MEDICINE AND SOCIETY

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Unclouded Judgment — Global Health and the Moral Clarity of Paul Farmer

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Wilfredo Matias, who was born in the Dominican Republic and grew up in inner-city New York, matriculated at Harvard Medical School (HMS) in 2011. Matias knew he wanted to return to the Caribbean to care for the neediest patients but had no idea how to carve that path. After hearing Paul Farmer lecture on global health and social medicine, he sent Farmer an email message, not expecting a response. But within days, he was in Farmer's office learning about the work Farmer's organization, Partners in Health (PIH), was doing in Haiti in the aftermath of a devastating earthquake and cholera epidemic. "He was doing that thing he does with everyone," Matias recalled. "He treats you like you are an equal and a colleague."

Matias soon accompanied Farmer to Haiti and discovered the kind of moral clarity Farmer instilled in others. When you're working in underserved settings to address inequities, Matias explained, it doesn't matter if you're winning or losing. What matters is that you're standing on the right side for a just cause. "I have never met anyone who embodied that spirit more than he did," Matias told me.

When Farmer died on February 21, 2022, at the age of 62, the outpouring of appreciation on Twitter suggested that his moral clarity has saved millions of lives. There are Farmer's poor, marginalized patients, for whom he made accessible both treatments and world-class health systems. There are the many health care workers he trained, now scattered around the world, committed to global equity. And there's the educational infrastructure he created so that countries like Rwanda and Haiti could train their own workers and support public health. As Farmer's friend and PIH colleague Joe Rhatigan told me, "He had this incredible vision of what it takes to transform the world." Many of us enter medicine hoping to change the world; Farmer actually did it.

WITHOUT CONSTRAINTS

He did it because he refused to believe it wasn't possible. Kevin Volpp, a behavioral economist at the University of Pennsylvania, encapsulated Farmer's ethos: "Economists say that people optimize subject to constraints," Volpp tweeted. "One of the many things that made Paul special is he didn't accept constraints — he was in essence solving a different optimization problem than others."

Take rules, for instance. When Farmer was a resident at Brigham and Women's Hospital (BWH), having already founded PIH (with Jim Kim and Ophelia Dahl) and built a clinic, Zanmi Lasante, in Cange, Haiti, he was constantly pilfering supplies from BWH to bring back to Cange — surgical instruments, thoracotomy kits, medications. As his friend John Meara, a surgeon at Boston Children's Hospital who directs the Program in Global Surgery and Social Change at HMS, told me, "He didn't care about the laws of physics, or nature, or normal." Meara describes Farmer as uncompromising in helping patients get high-quality care, whether in Boston or Haiti. With his training in medical anthropology, Farmer brought concepts such as "structural violence" and "social determinants of health" to the bedside, transforming the thinking of an entire generation. He insisted that since we had created the current inequitable health care delivery system, only we could change it.

Changing it sometimes meant rejecting constraints set by powerful organizations. In the mid-1990s, Farmer and Jim Kim became aware of an epidemic of multidrug-resistant tuberculo-

sis (MDR-TB) in a Peruvian slum.[1,2] Many experts believed that patients were simply not adhering to therapy, and the World Health Organization essentially declared that treating MDR-TB in resource-constrained settings was not cost-effective. Anthony Fauci told me that Farmer, having talked with the patients and caregivers directly, knew that nonadherence was not the issue. He and Kim found leaving impoverished patients to die unconscionable, though treatment was expensive and had side effects that were often intolerable. So they would fill their suitcases with drugs they charged to the BWH pharmacy (later paid for by PIH donor Tom White) and hired community health workers to help mitigate the despair of patients who, despite two rounds of treatment, had only become sicker and were being told to endure another course. Their tenacity paid off. They quashed the Peruvian outbreak and, says Fauci, "gave the clarion call to alert the world that MDR-TB is a problem and will continue to grow." Eventually, they negotiated lower prices for second-line therapies.

Farmer spent his life upending our "socialization for scarcity" — our willingness to accept that lesser care for impoverished patients was inevitable. Serena Koenig, a close colleague of Farmer's, recalled meeting him during her residency. One of Koenig's patients had a "tough life," so Koenig would visit her at home. The patient was admitted to Farmer's service and said she needed to talk to "Dr. Serena." Farmer was impressed and recruited Koenig to his cause. A young man in Haiti needed an aortic valve replacement; could she arrange a transfer to the Brigham? Koenig knew arranging such a transfer would be exceedingly difficult. But Farmer taught her to question why someone in Boston deserved a valve replacement more than someone in Haiti — and why we were conditioned to believe such inequities were acceptable. Inspired by Farmer's vision of equity, Koenig negotiated a price with the hospital, raised the needed funding (with help from a group of fifth-graders), and flew to Haiti to get the patient a medical visa and accompany him back to Boston, where he received a new valve.

