PRAISE FOR *TO REPAIR THE WORLD*

"Whenever there is a need, Paul is the first guy out the door. His humility is legendary and one hundred percent genuine. Medical students all over the world have told me they entered our shared profession because of Dr. Paul Farmer. Now, it is time for the rest of the planet to be inspired, and in these pages they learn what it takes to repair the world."

—Sanjay Gupta, Chief Medical Correspondent at CNN and Associate Chief of Neurosurgery at Emory University School of Medicine

"Paul Farmer is the most compelling voice for justice in a generation. In this volume are the stories and insights that have helped thousands of students imagine—and fight for—a better world. Read this to be inspired. Read this to learn. Most importantly, when you're done, give this book to a friend and join the movement for health equity."

—Jonny Dorsey, cofounder of FACE AIDS and Global Health Corps

"This is a bold read by a humble visionary. For those who care about humanity, this is a handbook for the heart."

—Byron Pitts, Chief National Correspondent, CBS Evening News

To Repair the World

Paul Farmer
Speaks to the Next Generation

Edited by Jonathan Weigel

With a foreword by President Bill Clinton

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FOREWORD

PRESIDENT BILL CLINTON

I've learned that in addressing any country's—and the world's—most pressing challenges, competition can almost always be fruitful. This shouldn't be surprising; think of how often we hear calls for competitiveness in business, or how we value the achievements of a superior jazz musician or athlete. But while good policy will draw on this tension among competitors, to solve the great social problems before us, from climate change to pandemic disease, we know we need to turn from competition to cooperation and partnership. This is especially true when these problems afflict the poor and marginalized, as they disproportionally do. It's this unfair distribution of the world's hardships that Paul Farmer has spent thirty years addressing tirelessly as a physician, a teacher, and an increasingly influential policy voice. It was Paul's belief in the power of cooperation, across lines of nationality, class, language, and race, that led him to found Partners In Health while still a student at Harvard Medical School. That abiding belief and a call for

renewed engagement from young Americans lie at the heart of the speeches collected here in *To Repair the World.*

The truth is I was the last in my family to get to know Paul. When Hillary was First Lady, she brought him to the White House to discuss one of the gravest new health problems facing some regions of the world: highly drug-resistant tuberculosis. Paul had been tackling this disease in Haiti, Peru, and Russia, not only working to cure patients but also sounding the alarm that this is not a problem that will go away and will only grow with inaction—a prediction, like many Paul made in the nineties, that has unfortunately come to pass. When I read a *New Yorker* profile of Paul in 2000, I immediately called Chelsea to draw him to her attention. She told me she already knew him and said something I never forgot. He is, she told me, "our generation's Albert Schweitzer."

Since then I've been lucky enough to work closely with Paul for more than a decade in Haiti and also in settings as far-flung as Rwanda and Malawi. He has been not only one of my closest advisers regarding global health but also one of those rare people who, along with his Partners In Health team, is actually on the ground providing health care. Paul is never content merely to point out and deplore problems. Instead, he and his colleagues go to work on solving them, which is why, from South America to Siberia, Partners In Health is still involved in caring for some of the most marginalized people suffering with tuberculosis, AIDS, and other diseases of the poor.

AIDS was a major challenge for my administration and for anyone who, like Paul, was working as a physician in settings of poverty, inequality, and disruption. During my time in office we doubled the amount of funding going into AIDS research, focusing on building up a portfolio of solutions reaching from

basic science to clinical trials. All of us were rewarded for this investment when the number of effective drugs went from two in 1992 to more than two dozen in 2000. But rolling these discoveries and advances out to the rest of the world was, and remains, a monumental task, and one that led to Paul's second and more consequential trip to the White House, this time under a new administration.

