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Response to Petchesky - 2

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Response

Janet Serie

I am grateful for the opportunity to study and respond to Rosalind Petchesky's thoughtful analysis of the impact of globalization on women's health. In my remarks, I will pose a question for Dr. Petchesky's consideration, and offer a perspective on a central theme expressed consistently throughout the Roundtable: that the current practice of addressing health concerns in the absence of their socially embedded influences is inadequate and a new, multi-sectoral approach is needed.

At the outset, I must come clean on my credentials by admitting that I am, alas, a mere biologist, and as such, I am not well versed in the data and theories that form the basis of Petchesky's claims. As an immunologist, I am far more used to analyses of the molecular world, where interactions are no less complex than in the realm of global economic development, but at least are governed by the predictable physical laws of the universe. Things are not so tidy in the realm of social science where individual humans struggle to survive, care for their kin, and enjoy their lives within the context of local, regional, and now global forces that influence, and, in many cases, dictate their fate.

Thus, I bring a naïve perspective to the central thesis of the first portion of Petchesky's essay. Here she claims that, while the World Bank is to be commended for making poverty reduction the centerpiece of its new agenda for global economic development, by failing to challenge the centrality of the private sector in health care system reform, the World Bank is bound to fall short of the endorsed goals of the Cairo and Beijing Conferences that conceived of women's health as a human right, including social and economic justice. This orientation is especially pernicious in light of the weakening of the state's ability to provide social services and education (due to a shift of economic resources toward the corporate sector in an attempt to attract capital investment in a highly competitive global economy). Petchesky further argues that, without a strong government hand to provide services that are considered to be a "pure public good" (i.e., not profitable), and to temper the tendency of unfettered capitalism to exaggerate disparities in wealth, much of the social welfare of nations will fall to the private sector where both incentives and accountability are driven by capitalist principles including the notions of scarcity and competition

for health care as a commodity and not by principles of social welfare and human rights.

To an American who is deeply critical of this country's health care policy, which currently leaves 44 million of its citizens without adequate access to health care, the World Bank's perspective seems all too familiar. I am left to wonder if this perspective is heavily influenced by the role of the United States in policy formation at the World Bank, or if it is based on a realistic analysis of health care economics in developing nations. In the United States, our failure to provide universal health care is due, in part, to our tradition of individualism and underdeveloped sense of collective fate. It is not due to a lack of national wealth or a bottom-heavy demographic or socioeconomic profile, or to the overwhelming burden of malnutrition, unchecked infectious disease, or civil war. However, at least one and sometimes all of these conditions exist in the nations aided by the World Bank. Given the hegemony of capitalist principles now and in the foreseeable future, is it economically feasible to craft a viable system of universal health care without forging alliances with the private sector?

In her introductory remarks, Petchesky details the growing disparity between public and private wealth, citing the finding by Barker and Mander that more than half of the world's one hundred largest economies are corporate conglomerates, not countries. The transfer of wealth from public to private coffers seems likely to continue hand-in-hand with global capital expansion. Many public health measures, such as programs of vaccination, improvement in water quality, basic nutritional support, and reproductive health checks and education, are relatively inexpensive, and might be managed through public investment. Such improvements in public health, already seen by the World Bank as a "pure public good," and therefore unquestionably the responsibility of the state, would greatly enhance women's health and quality of life. Curative medicine, on the other hand, is enormously expensive, especially if it involves the basic tools of Western medicine such as a full range of diagnostic tests and pharmaceutical and surgical therapies. To be sure, some relief from this burden could be negotiated through partnerships with community-based healers, including the adoption of many traditional healing methods that are effective but dismissed out of hand by Western medicine. However, if the level of curative medical care enjoyed in the West is to be a goal for all, how can this realistically be attained without the significant resources of the private sector? Collectively, corporations are likely to hold and gener-

ate the surplus wealth required for economic development. In addition, corporations in the health care sector play a vital role in making the agents of Western medicine available to the public. Regardless of the source of payment, the therapeutic agents that make Western curative medicine so effective are produced, virtually exclusively, in the corporate sector. It seems that partnerships with corporations involving philanthropy as well as at least the promise of a future health care market economy are required. I would like to hear more about alternative paradigms through which poor nations with heavy economic and disease burdens have made or could make the transition to a modern social democracy in which universal curative medical care is provided from public coffers.

