessary to understand the disease's pathology within a population. Juxtaposing these biological and social analyses with one another, Farmer evokes the term "biosocial" to characterize a more accurate approach to studying medicine.

While this descriptor "biosocial" Farmer uses to denote the combination of biological and social analysis of disease is relatively new, its concept is anything but and may be credited to Virchow. Not only was Virchow the founder of cellular pathology and, more specifically, "microscopical pathology" (Weller 1921: 35), he was also one of the first to argue "the social origins of illness and the multifactorial etiology of epidemic" (Brown and Fee 2012: 2015.) And as an avid disciple of Virchow's works, Farmer uses the same biosocial analysis with which Virchow approached the typhus epidemic in Upper Silesia when he studies the incidence and prevalence of HIV/AIDS and tuberculosis amongst various populations.

However, Farmer goes beyond Virchow's contention that the incidence and prevalence of a pathogen is facilitated by the socioeconomic conditions, an alternative way of saying that structural violence causes disease instead of also being a manifestation of it. Instead, Farmer goes deeper, and argues that the incidence and prevalence of certain pathogenic strains—particular antibacterial and

antiretroviral resistant—are both caused by and are manifestations of structural violence. In the case of HIV, for example, Farmer says, "HIV attacks the immune system in only one way, but its course and outcome are shaped by social forces having little to do to with the universal pathophysiology of the disease. From the outset of acute HIV infection to the endgame of recurrent opportunistic infections, disease course is determined by whether or not post-exposure prophylaxis is available, whether or not the steady decline in immune function is hastened by concurrent illness or malnutrition, whether or not multiple HIV infections occur, whether or not tuberculosis is prevalent in the surrounding environment, whether or not prophylaxis for opportunistic infections is readily available, and whether or not antiretroviral therapy (ART) is offered to all those needing it" (Farmer, Nizeye, Stulac, Keshavjee 2006: 379.) The molecular attack of HIV upon an individual's immune system is the same, for the most part, across the human race and thus may be studied from the universally standardized approach of the science method; however, the outcome or "endgame" of an individual—even before he or she is HIV positive—is determined by the social variables Farmer mentions, such as "malnutrition," a reliably available source of antiretrovirals, and simultaneous infection by tuberculosis. Simply put, if HIV's molecular pathology is, but for a few rare exceptions, universally standard according to science, yet its outcome is socially variable, then molecular science alone is insufficient to understand the pathogenesis of this disease. Thus, any social application of an exclusively scientific analysis of HIV is a form of structural violence because, for all of science's emphasis upon controlled variables, its "desocialization" of HIV purposefully neglects the

social variables that determine this disease's outcome. But how can macroscopic social variables affect microscopic scientific molecules? Just asking this question has distinguished Farmer from the past public health advocates like Virchow and Sigerist, and he seeks an answer as well. For antibiotic resistant strains of HIV and tuberculosis, Farmer argues that these strains have developed because of a "socially induced molecular change" in the genetic sequencing of a strain that was previously cured by antibiotics (Farmer 2000: 250.) Such social instigators of molecular changes—social forms of structural violence—include neoliberalism, philosophical reductionism, and habituation to inequality.

Unlike the scientific form of structural violence, neoliberalism is far more conspicuous. Farmer defines "Neoliberal theology" to be the prioritization of "'cost-effectiveness'" of healthcare programs with the overarching goal of the "reduction of public health expenditures" rather than the reduction of a disease's incidence and prevalence (Farmer 2000: 253.) A serious consequence of neoliberalism is that it places clinical health care services—those offering medical treatment—in opposition of public health ones—those offering preventative services (Farmer 2000: 259.) Farmer denotes this consequence to be the "Luddite trap," which is the exclusive focus on either preventative or clinical care at the cost of the other, and thus at the cost of the lives of those dependent upon it (Farmer, Nizeye, Stulac, Keshavjee 2006: 388.) He says, "Prevention and care are best seen not as competing priorities but as complementary, even synergistic, endeavors. Yet international public health today is rife with false debates along precisely these lines; many of its practitioners have fallen into the Luddite trap. For decades, we have seen subtle