When historians look back on George W. Bush's presidency, I'm inclined to think that they will agree with me that his leading contribution was PEPFAR, the President's Emergency Plan for AIDS Relief. What is less known is Paul's role in taking it from a concept—and what sounded to many like a pipe dream—to reality. When the Bush Administration began its due diligence on the draft policy, it called in physicians, including Paul and PIH, who were having remarkable success treating AIDS patients with antiretroviral therapy in rural Cange, Haiti. It put Cange on the policy map, earning a squatter settlement an improbable spot in the long history of fighting infectious diseases. It also set the stage for PEPFAR's success. PEPFAR has already saved millions of lives and is one of the reasons that PIH cofounder Dr. Jim Yong Kim went on to the World Health Organization to head up the "3 by 5" Initiative, seeking to put three million people on treatment by 2005.

When I left office, the prospect of millions of Africans on therapy was still a dream. One of the first things I did in 2002 was to start the Clinton HIV/AIDS Initiative, headed by Ira Magaziner. The first person I consulted was Paul, hard at work in rural Haiti. A few years later, understanding all too well that increased funding and decreased drug prices would not solve what Paul and Dr. Kim called "the delivery gap," we launched, jointly with PIH and local ministries of health, the Rural Africa

Initiative. This was designed to build up health care capacity in rural areas of Rwanda, Malawi, Lesotho, and Haiti, since AIDS is only one of many health problems in these settings. In Rwanda, PIH has worked closely with the Ministry of Health and with my foundation to expand primary care to a substantial fraction of that beautiful country's population. It's not by accident that last year Rwanda became one of the first two countries in sub-Saharan Africa to reach something close to universal access to AIDS therapy. The other country was wealthier Botswana. Rwanda is also the only country in the region on track to meet the Millennium Development Goals.

As AIDS, malaria, and tuberculosis take fewer lives and as life expectancy increases, new problems emerge. I was there not a year ago to cut the ribbon on what is probably rural Africa's first cancer treatment center, which the Ministry of Health opened with the help of many partners, including PIH and the Harvard hospitals where Paul works when not abroad. It is certainly one of the most lovely hospitals I have ever seen and stands as evidence of the potential that arises from the best kind of cooperation, from bringing together the skills and resources of the developed and developing worlds, of public and private entities, and of many countries, including the United States and Haiti.

In 2004, Haiti was disrupted by yet another coup, which made it difficult for me to work there, since CHAI only works in countries where we can partner with governments to have the greatest impact. As Paul and his family headed off to Rwanda, the PIH team continued its work in Haiti, expanding its public-private partnership across the country, from the Dominican border to the coast. A few years later, Paul called me from the drowned city of Gonaïves, hammered by four hurricanes in one month, asking what I might be able to do to help. Within

a few months, the Secretary General of the United Nations, Ban Ki-moon, named me the United Nations Special Envoy for Haiti. The idea was to bring in new partners to support Haitian businesses and entrepreneurs, since whatever one's political leanings, all agreed that it was Haiti's stagnant economy that had created an environment conducive to the kind of health problems Paul had seen for decades and also made the country particularly vulnerable to the impact of natural disasters. In the fall of 2009, Paul became my volunteer deputy and turned some of his talents and attention to improving policy around foreign aid for Haiti.

Then came the earthquake of January 12, 2010.

Paul and his family had just left Haiti, and we spoke that evening. I asked him to come immediately to the UN where I addressed the General Assembly: Haiti urgently needed the support of the world and also a sound plan for relief and reconstruction. With Hillary's help, we had Paul back in Haiti within a day, at first serving as a physician to the staggering number of earthquake victims and later as a policy expert to help Haiti "build back better." He has described this experience in another book, *Haiti After the Earthquake*, which vividly tells the story of that terrible time. The seismic disaster was followed by an epidemic of cholera, the first to affect Haiti in recorded memory, to which PIH brought vital scientific expertise, medical care, and investment in oral vaccines.