If the patient's life was forever changed, so was Koenig's. She recognized that rejecting the limits of scarcity was as much an emotional as an intellectual pursuit. Global health policy is rife with principles born of constraint, often packaged euphemistically as "cost-effectiveness," "prevention before cure," or "resource allocation." To all of which, I suspect, Farmer would respond, "blah blah blah."[3] Farmer, said Koenig, was driven by a love that knew no bounds, and it began with the person in front of him. Invoking the Haitian Creole aphorism "*Tout moun se moun*" (every person is a person), Koenig said, "He really felt like every person matters. I think he truly loved every person."

It was largely this universal love that made Farmer unique and successful. Noting that with his messianic nature, unparalleled impact, and global celebrity, Farmer could have been resented by his peers, Marshall Wolf, Farmer's residency program director, made a critical distinction: "Paul inspired love, not envy." He expressed his own love in kindness to everyone he met. On his first day as an attending physician at BWH, Eric Rubin, the *Journal*'s editor-in-chief, took over the infectious disease service from Farmer, who immediately flew to Peru. In the middle of rounds, Rubin got paged, twice, to an unknown international number. When he finally managed to get through to the number, the caller turned out to be Farmer, checking to make sure Rubin was doing OK. Rubin thanked him and went to see his next patient. "How are you doing?" he asked the patient. "That's funny," the patient said, "Paul Farmer just called and asked me the same question."

ONE VERSUS MANY

Yet a central philosophical tension in Farmer's life concerned investing heavily in a single patient when the same resources could help many others. One story in *Mountains Beyond Mountains*,[1] Tracy Kidder's biography of Farmer, involves Koenig and a Haitian boy named John, who had a rare nasopharyngeal carcinoma. Since the cancer could be treated only at highly specialized centers, Koenig and Carole Smarth, a Haitian American medical-pediatrics resident, spent a month arranging transfer to Massachusetts General Hospital. During that time, John's condition worsened so much that he could travel safely only by medevac, which would cost PIH $20,000 (Koenig, in desperation, offered to pay it herself). When they finally arrived, however, John underwent staging studies (unavailable in Haiti) that revealed widely metastatic, uncurable disease. He died

peacefully and without pain, but the heroic act raised eyebrows.

The utilitarian calculus also nagged at Kidder. Soon thereafter, as he and Farmer hiked several miles in rural Haiti so that Farmer could check on a few patients, Kidder confronted him about John. Why spend so much money on one person (who died) rather than on many others who could have lived? Similarly, why were they spending their whole day trekking to see two patients when Farmer could have used the time to see many more? Farmer responded with characteristic sarcasm: "'Every day all day long, that's all I do. Is not do things.'" But beneath his sarcasm lay the philosophy that made him effective. Though he understood trade-offs, he seemed to intuit that when you engage in the abstractions demanded by such calculations — the abstractions that shape global health policy — you perpetuate the inequities you're trying to solve. Summarizing Farmer's worldview, Kidder wrote, "If you say that seven hours is too long to walk for two families of patients, you're saying that their lives matter less than some others', and the idea that some lives matter less is the root of all that's wrong with the world."

Ultimately, Farmer's emotional connections to patients were essential to the fabric of his intellectual life and its pragmatic import. Matias recalls his first trip to Haiti in 2012 for cholera relief work and the touring of the PIH-funded Hôpital Universitaire de Mirebalais (a 350-bed hospital that now has six accredited residency programs). After an exhausting first day, the PIH-ers found Farmer at his Cange home with a woman who was clinically deteriorating from tuberculosis; he'd been up all night caring for her. Matias was amazed that a world-renowned scholar, writer, teacher, and health system builder was still willing to stay up all night for anyone who needed him. Yet I suspect that feeling people's suffering so profoundly is what propelled Farmer's endless fight on others' behalf. Whereas medical training cautions against emotional involvement, for Farmer the mistake was *not* feeling, which could trap you into thinking that some people's suffering was OK. As he said in a 2018 interview, "I think seeing patients *unclouds* my judgment, and that people who do not have direct exposure to the ill and suffering and poor . . . are much more liable to make errors in formulating policy."[3]

SOCIAL DETERMINANTS OF HEALTH

Such unclouded judgment allowed Farmer to revolutionize tuberculosis care. When he was a medical student, three Haitian patients died of tuberculosis after being treated at Zanmi Lasante.[1] Some health workers blamed spiritual beliefs that could make patients unwilling to take medications; others, who themselves had experienced extreme poverty, believed the barriers were economic. So Farmer did a randomized, controlled trial. Every patient got free medications (the standard of care), but the intervention group also got money, transportation to the clinic, and visits from community health workers. The results were striking: cure rates were about 57% in the standard-care group and 100% with the intervention.[1,4] In follow-up interviews, Farmer discovered that people's beliefs mattered far less than whether their material needs were met. If patients couldn't avail themselves of treatments, physicians needed to figure out why — and then fix it. All Farmer's subsequent work would be shaped by this insight.