discussion of the chief social determinants of disease give way to bitter struggles over resource allocation" (Farmer, Nizeye, Stulac, Keshavjee 2006: 387.) To place this reference in context, the Luddites were a rebellious group of factory weavers in the nineteenth century who destroyed new factory weaving machines replacing them to prevent further unemployment; as a punishment for their actions, fourteen of the Luddites were hanged (Bloy.) The Luddites' efforts to reduce unemployment by destroying technology were done in vain, because, instead of achieving their goal of increased employment opportunities, they were executed and barely paused the advance of technology. Thus, the Luddite trap is the misplacement of efforts in reducing costs with the ramifications of exacerbating both the immediate problem and long-term problem. For healthcare, the Luddite trap of the focus on reducing costs is a death sentence for those who need treatment that isn't classified as "cost-effective" and, as in the case of multidrug-resistant tuberculosis (MDTB), decreases neither the incidence nor prevalence of the costly diseases in the first place. In the neoliberal market global economy today, the Luddite trap has ensnared almost all healthcare organizations to a certain degree. For example, the World Health Organization does not provide funding for the treatment of MDTB because it is more expensive to treat. Quoting the regimen of the WHO, Farmer states, "'In many high TB prevalence countries, second-line drugs are prohibitively expensive and unavailable…. Multidrug-resistant TB is therefore often untreatable'" (Farmer 2000: 259.) WHO does not say that it MDTB is untreatable because no drugs exist to treat it; rather, WHO states MDTB is untreatable because it would rather accrue the cost of the lives of people suffering from MDTB, as well as the cost of the lives of people

to whom MDTB will be transmitted, than the cost of the drugs needed to treat it and the measures needed to prevent its transmission. What is more, Farmer cites evidence that by not providing the needed drug regimen for multidrug-resistant tuberculosis strains and instead using only standardized "cost-effective" drug regimens in fact increases costs by exacerbating the problem. He says, "We had documented that repeated empiric regimens—that is, getting the same medicines again and again—were both ineffective and costly. These treatments were also a source of the acquired drug resistance, both by changing the genetics of the microbe and by changing the host, the human, whose lungs were damaged badly by ineffectively treated tuberculosis. These patients were not cured but continued to transmit increasingly resistant strains to others (Farmer 2000: 261.) The continuation of the WHO's "cost-effective" drug regimens to treat cases of multidrug-resistant tuberculosis in fact increases the drug resistance of these bacterial strains and therefore increases the cost of the correct drug regimens needed to treat them. In this way, the mutations that give these strains their antibiotic-resistance are manifestations of the neoliberal form of structural violence that denied the resources that would prevent them. Hence, this antibiotic-resistance is an example of a "socially induced molecular change" (Farmer 2000: 250.)

This example of classifying certain strains of diseases' treatment methods as "cost-effective" and others as not entails a second serious consequence of neoliberal structural violence: the commodification of medicine in turn is a commodification of life. Farmer summarizes this "enormous flaw in the dominant model of medical

care" when he says that "as long as medical services are sold as commodities, they will remain available on to those who can purchase them" (Farmer, Nizeye, Stulac, Keshavjee 2006: 388.) This argument, in addition to the one Sigerist made that the fee-for-service economic healthcare model of the United States has created a system where physicians profit from illness, are two sides of the same coin. By placing a value on drugs needed to treat an illness, the illness rather than good health is the source of profit. Moreover, because the limited financial accessibility of these drugs increases the value of them, the lives of the people who do not have financial accessibility to them decrease in value. To make matters worse, the increase in the price of drugs in some regions has, in turn, decreased the value of life there. Case in point, Farmer refers to one unnamed drug that is sold in Boston for thirty dollars a gram, in Peru for twenty-one dollars a gram, and in France for less than seven dollars a gram (Farmer 2000: 261.) The more expensive the price of a drug is in one region, the less the number of people there who can afford it and, consequently, the less valuable their lives. In this way, the regional differences in the pricing of the same pharmaceuticals have created a foreign exchange rate for the value of human life. But why has nothing been done to change this? Farmer answers, "Since TB is a disease that has not affected many people in affluent settings, there is no vocal lobby agitating around it. There are no organized patient groups. This in itself is sobering, since TB is the world's leading infectious killer. But the patients are poor and marginalized and therefore do not constitute an effective lobby" (Farmer 2000: 261.) Because healthcare is a commodity, there exist the lobbies of those who profit from the increase its monetary value, such as Big Pharma, in opposition to the

