A History of Structural Violence

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I practice medicine in rural India. I regularly see people die of fully treatable or preventable disease because of the accident of their birthplace. A man died from a myocardial infarction because the nearest angiography with revascularization was three hours away. A young woman presented with advanced cervical cancer due to a lack of screening and vaccination. A newborn suffered hypoxic brain injury because the birth center nearby had no oxygen.

Ranjit was one such patient, a twenty-year-old man who came to us with over a decade of dyspnea.[1] He had advanced heart failure due to a prolapsed mitral valve. Because he had already developed cardiac cirrhosis, he was denied surgery, and we could only treat him medically. He was previously prescribed diuretics, but he had not taken them for the past two months. He immediately felt better after I took two liters of fluid out of his lungs. He was doing well, until one day he developed a fever and the next day rapidly developed septic and cardiogenic shock, from which he never recovered.

Ranjit's history started long before he stepped into our hospital, a story I learned piecemeal over the week he was under my care. His father died when he was a child. His family received only $4 per month as compensation, forcing both him and his mother to find employment. Despite worsening dyspnea, Ranjit worked throughout his teenage years until his heart failure got so bad he had to quit his job. This is when he presented to the hospital, but without an income he could not afford the diuretics we prescribed. Calling this "non-compliance" would be heartless, but without context, it is exactly what we did.

For the entirety of his two decades of life, Ranjit was subjected to structural violence, a term coined by Norwegian sociologist Johan Galtung to describe the systematic oppression that occurs due to the structure of society itself. Ranjit was born into a caste called, in stark linguistic evidence of oppression, "other backward class." He had no protection during his childhood from having to work for survival. His agrarian community suffered disproportionately more than urban areas did from climate change caused by industry, despite contributing far less to the carbon footprint. His government's decision to spend five times as much on defense as on healthcare limited his access to quality care. Rural isolation caused a delay in outpatient care that eventually necessitated inpatient admission. The reluctance of physicians to train or accept informal health providers led to a shortage of health professionals that increased wait times and decreased length and quality of medical visits, making the cost of visiting the doctor much higher than the benefit received.

The first few days after Ranjit died, I combed the details of his hospital course, wondering if I had somehow caused his death. Did I diurese him too much? Should I have started antibiotics earlier? Eventually, I convinced myself that I had not made technical errors in his care, but this conviction did not give me the relief I sought. Instead, it deepened my sense of powerlessness, knowing that even my medical best did not equip me to fulfill my responsibility to him as his doctor. Our medicine is not powerful enough to overcome the levels of health injustice routinely faced in India.

So began a whole new round of grief. My grief transitioned from one for him and his family to one for all the patients who came before or will come after him. Sunita must travel 600 km to be diagnosed with diabetes. Gopal will show up to his primary health center with dyspnea and be told there is no oxygen. Rajkumari would rather bleed internally at home than risk a catastrophic health expenditure that might bankrupt her family for generations to come.

As I began to take measure of the structural factors in my patients' lives, I confronted the violence I personally exerted. As an American physician, I actively participate in the capitalistic structure that created the wealth inequity I claim to be against, receiving a salary exponentially higher than that of the patients I treat. As an academic, I actively participate in a system of knowledge inequity as well, where the majority of research in the world is funded by and thus done for Western interests. This research is then used to guide recommendations and policies, which are often irrelevant or impractical for people like Ranjit. In these ways and many others, I perpetuate systems that were designed to consolidate power and serve the interests of those that already possess it.

I have taken care of patients like Ranjit before, but rarely have their stories elicited such a visceral response in me. It dawned on me that I never really knew my patients' stories; all I knew were the final few pages that we call a "history of present illness." Structural violence was not a part of my medical training until I began my fellowship in global health equity, but it is ubiquitous. Like Ranjit, Sunita, Gopal, and Rajkumari, all our patients have histories of structural violence that extend as far back as we are willing to delve.

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We owe it to our patients to not only treat their present illness but also explore their social and economic determinants. As we determine those causes, we can exert our power as health professionals to advocate for change, because although structural violence emanates from properties embedded in our society, it is neither innate nor immutable. I hope we each find our own Ranjit, that patient who can make us a more empathic physician by opening our eyes to the vastness of structural violence. By knowing how our patients' histories of present illness extend into the histories of cultures and races and civilizations, we can transition from technical guilt to familial grief to a societal conviction that our professional oaths and training empower us to change the way our medicine is practiced.

NOTES

1. This reflection is non-fiction. I have changed the identifiers for the patient described as much as I could. Ranjit's family did not have a cell phone. To get consent to publish this story, I called every patient from Ranjit's village until one knew his family. Ranjit's brother called me from a neighbor's phone. I described the purpose and contents of this reflection with him via a Hindi translator. As their father had died and his mother gave him decision-making responsibility, he granted me permission to share Ranjit's story, stating: "As long as you do not use our names, you may tell his story. Anything that may help another family like ours."

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