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I would like to turn now to the latter portion of Petchesky's thoughtful critique of the inadequacy of health sector reform in meeting the real health needs of real women. Petchesky's central thesis here is that, in compartmentalizing women's health and separating it from the economic, cultural, and domestic realities of women's lives, institutions fail to craft effective systems that have a significant impact on health and genuine quality of life. Physical and mental health can only be fully attained when women gain full agency in their lives, free of the threat of violence, mutilation, sexual slavery, starvation, dislocation, and forced pregnancy. In many cases, women's oppression, including lack of access to education, meaningful employment, and economic autonomy, is a greater threat to women's health than the bias-free assaults of infectious disease.

In fact, those of you who have attended other sessions in this Roundtable can now see a kind of consensus developing around this issue. Dr. Davis's comprehensive analysis centered on the thesis that the physical and social environment is a major factor in assessing the health potential and status of populations. Continuing this theme, Dr Nef began his remarks on health security in Latin America by claiming that "the role of academic analysis is not to simplify complexity, but (rather) to make complexity intelligible." He challenged us to adopt an "ecosystemic paradigm"—a view that extends across traditional but artificial boundaries that divide the seamless subjective experience of life into non-intersecting categories such as health, education, family, and culture.

I agree with this analysis, and would like to bring these ideas a bit closer to home by arguing that the removal of the concept of "women's health" from the context of women's lives is deeply influenced by two failures in the academy's representation of knowledge. Insofar as public policy is based on academic scholarship and formulated by people educated in the Western academy, these scholarly habits are far from purely academic, but rather have far-reaching consequences in the real lives of real women on a global scale.

First, even after decades of feminist scholarship, when it comes to women's health, we still continue to define the word "women" as "not men" in the Boolean sense. That is, women's health represents only those aspects of health that are experienced primarily or exclusively by women. Thus, when one thinks of women's health in the Western context, one thinks of such conditions as pregnancy, breast cancer, osteoporosis, and menopause; and not conditions such as lung cancer, cardiovascular fitness, alcoholism, or AIDS. Even the feminist authors of textbooks on "the biology of women" consider only those aspects of women's health that are unique to the female sex. More mainstream presentations of physiology continue the irritating practice of using males as the default category and representing females as exceptions to the rule. In addition to reinforcing the "otherness" of women, this practice has real world consequences for women's health. For example, studies have shown that physicians are apt to under-diagnose and inadequately treat coronary heart disease in women, at least in part because it is not seen as a women's health concern, and because the disease presents itself slightly differently in women than in men.[1] We cannot find what we do not seek, and our seeking in matters of health is deeply influenced by our equating women's health with women's reproductive health.

A second, more fundamental academic practice is at work here as well. It is the tradition of compartmentalizing knowledge and epistemologies. This narrowness of view is fundamental to the academy and is the basis of the disciplinary boxes into which we divide the curriculum and the collegiate fiefdoms we call departments. In fact, in the political hierarchy of knowledge and epistemologies, in the natural and social sciences at least, traditions of empiricism dictate that the more decontextualized the object of study, the higher the prestige of the discipline. High prestige is, in many cases, associated with the ability to express ideas in the ethereal language of mathematics, which is

thrilling in its ability to communicate the essence of an idea, but inadequate to the task of conveying the vast majority of human experience.