lobbies of those who suffer from its high costs and want to decrease its monetary value to increase its accessibility—the poor. Unfortunately, the a posteriori of neoliberalism indicates that money is power, and the people in poor countries who do not have it are subjected to the business practices in affluent countries of those that do.

This neoliberal form of structural violence that facilitates global inequality is further reinforced by a philosophical form of structural violence that legitimizes it. In this way, the physical, geographic distances that separate affluent countries from poor countries are compounded by metaphysical, socially constructed distances. This philosophical form of structural violence is best expressed by a question posed by Deen Chatterjee in his book *The Ethics of Assistance*: "'If we have duties and obligations toward each other in everyday moral contexts, should these duties be extended to the distant needy?'" (quoted in Farmer 2006: 529.) Under the assumption that social responsibility does exist, Chatterjee's question has two significant implications insinuated by the phrase "distant needy." The first word of this phrase, "distant," suggests limiting social responsibility to those who are socially constructed as "proximal" but not those who socially constructed as "distant" (Farmer 2006: 530.) Farmer condemns such philosophic social constructions because they depict a world that does not accurately reflect reality, which he says is "a world in which HIV and other pathogens spread readily across such boundaries while the fruits of science, including treatment, are blocked at customs" (Farmer 2006: 530.) The philosophical divisions between "proximal" and

"distant" legitimize neoliberal structural violence's concentration of wealth to affluent countries. But this philosophical form of structural violence does more than legitimize inequality; it also legitimizes negligence.

What is more, the terms "proximal" and "distant" not only convey the spatial separation between affluent and poor countries, but also convey the temporal separation between the immediate benefits of treatment as opposed to the far-off benefits of prevention. Just as to how scientists' focus limits them to analyze the microscopic origins of disease, physicians' training limits them to providing only the "proximal" spatial and temporal forms of treatment, causing them to consider preventative healthcare projects with "distant" spatial and future benefits as "'not our job'" (Farmer, Nizeye, Stulac, Keshavjee 2006: 387.) Farmer argues that this type of negligence of "distant" healthcare projects must be overcome when he states, "Although these are not the tasks for which the clinicians were trained, such projects are nonetheless central to the struggle to reduce premature suffering and death. The importance of such societal projects to the future of health care means that practitioners of medicine and public health must make common cause with others who are trained to intervene more proximally" (Farmer, Nizeye, Stulac, Keshavjee 2006: 389.) Programs for proximal treatment and distant prevention share the same goal: to improve the health of as many people as possible. In spite of this shared goal, however, they do not work together, and as a result, people's lives fall between the cracks that separate their efforts. This temporal separation leads to the second ramification of the phrase "distant needy." Because social responsibility

is divided between the proximal and distant, the historical cause of social responsibility—affluent countries' past exploitation of poor countries—is separated from its present effect—the obligation of the affluent countries to distribute their healthcare technology to the poor countries. This is conveyed by the word "needy," which is the result of an ahistorical philosophical interpretation of the status quo that neglects the "history of transnational resource flows" (Farmer 2006: 531.) Quoting the philosopher and political scientist Thomas Pogge to convey the error of this ahistorical perspective, Farmer says, "'By seeing the problem of poverty merely in terms of assistance, we overlook that our enormous economic advantage is deeply tainted by how it was accumulated over the course of one historical process that has devastated the societies and cultures of four continents'" (Farmer 2006: 531.) Placing the distribution of healthcare from affluent to poor countries in "terms of assistance" such as "needy" is ahistorical because it neglects that the colonialism and imperialism of the poor countries by the affluent countries is why they are in need of assistance. Like Sigerist, Farmer argues that future action must be based upon the present conditions placed within a historical context. By analyzing "how our world got to be the way it is and where it is going," we can see the temporal and spatial divisions between the proximal and distant collapse and those who were erroneously characterized as the "distant needy" are "more accurately described as our victim" and "remote citizen of another society" (Farmer 2006: 531.) And yet, because of these proximal and distant social constructions, countries, which in reality are only separated by national lines and oceans, are instead worlds apart in

practice when they are classified as belonging to the first, or developed, world, or to the third, or developing, world. ("Global Health" 2011.)