The speeches included in this book cover all these topics and many more, and they also reflect Paul's insistence as a lifelong teacher that young Americans—especially those privileged enough to attend our best universities and medical schools and who later move into the kind of roles he has pioneered—embrace his vision of a world of shared opportunity and shared responsi-

bility. I've often said in print and in person that the explosion of private citizens doing public good is the most meaningful trend of our times, which is why I strongly believe Paul's efforts should be recognized by a Nobel Prize, to inspire other bright young men and women to follow in his footsteps.

Paul's personal strengths—his commitment to justice, his determination to fight on behalf of the poor, his tenacity in following up with patients and families, his dogged focus on making good policies and seeing them through to implementation, and his immense reservoir of optimism—make him the ideal teacher of how to change the way we see the world and how each of us can do the kinds of things he does in our local communities or halfway around the world. The essence of Paul Farmer's inspiration is here in these pages, as it is in every chapter of his life so far and will be in the days and years to come.

INTRODUCTION

JONATHAN WEIGEL

Anyone who has heard Dr. Paul Farmer speak knows the pull of his stories, the speed of his wit, and the force of his vision. When he describes the work of Partners In Health (PIH) in Haiti or Rwanda or Russia, we can't suppress the feeling that he's figured out what it means to do the right thing, to make the world a better place. It's inspiring. It's also uncomfortable because that right thing rarely resembles what we do every day. He makes us face poverty and injustice, which most of the time we are content to ignore. He makes us pay attention to people suffering, sometimes dying, from diseases for which we could pick up treatments in a corner pharmacy. We can't help asking ourselves what we, each of us, might do to help lessen such towering inequity.

This book is a collection of some of Paul's most memorable speeches, at university graduations and other public venues. Unlike many of his writings in clinical medicine, global public health, and anthropology, these are written principally for a general audience and especially for young people considering what

path to tread in the years that await them.[1] We hope this volume will make Paul's vision of social justice and radical solidarity with the world's poor accessible to readers from all walks of life.

I. "YOU GUYS ARE MY HEROES"

I met Paul when he came to speak at my high school in 2005. We were excited to meet a person of such stature and were prepared to be impressed and inspired. But we were not at all prepared for how funny he was, how he seemed to look each of us straight in the eye with the full weight of his big personality, how he got away with being so sincere and so passionate, how he made complicated ideas accessible and exciting, how he made us feel like peers, partners, coconspirators.

His presentation detailed PIH's efforts to provide AIDS treatment in an impoverished squatter settlement in rural Haiti. I was moved and inspired and more than a little uncomfortable. My planner was filled with biology classes, piano lessons, cross-country practice, and other things wholly alien to the hard-scrabble life Paul described in Haiti. My main goal was getting into college. Should I harness the good fortune of my privileged upbringing to work on behalf of those born in less fortunate circumstances thousands of miles away?

At one point, someone asked him an awkward, perhaps impertinent question: what is it like to be a hero? "Well," he said without hesitation, "you guys are my heroes," referring to all of us packed in the auditorium, which was overflowing into the hall. "In fact, you're my retirement plan." Maybe it sounds trite now, but we could tell he meant it. Paul Farmer was in high demand as a speaker nationally and internationally; he wouldn't have made the effort to come to our high school if he didn't believe that stu-

dents had a key role to play in the movement for global health equity.

This realization—that students were protagonists in Paul Farmer's vision of a more humane world—became clearer when I arrived at Harvard College a year later. In between running a department at the Medical School, a division at Brigham and Women's Hospital, a center at the School of Public Health, and of course continuing the work and expansion of Partners In Health, Paul and PIH cofounder Dr. Jim Yong Kim made time to advise a global health student group I joined. Sometimes they asked us to organize events; sometimes they solicited our advice about new courses they were developing; always they were eager to learn how to draw more students toward global health. The point is that they took us seriously. We weren't just pesky students asking for good grades and recommendation letters (though we were all that, too); we were partners in something big and important.

