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Medicine and health: a necessary reunion

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Medicine has always known, on some level, that it is not enough. The physician who treats the wound but ignores the conditions that produced it has done something—but not everything. The scientist who maps the pathogen but not the poverty in which it thrives has answered one question while leaving the larger one unasked. This tension—between medicine as it is practised and health as it might be understood—is as old as the discipline itself. What has changed, across the past century, is that the world has progressively formalised its understanding of what health actually requires. It is a tension this journal has decided, with the addition of a single word, to formally acknowledge.

The World Health Organization's Constitution of 1948 made the first and most consequential move: defining health not as the absence of disease but as a state of complete physical, mental, and social well-being [1]. Revolutionary for its time, the definition was also deliberately ambitious—its authors understood that aspiration precedes achievement. It drew immediate criticism for its breadth, its apparent utopianism, and its resistance to measurement. Those criticisms were not wrong. But the definition's enduring power lies precisely in what it refused: the reduction of health to a clinical transaction.

A progressive widening of that refusal followed. The Alma-Ata Declaration of 1978 embedded health in social and economic development, named peace as its active prerequisite, and demanded that communities—not only health systems—be its agents [2]. The Ottawa Charter of 1986 went further still, identifying peace, shelter, education, food, income, a stable ecosystem, and social justice as health's fundamental conditions [3]. Global Health, emerging as a field in the late twentieth century, extended the frame beyond national borders, insisting that health inequity anywhere was a concern everywhere. And One Health—perhaps the most radical expansion yet—dissolved the boundary between human, animal, and environmental health entirely, recognising that the well-being of each is inseparable from the well-being of all.

These were not merely definitional refinements. Each represented a shift in who counts, what counts, and who bears responsibility. Each made health more inclusive, more ecological, more political, and more human. Together they describe a concept that has been moving, consistently and deliberately, away from the clinic and toward the world.

And yet the story of health's conceptual expansion is inseparable from the story of its practical resistance. For every step the idea of health took toward greater inclusivity, there was a countervailing force pulling medicine back toward the manageable, the measurable, and the profitable.

The Declaration of Alma-Ata represented the most ambitious attempt to translate the expanding concept of health into institutional reality [2]. What followed was a systematic dismantling. Within a year, a paper in the New England Journal of Medicine, presented at a Rockefeller- and Ford Foundation-sponsored conference, introduced "selective primary health care," redirecting attention toward discrete, disease-centred interventions [4]. Comprehensive, community-centred care was displaced by cost-effectiveness logic and privatisation incentives. Health was being converted, quietly and deliberately, into a commodity [5]. This retreat of medicine from its social foundations was not an accident. It was a political and economic project [6, 7].

Nowhere is that logic more legible—or its cost more measurable—than in surgical care.

The Lancet Commission on Global Surgery demolished this long-standing complacency: five billion people lack access to safe surgical and anaesthesia care, with 143 million additional procedures needed annually, and ninety percent of that burden being in low- and middle-income countries [8]. In acute humanitarian settings—conflict zones, post-earthquake rubble, and flood-stricken communities—these deficits are compressed into their most lethal form. Our experience in such environments has shown repeatedly that surgical emergencies are not random events: they are the predictable consequence of destroyed infrastructure, displaced personnel, and the deliberate targeting of hospitals as instruments of war [9, 10].

Disaster preparedness, education, and task-sharing of surgical skills are health projected forward—and they are precisely the investments that are first abandoned when medicine retreats into its narrowest definition of itself [11]. Indira Gandhi, addressing the World Health Assembly in 1981, understood what was at stake: health, she argued, is neither a commodity nor a service, but a process of knowing, living, and participating [7]. It is medicine's most powerful and most neglected instrument.

And yet none of it survives war.

We must state plainly what our operating theatres show us: war is the most destructive public health intervention ever practised. Armed conflict destroys hospitals, drives out clinicians, fractures supply chains, contaminates water, and generates injuries of staggering complexity—blast trauma, burns, polytrauma, and

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psychological wounds that persist across generations. The ICRC has documented that attacks on healthcare are increasingly instrumental to modern warfare, carried out in violation of international humanitarian law and with near-total impunity [12]. The medical community's tradition of neutrality in conflict is honourable. But neutrality cannot become silence [13]. It is our obligation to speak.

What would a medicine adequate to this moment look like? One that rejects the selective, vertical, disease-centred logic governing Global Health policy since the 1980s and returns—with twenty-first century evidence—to the comprehensive, community-anchored vision of Alma-Ata [2, 6]. One that trains clinicians who understand not only pharmacokinetics and surgical anatomy, but the social determinants of disease, the political economy of health systems, and the mechanics of humanitarian response. One that invests in prevention with the same intensity directed at tertiary cure, and designs health systems for resilience as much as efficiency. One that embraces, rather than resists, the expanding definition of health that a century of scholarship has built—from the WHO's foundational ambition through Global Health's borderless solidarity to One Health's recognition that human well-being cannot be separated from the well-being of the world we inhabit.

Equitable access to essential surgical and anaesthetic care is not a development aspiration. It is a human right—non-negotiable, measurable, and enforceable. The patient is not a consumer but a person, and the clinician's obligation extends beyond the individual encounter to the conditions that made it necessary.

No operating theatre can undo the harm of a collapsed building that was never reinforced. No intensive care unit can restore the health of a community whose water has been poisoned, whose crops have failed, or whose hospitals have been bombed. Health belongs to every human being—and securing it requires not only scalpels and syringes, but policy, politics, education, and peace.

This is the understanding that animates the decision to rename this journal. *Academia Medicine* was founded on two commitments: inclusiveness and quality. By adding *Health* to its name, it reaffirms the first of these—and does so at a moment when that commitment is not merely aspirational but urgent. The journal will publish the science of both medicine and health, hold them in relationship, and resist any logic (economic, political, or institutional) that treats their separation as natural or inevitable.

The world we have is not the world we are obliged to accept. It is our obligation to restore them to each other: medicine and health.

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