Like the result of any common practice, a habit has been formed. In this case, the result of practicing these temporal and spatial forms separation has led to a most serious form of structural violence: the habituation to inequality. In his "Report on the Typhus Epidemic in Upper Silesia," Virchow calls this a "habituation to misery" and a "hardening of feeling toward the sufferings of others" (Virchow 1848: 17.) Specifically, Virchow allotted this hardening of the local Prussian authorities to the sufferings of the Upper Silesians. He said, "It is the curse of humanity that it learns to tolerate even the most horrible situations by habituation, that it forgets the most shameful happenings in the daily shame of events, and that it can hardly understand when individuals aim to destroy this infamy" (Virchow 1848: 16.) By the statement, "[the curse of humanity] can hardly understand when individuals aim to destroy this infamy," Virchow is referring to the Prussian officials, who were "dulled by the daily sight of this sunken nation," who had objected to the distribution of one pound of flour to the starving Upper Silesians on the grounds that they would become "*spoiled*" (Virchow 1848: 16.) To convey his incredulity at the folly for such grounds of objection, Virchow utilized the literary devices of sarcasm and rhetorical questioning when he exclaimed, "When those who had nothing, absolutely nothing, to eat were allotted one pound of flour daily, it was feared they would be spoiled! Can one imagine something more frightful than the idea that somebody would be spoiled by a small handout of flour, mere flour alone, and that others would fear such a thing?" (Virchow 1848: 16-7.) Not only does

Virchow convey vast insight into this "habituation to suffering," but he also conveys profound farsightedness in his ability foresee its historical "infamy."

In spite of Virchow's keen farsightedness, however, Paul Farmer discusses the same problem, which he refers to as "socializ[ation]" instead of "habituation" one-hundred and sixty-three years after Virchow published his "Report on the Typhus Epidemic in Upper Silesia" ("Global Health" 2011.) In the same discussion with Father Gutierrez in which he discussed "structural sin," Farmer relates the first time he observed this form of structural violence while working in Haiti before he began Harvard medical school. There, in the clinic of a small, rural village of Mirebalais, he had assisted a young physician by taking the vital signs of patients. After Farmer had earned the trust of this physician, the physician confided to him that he thought the clinic was more like a "'mediocre medical factory'" than a healthcare provider because it had "'No lab, no real chance to examine the patients, or do more than the perfunctory work'" ("Global Health" 2011.) And yet, in spite of this physician's frustration, Farmer said, "he never did much to change it. The doctor, not yet thirty, was socialized for scarcity and failure, I came to understand, even as I had been socialized for plenty and for success. In other words, poverty had worked its way into his life, too, even though he was not poor" ("Global Health" 2011.) This statement reveals several integral concepts. First, the passive tense of the word "socialized" conveys the ubiquitous subjection of all people the practice of upholding the unequal standards of "scarcity and failure" in juxtaposition to those of "plenty" and "success." While other forms of structural violence—such as

neoliberalism and the social constructs of distance—enforce these unequal standards, the habituation to these standards is another form of structural violence in itself.