My senior year, Paul, Jim, and Dr. Arthur Kleinman, who had taught Paul and Jim as doctoral students, offered a new class.[2] It was just what we had asked for: a comprehensive introduction to global health. The professors had lines out the door every week during office hours, but they stuck around until all of our questions had been answered. (I would later learn that, much to the bewilderment and occasional consternation of his staff, Paul regularly delayed "real" meetings and flights to stay in office hours until we students had had our fill.)

I started working on Paul's team at Partners In Health a year later. Orientation consisted of a one-line Blackberry-typed email from the doctor himself: "It's going to be a baptism by fire." No one could have said it better. Paul is all in, all the time. And everyone who works with him feels inspired—compelled—to

do the same. I soon found myself helping Paul prepare for lectures, editing books and articles, and accompanying Paul as he traversed the globe, building an army of young people dedicated to fighting social injustice.

II. COUNTERING FAILURES OF IMAGINATION

Six weeks into the job, cholera appeared in Haiti for the first time in at least a hundred years. This nineteenth-century disease persisted throughout the twentieth and early twenty-first centuries in many settings where poverty also persisted. But somehow Haiti—long labeled the "poorest country in the Western Hemisphere"—had been spared until October 2010, nine months after a magnitude 7.0 earthquake leveled much of the capital city, Port-au-Prince. Within days of the cholera outbreak, it looked unlikely that the local and international response in Haiti would be sufficient to prevent great suffering and death. Paul immediately got to work, seeking to reverse the cruel fate that seemed to await this beleaguered country in which he's worked for three decades.

In Paul's class, we had learned how failures of imagination undermined global efforts to respond to AIDS, tuberculosis, cancer, and other modern plagues.[3] When dealing with the health problems of the poor, public health policymakers often adhere so strictly to the doctrine of "cost-effectiveness"—a valuable tool for setting priorities, but just one tool among many—that responses to the big challenges in global health are anemic. Only inexpensive medical care is deemed appropriate for settings of poverty. Paul has a pithy expression for this perverse outcome: "cheap shit for the poor." (He left that one out during class.)

When used in a vacuum, cost-effectiveness analysis at times produces incorrect and unethical claims. To cite just one example, a 2002 study concluded that in Africa it is 28 times more cost-effective to prevent new HIV infections than to treat people who already have AIDS.[4] The authors thus effectively recommended letting 25 million people—all those living with AIDS in Africa at the time—die because they thought it would be too expensive to save them. How could well-meaning people make such a monstrous (and ill-founded) suggestion? Is anyone authorized to wield instruments like cost-effectiveness analysis with such certainty when so many human lives are at stake? These are questions Paul takes up throughout this volume.

The short answer is that claims such as these are failures of imagination. The authors of the 2002 paper arrived at their conclusion by treating "cost" and "effectiveness" as givens, but both turned out to be highly variable. Consider cost. Within a decade, the cost of AIDS therapy dropped from $10,000 per patient per year to less than $100 per patient per year. Meanwhile, AIDS drugs proved more effective than initially thought. Not only do multidrug regimens suppress the virus indefinitely, they also reduce transmission by 96 percent.[5] Put simply: treatment works as prevention, too. Today more than 8 million people are on treatment worldwide; some 6 million of them live in Africa.[6] Few experts of any stripe could have imagined, in 2002, just how cost-effective AIDS treatment really is.

As this example reveals, global public health experts have sometimes become the tools of their tools, to paraphrase Thoreau.[7] This is a problem when dealing with lethal infectious diseases that cross borders and burn through the ranks of the poor. The quick fix will never be enough to contain the really difficult diseases or protect the populations most vulnerable to them.

