Massey Grand Rounds
3rd Annual Symposium on
"Social Responsibility and Social Entrepreneurship:
A Public Health Perspective"
April 22, 2009
Summary remarks by David Goldbloom

I am proud to speak as one of the few doctors not from Winnipeg at this symposium. It has been impressive how all the speakers have introduced themselves in a self-effacing way. If James Orbinski says he doesn't know anything about social responsibility, what hope is there for the rest of us? As for myself, I have the gene for self-confidence unrelated to ability, which I believe rests firmly on the Y chromosome.

I have the good fortune to come from a line of physicians. My grandfather, Alton Goldbloom, worked through diphtheria and polio outbreaks. My father worked through measles and scarlet fever outbreaks and assured me all the great infectious scourges of the world were over. Then as an intern in Montreal in 1981, we encountered our first AIDS patients; as Physician-in-Chief at CAMH, we worked through the SARS outbreak.

Jack Mandel has provided us with a sweeping overview of public health, leaving me wondering how scared we should be to inhale or to eat – but perhaps this is the safest time in human history to eat IF you are lucky enough to have access to food. Talks about prevention always leave me wondering what exactly people want to die of eventually. When he presented data on disability-adjusted life years (DALYs), we saw that the number three cause currently is unipolar major depression, which is predicted to be number one by 2030. In fact, if you look at the WHO data on DALYs, 5 of the top ten causes are mental illnesses and substance abuse.

And yet we have heard almost nothing today from a public health perspective about mental health. This is despite the fact that suicide is the leading cause of violent death around the world according to the WHO in 2002. It accounts for 50% of such deaths, while homicide accounts for 30% and war-related deaths 20%. There are one million suicide deaths worldwide annually. Deaths from suicides have exceeded deaths from AIDS by 200,000 in the last 20 years.

Shannon Wells, in her commentary on inequality, introduced either a typo or an intentional pun in her title slide: Wither The Kinder, Gentler Nation. It reminded me that within the politics of public health is the question of how to deal with income disparities; is it by flattening from the top or raising from the bottom?

Kue Young, in his terrific presentation on the Canadian death, gave us the maxim that things can be false but useful from a public health perspective. I suspect James Orbinski would counter that with the idea that things can be true but useless from a policy change perspective. He noted that the origins of the term "third world" were celebratory, despite its current derogatory use – a reminder that culture can shape semantics.

James Orbinski quoted the great scientist and physician Rudolf Virchow. Let me respond with another Virchow quote: “the physician is the natural attorney of the poor”. James described the policy change process as containing 4 essential components:

- Evidence
- Understanding the political process and its organizational dynamics
- Preparedness
- Opportunism

This perfectly describes the confluence surrounding the Mental Health Commission of Canada, which is about to engage in Canada’s largest ever public health experiment – a randomized effectiveness trial of housing and treatment for people with mental illness who are homeless – funded by a Tory government to the tune of 110 million dollars.

Abdallah Daar described the Nestle’s case of providing free baby formula in Africa to foster further need to buy it; how different is this than accepting free drug samples from pharmaceutical representatives in Canada for conditions that often require long-term treatment? However, he has also described entrepreneurial ingenuity, such as the cheap manufacture of anti-retrovirals in India (to which I would add the Tata Nano as another example!).

Jeannine Banack and Geoff Anderson have closed the symposium, fittingly, with a pedagogical perspective on teaching advocacy and leadership. Geoff described leadership historically as “accidental” rather than trained – and I speak as someone who has been accident-prone at various times in my career. My only request is that we look carefully at whether the efforts to teach these skills result in sustained advocacy and leadership activity after medical school as an outcome measurement, remembering that the real outcome measure is the improved health of our patients.