In medicine, the habituation to social inequality is the reason most physicians are ignorant of the social determinants of disease and thus is why many are negligent of the social remedies that are needed to ameliorate them. Case in point, according to Farmer, while many physicians understand how the "distribution and outcome of chronic infectious disease are so tightly linked to social arrangements," most of them have incorrectly ascribed these "social factors" to individual "'behaviors' or 'lifestyles' that place some at risk at AIDS, while others are shielded" (Farmer, Nizeye, Stulac, Keshavjee 2006: 378-9.) This is erroneous because, as Farmer says, "risk has never been determined solely by individual risk behaviors. Susceptibility to infection and poor outcomes is aggravated, instead, by social factors, including poverty, gender inequality, and racism. In less than a decade, AIDS became a disease afflicting America's poor, many of whom engaged in 'risk behaviors' at a far lower rate than others who were not at heightened risk of infection with sexually transmitted diseases" (Farmer, Nizeye, Stulac, Keshavjee 2006: 378-9.) In other words, attributing individual behaviors as the social determinants of AIDS is not only misplaced, but it diverts attention from the actual social determinants—"poverty, gender inequality, and racism"—while stigmatizing HIV-positive patients as "druggies" and "prostitutes"—effectively saying these

individuals have brought this disease upon themselves by engaging in risky behaviors.

What is more, many physicians are also erroneously attributing the emergence of antiretroviral-resistant strains of HIV to individual behaviors as well, specifically individuals' non-compliance with complex time and resource demanding drug regimens. This allocation of blame is wrong because, as Farmer simply puts it, "Throughout the world, those least likely to comply are those least able to comply" (Farmer 1997: 186.) Physicians' equating noncompliance with patients' inability to comply is inaccurate because it does not address the forms of structural violence that prevent many people from being able to comply as well as stigmatizes them as "lazy," "unreliable," and "irresponsible." In this way, structural violence undermines any progress in medical technology physicians and researchers make in combating antiretroviral-resistant strains of HIV by preventing HIV positive patients from regularly accessing the treatment they need. To provide an example of this phenomenon, Farmer points to a study made by Carlos del Rio and colleagues that focused on the efficacy of treatment provided by the Emory HIV Clinic located in Atlanta. Even for a "state-of-the-art HIV clinic," which was located "in an area close to the epicenter of the city AIDS epidemic" and benefited from the funding and research made by Emory University, "fewer than 15 percent of all patients offered ART could be shown to have suppressed viral loads only a year after the initiation of therapy" (Farmer, Nizeye, Stulac, Keshavjee 2006, 381.)

By a habituated scientific standpoint, the lack of measureable improvement of the majority of the patients given ART conveys their noncompliance with the rigorous ART drug regimen. And by this standpoint, the description of the study's focus as "a largely African American patient population with high rates of addiction, housing instability, and co-morbid disease" shows how physicians can be misguided to believe that noncompliance—and antiviral resistant HIV strains—is facilitated by the behaviors common to druggies, African Americans, the homeless, and co-morbidly ill people and thus may be remedied by behavioral solutions. Given that the etymological root of the word "science" is the Latin verb "scire," meaning "to know," it is hard for many physicians and researchers to understand how this scientific reduction of a complex disease could be so far from the truth (*Merriam-Webster*.) The lurking variable that scientists—physicians and researchers alike—are not recognizing is structural violence, and its form of habituation to poverty is what is preventing them from even recognizing this variable in the first place.

In the case of the study by Carlos del Rio, the impact of the state-of-the-art clinic was limited to its walls because, according to Farmer, it was limited *by* its walls. On this he says, "Like most U.S. clinical care, however, the services offered are largely within clinic walls: patients have to reach the clinic and remain in care in order to enjoy long-term benefit. As elsewhere, the dominant model is one in which patients are prescribed ART by physicians and then seen in follow-up by physicians, nurses, and even social workers within the facility, rather than in their homes or neighborhoods" (Farmer, Nizeye, Stulac, Keshavjee 2006, 381.) Farmer, who has

personally walked miles through the Haitian mountains to deliver medications to patients, contends that antiretroviral resistance cannot be attributed to patients' noncompliance in following antiretroviral drug regimens, but rather to physicians' and healthcare workers' noncompliance in making sure their patients get the antiretroviral treatment they need when they need it. To simply express this, Farmer says, "Throughout the world, those least likely to comply are those least able to comply" (Farmer 1997: 186.) Antiretroviral-resistant strains of HIV, as well as antibacterial-resistant strains of tuberculosis, are manifestations of physicians' and healthcare workers' habituation to inequality because they are the product of patients' unequal access to treatment.