We learned this lesson, once again, in Haiti. In late 2010, the World Health Organization and other public health heavyweights got to work making policy recommendations about cholera in Haiti. Instead of using every weapon in the arsenal, as would have happened had the disease appeared in the United States or any other wealthy country, the post-quake aid apparatus balked, opting to promote certain interventions over others. In particular, oral cholera vaccine was ruled out as "too expensive" or "too complex to deliver" in Haiti. As Paul's students know, these are precisely the arguments used to lowball the global response to malaria, drug-resistant tuberculosis, AIDS, heart disease, mental illness, and many other afflictions of the world's poor. And they are spurious arguments: the vaccine is administered orally and costs only $3.70 for the two required doses; increased production would lower prices even further. Providing health care doesn't get much easier than that. Accompanying Paul from policy meetings in New York to cholera treatment facilities in Haiti, I felt like I had a ringside seat as the latest installment in the sorry history of global health ran its course.

Predictably, the cheaper approach did not stop cholera. Within weeks, the epidemic had spread across the country, tracing a grim map of the scarce access to safe drinking water and modern sanitation across Haiti. Thousands have since perished from a disease that can in most cases be treated with simple rehydration, and transmission continues at alarming rates. The epidemic in Haiti is now the world's largest in half a century.

Could a more forceful and a truly comprehensive response—one that integrated cholera vaccine with other interventions—have stopped cholera? We'll never know, but surely it would have

slowed the pace of the epidemic. It might have saved thousands of lives.

A year and a half after cholera hit Haiti, PIH finally got the green light to roll out a modest vaccination campaign in conjunction with its Haitian sister organization, the Haitian Ministry of Health, and another Haitian medical nonprofit. From April to June 2012, about 100,000 Haitians received the two-dose vaccine course in rural and urban Haiti. It is too early to claim success, but the news has been only positive to date: demand for the vaccine is high in the population, and the Ministry plans to scale up the campaign across the country with support from the United Nations and many other organizations. The World Health Organization recently endorsed the initiative, too. Long-term control of cholera will require building robust water and sanitation systems across Haiti, which will take time.[8] In the interim, it would be foolish not to use every weapon we've got to help slow the world's worst cholera epidemic in recent memory.

Failures of imagination—claiming that you can't treat AIDS in Africa or that you can't deliver cholera vaccine in Haiti—and what we can do to reverse them are, in my mind, what this book is all about.

III. ACCOMPANIMENT

Why is it acceptable to lower our standards when considering the health problems of the poor? How might we usher in a bolder chapter in the history of global health? The speeches in the first section ask readers to think hard about these questions. Paul encourages us to *reimagine* equity: what kind of world do we want to live in? What might our world look like if the next generations

take poverty and inequality seriously? What kind of movement will it take to bring this vision into being?

One necessary part of a movement for global health equity is a cohort of medical professionals dedicated to serving the poor. In Paul's commencement speeches at medical schools, many of which appear in the second section, he asks new doctors to keep in mind the big picture: all that lies beyond cutting-edge laboratories and clinical facilities. The upper echelons of health research and practice in the wealthy world embody the promise of modern medicine. But without an equity plan, that promise remains unrealized to billions of people around the world—the very people who shoulder the lion's share of the burden of disease. Paul isn't calling for everyone to drop what they're doing and start working on the frontlines of global health. He's always been a stalwart cheerleader for scientific innovation, and commends all those who devote their lives to pushing the frontier. He just asks that every member of the medical professions, broadly defined, remember that even the greatest therapeutic or diagnostic breakthroughs will mean little unless they reach the people they were designed to help.

Paul also encourages new doctors to remember the importance of old-school caregiving.[9] He sums up the simple business of caring for others—visiting them in their homes, helping them fill prescriptions, washing their dishes—in a word that appears throughout this volume: accompaniment. Doctors and nurses and community health workers should, Paul suggests, be *accompagnateurs* (a word adopted from Haitian Creole) to their patients. The practice of accompaniment is one of the main reasons why PIH achieves outstanding clinical outcomes when treating complex diseases like cancer, drug-resistant tuberculosis, AIDS, and depression in some of the poorest parts of the

world.[10] By attending to the social and economic deficits that deny billions of people fundamental human rights—the topic of this book's third section—PIH teams attack ill health at its root: poverty, joblessness, homelessness, hunger, decrepit schools and hospitals, a lack of municipal water and sanitation systems. As Paul reminds medical school graduates, accompaniment isn't just humane practice; it's best practice.