Allow me to illustrate my point using the natural sciences, where one might construe the hierarchy of prestige as physics at the top through biology at the bottom. You are probably familiar with this hierarchy if you think about how awestruck you are when someone tells you she is an astrophysicist versus, say, a botanist. In physics, matter and energy are only rarely studied in their natural state. Rather, they are purified and isolated so that their inherent properties can be investigated free of the context, which, in the field of physics, is called contamination. Chemistry comes next. Here, matter and energy are studied in the context of solvents and in relation to each other as chemical reactions. However, chemists are careful to isolate just the molecules of interest in highly controlled environments, which they call "standard conditions," when really there is nothing standard about them at all, in that they never actually exist outside of the laboratory beaker. By the time one gets to biology, things are really out of hand. There are all types of living organisms containing billions of chemicals all reacting with one another at once.

Despite our position at the bottom of the heap, we biologists are smart enough to know that we can improve our position in the hierarchy by removing all that messy context, and reducing our systems to purified molecules or cells reacting in a highly controlled environment. Thus, the reductionist tendency in biology has, of late, run amok, and perhaps reached its zenith in the pronouncements of James Watson and others that, upon sequencing the human genome, we would understand what it means to be human.

Of course, my argument about reductionism and prestige was elegantly presented by Sandra Harding in her landmark work *The Science Question in Feminism.*[2] Effective scholarship, she argues, endeavors not to cull systems from their context, but rather to take context into consideration. In addition, feminist science demands that the relationship between the subject and observer be interrogated as part of the scholarly work, and that the perspective and biases of the observer be made as transparent as possible.

However, even at its best, disciplinary analysis is just that—analysis of a problem through the lens of a particular discipline with its historical scholarly traditions and exclusionary methodological and analytical boundaries. For example, even interdisciplinary clinical groups in the West treat patients as if they are autonomous individuals making

choices from positions of informed agency. If an unhealthy social condition such as domestic violence is recognized at all, it is treated as a case of individual moral failure, rather than as a systemic problem in the way men are socialized within families and cultures. The link between the socialization of men, violence in the media, and domestic abuse, while a centrally important analysis in the promotion of women's health, is not explored in American medical school curricula.

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I will conclude by arguing that the only way to create **valuable** knowledge, i.e., knowledge that works effectively in the real world, is to forge workable solutions through interdisciplinary and cross-cultural alliances that base their analyses on the messy business of real life. Our tendency to compartmentalize is great and is reinforced by the current rules of empiricism, which privilege experiments and analyses that are likely to result in definitive answers and measurable differences, rather than rich and informative descriptions aimed at allowing the reader to see deeply into the problem before attempting to address it. As Nef stated, "We have the propensity to develop solutions before we understand the problem." The bias against phenomenology and narrative and toward quantitative analysis can preclude a careful, extended period of open-minded exploration of the problem from multiple perspectives.

I am not advocating the dissolution of disciplines and the blending of faculties into a kind of interdisciplinary mush. Our failure is not that we develop theories using disciplinary methodologies and frameworks. It is that, once we have developed these theories, we think they represent *the truth* when really they represent a single perspective that must be informed by the perspectives of other disciplines and other cultures in order to become **truly valuable** in the world. Thus, to effectively educate future scientists, doctors, policymakers, and leaders, no matter how we structure our support, we must continue to build interdisciplinarity into the foundation of the curriculum at Macalester.

Kofi Annan's Nobel Peace Prize should remind us that the work we do on this campus has an effect in the world. In working with students, we should remember that it is not enough to teach critical analysis if we fail to also teach that our views are distorted by the lens of subjective position. This Roundtable has taught us that failure to understand

this simple lesson has real world consequences in the lives and health of real people.

Notes

1. R.B. Wray, “Coronary Heart Disease in Women: Evaluation and Management,” *Clinical Obstetrics and Gynecology* 4 (1988): 955–62.

2. Sandra Harding, *The Science Question in Feminism* (Ithaca, N.Y.: Cornell University Press, 1986).