On a similar note, just as the impact of the Emory Clinic, which was built to increase patients' access to antiretrovirals, was limited by its own self-imposed material and figurative walls, the analytical approach of structural violence is also limited by the very object of its condemnation—reductionism. One of the most respected voices of this opinion belongs to the sociologist Loïc Waquant from the New School for Social Research in New York, who, in a published response to Farmer's "An Anthropology of Structural Violence," stated that the concept of structural violence is "limited and limiting, even crippling" because it "threatens to stop inquiry where it should begin, that is, with distinguishing various species of violence and different structures of domination so as to trace the changing links between violence and difference rather than merging them into one catchall category liable to generate more moral heat than analytical light" (Waquant 2004:

322.) In other words, Wacquant believes that structural violence as an anthropological approach inaccurately assesses the cause and effect relationship between violence and inequality.

More explicitly, Waquant found three "major defects" with Farmer's analysis of structural violence present in Haiti (Waquant 2004: 322.) First, Wacquant contends that Farmer's definition of structural violence is inconsistent with the examples of structural violence he lists in this specific paper. He finds fault with Farmer's structural violence denotation's inclusion of "structures that are both 'sinful' and ostensibly 'nobody's fault'" as enabled by "the erasure of historical memory" and "other forms of desocialization" (Farmer 2004: 307.) Based upon this definition, Wacquant believes that the examples Farmer gives of structural violence in Haiti, specifically the "imposition by France of 'reparations' to slave owners and the diplomatic quarantine of the new republic by the United States, its military occupation of the island and steadfast support of a string of vicious dictatorships, and the recent delay of funding by the Inter-American Development Bank'" all have definitive culpable actors, and thus cannot be "'ostensibly 'nobody's fault" (Wacquant 2004: 322.) In this way, Wacquant claims that Farmer's definition of structural violence "somehow diffuses responsibility in order to expand its ambit" instead of promoting "the need for a multisited historical ethnography that would tie the contemporary social scenes of rural Haiti to the suites of the French monarchy, the U.S. state agencies, and the international bodies that have held the fate of the island [Haiti] in their grip" (Wacquant 2004: 322.) In other words,

Wacquant is saying that Farmer's definition of structural violence does not rigorously assign guilt to the actors responsible for both the historical and contemporary exploitation of Haiti nor does it accurately portray it.

Secondly, Wacquant claims that structural violence does not distinguish between the various forms of violence that lead to inequality. He contends that structural violence "conflates full-fledged domination with mere social disparity and then collapses forms of violence that need to be differentiated, such as physical, economic, political, and symbolic variants, or those wielded by state, market, and other social entities" (Wacquant 2004: 322.) In other words, Wacquant believes Farmer's characterization of structural violence in his paper "An Anthropology of Structural Violence" allots blame for Haiti's poverty to neither specific actors nor to specific anthropological domains.

Lastly, Wacquant asserts that Farmer's characterization of structural violence as "'sinful'" not only is sanctimonious, but also lacking contemporary context. On this he says that "the concept [of structural violence] is saturated with moral judgments that invite anachronism" (Wacquant 2004: 322.) He specifically points to Farmer's historical example of slavery in Haiti as a form of structural violence and contends it is an anachronism because "to declare it 'sinful' hardly accords with the full historical record that reveals it to be not a 'peculiar' institution but an embarrassingly banal one" (Wacquant 2004: 322.) In other words, Wacquant believes that the contemporary characterization of the historical institution of

slavery as "sinful" is an anachronism because it misplaces the dichotomy of "right" versus "wrong," which has only been developed by hindsight, in a time period when the practice of slavery was ubiquitous and therefore lacked such a dichotomy. In addition to "invit[ing] anachronism," the noun "violence," although abstract, in "structural violence" is a nominalization of aggressive action with the purpose of ethically polarizing the object and the subject. In this way, Farmer's entire analysis of structural violence rests on the implicit moral assumption that violence, of any sort, *is* wrong without addressing the question as to *why* it is wrong. This discrepancy allows Wacquant to declare Farmer's ethically charged analysis of structural violence generates "moral heat instead of shedding analytical light." Here, Wacquant is analogizing the concept of structural violence to friction, which futilely releases energy in the form heat, in juxtaposition to its intent to release energy in the form of light, a metaphor of anthropological enlightenment.