But, as the speeches in the fourth section make clear, accompaniment goes well beyond the clinical realm. Paul sees in it a new model for all "aid" work. What does "accompaniment" really mean? Although it might at first seem simple, I think it is among the most difficult concepts to grasp in the speeches that follow. But there might be no more important principle animating Paul's work and vision. In his own words, then:

> "Accompaniment" is an elastic term. It has a basic, everyday meaning. To accompany someone is to go somewhere with him or her, to break bread together, to be present on a journey with a beginning and an end. . . . There's an element of mystery, of openness, of trust, in accompaniment. The companion, the *accompagnateur*, says, "I'll go with you and support you on your journey wherever it leads. I'll share your fate for a while"— and by "a while," I don't mean a little while. Accompaniment is about sticking with a task until it's deemed completed—not by the *accompagnateur*, but by the person being accompanied.[11]

Accompaniment is different from aid. "Aid" connotes a short-term, one-way encounter: one person helps, and another is helped. Accompaniment seeks to abandon the temporal and directional nature of aid; it implies an open-ended commitment to another, a partnership in the deepest sense of the word.

Partners In Health was founded on the notion of accompaniment. Paul, and everyone at PIH, pledged to take this lon-

ger, more unpredictable road in serving the poor. They brought resources—medical, human, financial—but instead of imposing their own agenda on their intended beneficiaries, they formed partnerships and resolved always to accompany, not to lead. PIH sought to replace the hubris of traditional foreign assistance with humility, trust, patience, and constancy—to replace aid with accompaniment.

This is not an easy approach. It entails radical availability. (Paul rarely stops working, despite frequent attempts by friends and family to get him to take a vacation.) It means investing in ambitious projects that take years to complete and are unlikely to produce frequent bursts of measurable outcome data, as demanded by many donors concerned with impact evaluation.[12] And it means always trying again when projects fail. "It's not easy to admit, even today," Paul writes in one of the speeches in this volume. "We tried and mostly failed. . . . Haunted by mediocrity, we keep returning to the task of raising the standard of care."[13] This dogged commitment to doing whatever it takes to give the poor a fair shake is the essence of accompaniment.

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Over the last two years, I've learned a little bit about what it means to be an accompagnateur. Paul is the first to say that everyone needs accompaniment, and that includes Paul, the consummate accompagnateur himself. Beneath his irrepressible good humor lie enormous cares and, as he describes in the speeches that follow, doubts and fears. Trying to be his accompagnateur isn't easy for any of us on his team. Despite regular all-nighters and feverish last-minute scrambles, it is hard to catch up to Paul's steady, burning commitment to fighting injustice. We struggle with feeling inadequate, frustrated, and trivial; some-

times we want to leave work with an evening ahead. "Radical availability" is a physical, mental, and emotional challenge. With time, however, I realized that even small steps toward a more inclusive and compassionate vision, toward accompaniment of any measure, can earn you membership in Paul's army.

Probably none of us can do as much as Paul Farmer has done to bend the arc of history toward justice. But as Paul reminds us throughout this volume, no matter what paths we tread, each of us can strive in some way, however small, to be an accompagnateur to those who have not been blessed by good health and good fortune. And in so doing, we are, one baby step at a time, helping to repair the world. If my generation and the generations that follow take Paul's entreaty to heart, I have little doubt we can expand the promise of modernity—the chance at a life free from poverty and premature death and unnecessary suffering—and move the world toward equity, peace, and prosperity.

PART I

Reimagining Equity

For most of us, the phrase "modern medicine" brings to mind the rapid development of health interventions since the mid-twentieth century and the sharp declines in mortality they have brought to many parts of the world. And it should. The progress of medicine and public health in the last sixty years has been nothing short of stunning. But such cheering often obscures the fact that so many simply don't have access to health care, period. This was the take-home message, as my medical students say, of the first speech in this volume, "General Anesthesia for the (Young Doctor's) Soul."