Anatole Manzi, PIH's deputy chief medical officer, trained as a nurse in Rwanda, where he started working with Farmer in 2005. Manzi was socialized to believe that individuals and communities were responsible for the miserable conditions that made high-quality medical care nearly impossible. Farmer called this mindset — that "it's too difficult to treat this disease in this setting" — clinical nihilism.[5] Manzi remembers a clinic visit of a woman with HIV and tuberculosis coinfection. He expected Farmer to prescribe medications, but first, Farmer checked to see if the woman had food; she didn't, so he prescribed a food package. Then he assessed her social supports; she was lonely, so he prescribed an *accompagnateur*, someone to support her emotionally and help her take her medications. And her children? Her oldest son, it turned out, had had to leave high school because they couldn't afford tuition. So Farmer handed Manzi a prescription that included money for her son's education. The young man is now a pharmacist. Manzi explains that "modern medicine" should be as much about addressing root causes of poverty and disease as about sophisticated diagnostics and therapeutics.

As medicine commits to addressing structural factors shaping health, one challenge is understanding what that commitment means for an individual patient with problems you can't im-

mediately solve. David Walton, a BWH hospitalist who essentially built the Mirebalais hospital while working for PIH, recalls rounding with Farmer as a medical student in 1998. An intern reported that a patient was "noncompliant" with medications, and Farmer went crazy — and then outlined the myriad barriers patients face in a medical system that fails to meet their basic needs. So how can we begin to meet them?

ACTIONS, SMALL AND LARGE

Farmer often asked Walton for small favors, gestures that helped forge the connections so essential to Farmer's therapeutic efficacy. Could Walton, for instance, pick up a sandwich for a patient before rounds? With these gestures, Walton began to appreciate something medicine doesn't teach, and actually often cautions against. Recently, for example, Walton cared for a patient with osteomyelitis who was contemplating leaving against medical advice. He asked the patient what would make it easier for him to stay. Cigarettes, the patient said. So Walton brought him cigarettes. "I learned that from Paul," he said. "We all know if [the patient] leaves, he will come back with sepsis, will maybe need a leg amputation"; and yet "it's verboten to go buy someone cigarettes."

Farmer's recognition of clinical medicine's limits seemed to extend to his perceptions of academia. He once told Kidder that among the aspects of academia he disliked were its "arrogance" and "orthodoxy." There was a place for scholarly work (and Farmer produced lots of it), but conceptual frameworks could take you only so far. Theory without action was just another constraint. Justice, by contrast, was a way of life.

But it wasn't an easy one, for Farmer or his colleagues. Louise Ivers, the chair of global health equity at MGH who led PIH's anticholera efforts after the 2010 earthquake, described the enormity of Farmer's expectations. She recalls being in central Haiti, on a cell phone with horrible reception, trying to participate in a conference call that included Farmer. Suddenly she found herself responsible for a 100,000-person cholera-vaccination campaign (which she successfully led). "There was no trying in Paul's world," Ivers told me, "only doing."

Walton echoed this assessment, recalling Farmer's unwillingness to accept any delays in the Mirebalais hospital construction; every delay, Farmer insisted, meant another life lost. "He pushed us further than we ever thought we could be pushed, to do more than we ever thought could be done," Walton told me. "And he was always right."

Insofar as Farmer simultaneously built public health infrastructure and maintained a palpable sense of every life's value, I think he was right about something else: our systems are only as strong as our connections to the people we're trying to serve. If the Covid pandemic revealed cracks in public health infrastructure everywhere, it also reminded us that those cracks can't be sealed without restoring institutional trust. Farmer understood that this trust must be built "one patient at a time."

Such moral clarity, however, can take a toll. Heidi Behforouz, now medical director of Housing for Health in Los Angeles, who began working with Farmer in 1991, described a moment, decades ago, when she witnessed the suffering Farmer experienced on others' behalf. They were in Cange, talking late into the night, and Farmer started sobbing, saying "I just don't know if I can take it anymore." Every night, he told her, starving people came to his door, begging for food. "And every night," Heidi told me, "he freakin' answered the door." But that night he said, "You know, sometimes it wears you down." Behforouz appreciated his raw honesty — and knowing that even Paul Farmer sometimes got tired. But his optimism was unwavering. "He believed that if we all could just do a little bit, we would be in a better place." To always answer the door, Behforouz told me, "that's what it means to be in solidarity with people who are struggling. I don't think most of us have the mettle to do that."

One of Farmer's gifts, though, may have been seeing potential in others that they couldn't see themselves. When I told Ivers that I could never do what she and other people whom Paul inspired spend their lives doing, she was quick to correct me. "Paul had this incredibly inclusive vision of global equity," she said. "His notion of fighting for social justice didn't mean you have to get on an airplane." Instead, he believed that, given the magnitude of global suffering, there is a role for all of us, wherever we may be.

Farmer has left us with much work to do. But he also left us with a vision of how it might be achieved. By looking people in the eyes. Sitting

beside them. Refusing to accept — for others but not ourselves — anything less than the best that medicine can offer. And by leading with a love unconstrained.

Disclosure forms provided by the author are available at NEJM.org.

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