But, to offer an analogous metaphor for the counter-argument to Loic Wacquant's critique of structural violence, the friction created by the analysis of structural violence is needed in order to spark the flame anthropological enlightenment. In the case of healthcare, the concept of structural violence is a vital analytical tool to establishing healthcare as a public good. There is truth is each of Waquant's claims: Farmer's analysis of structural violence does not hold specific actors culpable, it does not distinguish between every form of structural violence, and its does not address its fundamental moral premise that healthcare is a human right.

Conclusion

With regards to the lattermost of Lacquant's claims, there is no contention. Farmer's argument, as well as those of Virchow and Sigerist, are all based upon the simple moral conviction that physician is obligated to provide care to those who need it. Given that 100% of U.S. medical school graduates today take some version of the Hippocratic Oath, this shared premise of these physicians' arguments is not the least suspect (Tyson 2013.) By the widely used, modernized version written in 1964 by Louis Lasagna, the then Academic Dean of the School of Medicine at Tufts University, medical school graduates across the nation swear:

> I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.
>
> I will prevent disease whenever I can, for prevention is preferable to cure.
>
> I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm. (Tyson 2013)

Here, the phrase "special obligations" is an indication of the moral responsibilities—specifically to "human beings" both "sound of mind and body as well as the infirm"—American physicians avow to uphold. Though the words of this vow have changed form since fifth century B.C. Greek physicians first swore it, its significance has not. So if its contemporary words do not have the same weight to American physicians today as those of the original, classical oath had to Greek physicians then, that is a reflection upon the degression of American medical ethos rather than upon the depreciation of the ethos conveyed by this oath. To reverse this trend so that the

reality of U.S. physicians' actions may accurately reflect their profession—both as an affirmation and a vocation—healthcare must be established as a public good in the United States. This will not be easy, and perhaps is not even possible. Nonetheless, as Paul Farmer tells the author Tracey Kidder in *Mountains Beyond Mountains*, the attempt to do so must be made all the same:

> How about if I say, I have fought for *my whole life* a long defeat. How about that? How about if I said, That's all it adds up to is defeat?. . .I have fought the long defeat and brought other people on to fight the long defeat, and I'm not going to stop because we keep losing. Now I actually think sometimes we may win. I don't dislike victory. . . .You know, people from our background—like you, like most PIH-ers, like me—we're used to being on a victory team, and actually what we're really trying to do in PIH is to make common cause with the *losers*. Those are two very different things. We want to be on the winning team, but at the *risk* of turning our backs on the losers, no, it's not worth it. So you fight the long defeat. (Kidder 2004: 288)

In other words, Paul Farmer, as well as Rudolf Virchow who said that "physicians are the natural attorneys of the poor" (quoted in Sigerist 1950: 93) and Henry Sigerist who said that the academics' place "'is with the coal miners and stevedores, not with the bankers and industrialists'" have fought the "long defeat" for the establishment of healthcare as a public good (Hutchinson 1997: 252.) By analyzing healthcare from the emic and etic perspectives, they were each able "to make common cause with the losers"—those who do not have equal access to healthcare—and argue on their behalf. Why? As Dr. Martin Luther King Jr. once said in his famous "Letter from a Birmingham Jail" written on April 16, 1963, "Injustice anywhere is a threat to justice everywhere" (King.) Although Dr. King's statement was in reference to the "injustice" of excluding civil rights from minorities mainly in

the Southern United States, its sentiment holds true for the injustice of excluding the right to healthcare access from those who cannot afford it. Therefore, it is for this reason that, until healthcare becomes accessible to all Americans by establishing it as a public good, all of those who already recognize it as thus must continue to "fight the long defeat."

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