Anesthesia is more than a metaphor here. Diminution of pain, whether during childbirth or during the course of surgical intervention, is the goal of anesthesia. Lessening suffering can be seen as a quest of modernity and even as a marker of civilization.[1]

When historian Drew Faust described the American civil war as "the late middle ages of medicine," she meant that the mechanization of war outpaced any real ability to lessen either the suffering of the injured or the infectious complications of

overcrowding and battlefield surgery.[2] Of the estimated 750,000 killed during this conflict, most were felled by "camp epidemics"—typhoid fever topped the list—or by staphylococcal and streptococcal complications of wounds and amputations. This was indeed the dark ages of medicine and public health.

Great progress has been made since 1865. We have seen remarkable technological advances in biomedicine; plagues that once claimed countless lives are now treatable and sometimes preventable. The difference between 1865 and the present holds in one concept: triage. The line drawn between those with a chance of survival and those given up for dead has been steadily pulled in, with more and more desperate cases becoming manageable cases.

But the fruits of modern medicine have been slow to reach those in greatest need of them: the poor and otherwise vulnerable. Poverty operates its own triage on civilian populations. The poor are saddled with the greatest share of disability and disease even as they are deemed less worthy objects of health care by a medical establishment that privileges *ability to pay* over *need*. In settings of privation, medical personnel are socialized for scarcity and failure in a way reminiscent of the practitioners of battlefield medicine in ages past. We are urged to avoid "wasting" resources on groups of people who are not expected to make significant improvement. In the face of such stinginess, doctors and nurses working in settings of poverty must resist the impoverishment of aspirations.[3]

This ratcheting down of expectations for the sick and poor takes us in the opposite direction from the proper aspiration of all global health work: a world in which the poor and sick get their fair share of our planet's vast resources, medical and otherwise. But the medical profession has too often left equity for others to worry about.[4]

We fail to think about equity because we are anesthetized. This kind of anesthesia—the bad kind—occurs chiefly because we live in a violently unequal world. In the speeches reprinted here, I've drawn a distinction between *event violence,* such as war and genocide, and the insidious *structural violence* that accompanies poverty and inequalities of all sorts. Psychological, moral, or economic anesthesia dulls us most effectively to structural violence. We interpret disparities in health and income and good fortune as "the way things are." Structural violence is never anybody's fault.

Inequalities of risk and outcome—and our toleration of them—are evidence of the effectiveness of such anesthesia. When giving a graduation speech, one is speaking to an audience of people who have been socialized for success: graduates of top-tier American universities and their families. Most have not seen battlefields, nor have they lived in settings of impoverishment and instability, which can be found in every country. Many have, however, visited or worked briefly in such places, and some have struggled with an alienation common among young people of privilege who are beginning to understand their good fortune. Some turn away from the work of repairing the world because of the pain of this alienation; others, because of the many discomforts, not all of them psychological, that are native to social justice work. I was invaded by similar feelings and doubts during my first years in rural Haiti and experienced them again more than 25 years later, when that country, my greatest teacher, was hit by an earthquake that took a quarter of a million lives.

How to bring focus and reflection to issues of equity and anesthesia? Perhaps stories communicate best. Most of these speeches, from "General Anesthesia for the (Young Doctor's) Soul" (2001) to "Countering Failures of Imagination" (2012) turn on personal experiences, my own or others'. I haven't wanted

to cause pain—to withdraw anesthesia—but to make room for awareness of some ugly facts we all know anyway, to some degree. It's my conviction that poverty and inequality are the two ranking problems facing our crowded and beautiful planet—not the only problems, but perhaps the most severe, and two that, if addressed, could bring us a little closer to tackling some of the other ones.

General Anesthesia for the (Young Doctor's) Soul?

Brown Medical School, Commencement

MAY 28, 2001

Last Monday, sitting in clinic in rural Haiti, I realized that I was sweating for two reasons. One, it was seasonably hot. We always sweat in clinic. Two, I was frightened about giving this address. The fear itself had two sources. One, it's a great privilege to be here on this day, the day of your oath taking and transformation. Two, most graduation speeches are boring and forgettable. (Some are memorable largely because they are so boring.)

This latter realization struck fear in my heart. I sat there, hearing the multitudes outside, and tried hard to think of a single scrap, a word, an idea from a commencement address heard in high school, college, medical school, or grad school. But not one of them stuck. I say this apologetically, of course, since good things must have been said. I was inattentive or perhaps engaged in overly robust celebration afterward. I'm not sure what happened, but it was neither a neurologic nor a vascular event that erased these speeches. (Nor, I must add as an infectious disease guy, was it an embolic event.) The speeches never got logged in!

On that Monday, I knew I had one week to find what might be called the roach-motel approach: speeches check in, but they don't check out. How could I find a way to get in your heads and stay?

On Tuesday, I did a literature search. We don't have access to MEDLINE in rural Haiti, so I went into my own library.[5] I've been living in Haiti for a long time, so let's just say I have a big, if uneven, collection. Graduation, graduation. I remembered something from the English writer P. G. Wodehouse about a memorable graduation speech. It was a story of a certain Augustus Fink-Nottle, a bookish herpetologist who's gang-pressed into delivering the commencement speech at a boys' school. I recalled that Gussie, like yours truly, was terrified and did something, I couldn't remember what, to make it memorable.

After clinic was over, I found the story. Rereading it did not inspire calm. In fact, where I'd once laughed, I now found myself sweating and trembling. Fink-Nottle, normally an abstemious chap, had gotten smashed before going on stage. Gussie proceeded to insult distinguished members of the audience and to accuse the winner of the prize for scripture knowledge of cheating after the kid failed to answer the question "Who was What's-His-Name—the chap who begat Thingummy?" Wodehouse draws conclusions about speeches: "It just shows what any member of Parliament will tell you, that if you want real oratory, the preliminary noggin is essential. Unless pie-eyed, you cannot hope to grip."[6]

This counsel did not help me grip. Getting pie-eyed in the morning would be frightening enough even when you don't have to drive from Boston to Providence. Surely there was something else I could do if I wanted to make a memorable point or two?

I scarcely slept on Tuesday night, as my nightmares included a slurred speech punctuated by insults to your dean.

On Wednesday, I decided to base my Brown intervention on data. The problem called, clearly, for more research. I mean, what sort of Harvard faculty could conclude otherwise? I conducted a double-blind, controlled study of the entire population of central Haiti. I flew in a large research team and expensive consultants from the Harvard School of Public Health.

The survey showed a statistically significant correlation between amnesia and graduation speeches. Granted, the N was small: this was central Haiti, where not many have had the privilege of going to high school, much less graduate school. But chi-square tests do not lie: the picture was grim if I followed the norms. I trembled with fear, not malarial rigors. Would I have to do what Gussie Fink-Nottle had done? Do you need a designated driver in order to deliver a good graduation speech?

On Thursday, I fasted and prayed. I lit incense. I chanted and sat in the lotus position until I had bilateral nerve palsies. The medical staff and patients wondered what on earth was wrong, since I am usually a rather reliable guy. And still no inspiration came.

On Friday, I bit the bullet and did what we do in internal medicine: I called a consult.

Deep in the Haitian hills there lives a wise woman. She's called a "mambo," which translates in Hollywood-speak to "voodoo priestess." I've known her for years, and she's said to have an answer for everything. She's a bit like the woman who bakes cookies in *The Matrix*, and especially so on that day as she was sitting on a low chair stirring something in a charred pot.

I laid out my dilemma. A pregnant pause ensued; my mambo friend did not look up from her work.