DO WE REALLY MEAN EVERYONE?

GLOBAL HEALTH EQUITY AND THE NEED FOR INTERDISCIPLINARY MEDICAL ETHICS EDUCATION

The current state of global health equity is falling short of the standard agreed upon in the Universal Declaration of Human Rights. What can the functioning and aspiring medical community do about it?
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Abstract

In 1948, the Universal Declaration of Human Rights document became the ethical standard for healthcare by policy makers and medical professionals worldwide. However today, instead of equal healthcare ideals, structural violence determines who falls ill and who has access to care. An exhaustive study on medical ethics education shows that the medical community largely ignores this broader context of social injustice. The comparison between the U.S. and Mozambique and several economic statistics portray the unequal access to basic health care brought about by capitalism. A case study on a woman from Haiti represents the need to treat not only the disease but to address the economic, political, cultural, and social structures that silently damage so many. The fostering of solidarity between medical professionals and the suffering class will play a crucial part with any positive change in health indicators worldwide. A look at the human nature theories of Fukuyama and Singer reveal both hope and hindrance to this solidarity development. If equal access to care is considered to be ethical, what levels of quality can medical ethics aspire if it ignores the population of poor? The first step towards reducing inequality will start in the university classroom and continuing education context, with a more interdisciplinary approach to medical ethics education. A new level of cooperation and collaboration between disciplines ranging from social anthropology to molecular epidemiology should be used to develop a new body of knowledge that will increase awareness of structure violence and promote volunteerism. Incredible hope lies in the potential of medical community to broaden their definition of neighbor. In conclusion, findings prove that this redefinition is not only possible but ultimately beneficial for all who are involved.
On December 10, 1948 the General Assembly of the United Nations proclaimed everyone had the right to a standard of living adequate for the health and well-being of themselves and their family. Meaning everyone should have access to food, clothing, housing, social services, and medical care regardless of race or social status (1948). This proclamation was adopted as the common standard of achievement for all peoples and all nations as part of the Universal Declaration of Human Rights. Are medical professionals and policy makers still promoting this universal right to health 60 years later? Statistics indicate the answer is no. In 2008, 850,000 people died of preventable and cure-able Malaria (UNICEF, 2009). In 2005, AIDS therapy was delivered to 150,000 people, but the remaining 6 million that needed care did not receive it (Farmer, 2005). In the same year, 1.4 billion people were living on less than $1.25 per day, lacking finances to pay for food let alone healthcare (World Bank, 2005). Despite these startling statistics, the medical ethics focus in most of America’s medical education and research institutions remains on end-of-life decisions, medico-legal questions of brain death and organ transplantation, and medical disclosure (Farmer, 2005). The countless people whose life course is shortened by unequal access to health care are not topics of discussion.

While medical professionals claim to remain ethically grounded in the ideals of the Universal Declaration of Human Rights and the Hippocratic Oath, an evaluation of worldwide health inequalities show that our global society still lacks solidarity for the suffering. The barriers to equality in health care are numerous and daunting. As disease and inequalities fester, we are oppressed by globalization, structural violence, and self interest founded in human nature. The ultimate goal is to outfit those with the potential skills to save lives with a foundation of global awareness and social justice. This will be the most effective way to overcome the barriers we face. How can this world changing solidarity be fostered in aspiring medical professionals?
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MARKET DRIVERS

Ethical aspirations and statistical health indicators drive the need for the development of solidarity. The International Population Crisis Committee devised an International Human Suffering Index, ranking 141 countries on the basis of 10 indicators: Life expectancy, daily calorie supply, clean drinking water, infant immunization, secondary school enrollment, gross national product per capita, rate of inflation, communications technology, political freedom, and civil rights (1992). Success or failure in each indicator could be linked to the overall health and well-being of country residents. It came as no surprise that most western, developed nations had a significantly lower suffering index than their third world counterparts. The comparison between the most suffering nation, Mozambique, and the 8th most comfortable nation, America, put the current state of health disparity in perspective. The World Health Organizations compiled statistics from both countries show a life expectancy difference of 28 years. Mozambique’s low life expectancy rate can be blamed on the high child mortality rates and the prevalence of communicable diseases because of the lack of access to clean water and sanitation. Even in their distant occurrence, deaths caused by insufficient modern amenities should not sit well in a medical community supposedlly “educated” in ethics.

The mere existence of the Universal Declaration of Human rights proves that equality and virtuous habits in the realm of health care are considered significant. The Hippocratic Oath was comprised nearly 2,400 years ago, as patients and physicians alike desired doctoring to be more than just a job (Miles, 2004). This altruistic code of ethics is still recited at medical school ceremonies today. A powerful clause in the modern version of the oath states, “I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.” (MedicineNet, 2011). In Mozambique, 42% of deaths of children under 5 are caused by preventable and treatable diseases like pneumonia, malaria, and diarrhea. Not only do they lack access to medical care and medicine to cure their symptoms, but there is no higher power fighting against the structure causing their problems. High child mortality rates might be caused by the fact that only 47% of people in Mozambique have access to clean water, and 17% have access to clean sanitation facilities. How well are medical professionals being trained to recognize and address these “related problems” associated with disease? If the medical community affiliates itself with the ideals in the Universal Declaration of Human Rights and the Hippocratic Oath, to what extent can they be considered ethical if the structures driving the statistics are not taken into account?

It is important to consider the direct and causal relationship between a fortunate majority enjoying great ease and the billions who go without bare necessities of food, shelter, potable water, and medical services (Farmer, 2005). In the past 100 years, capitalism has been a powerful tool increasing technology and improving health and living standards around the world (Gates, 2008). Bill Gates, an uncontested member of the “fortunate majority”, now devotes a great amount of time and money to improving healthcare access for the poor and pointing out failures in a flawed capitalistic system. He notes that as capitalism benefits the upper class, it only further separates those countries trapped in underdevelopment from the healthcare access they need. These countries lack the economic incentive for pharmaceutical companies to invest in developing and producing drugs for the common diseases of the region. For example, ten times more money is spent on developing anti-baldness drugs than finding a cure for malaria because of the profit margins. One must acknowledge that this type of market, which Americans benefit from, is responsible for many of the negative health statistics as discussed previously. Like Gates, medical professionals have the choice to see capitalism as an opportunity to reallocate knowledge and resources to those who were denied access before. If not, the gap will continue to grow between the rich and the poor.
The barriers to developing awareness of global issues and foundation of solidarity for the suffering seem insurmountable at times. The biggest challenge lies in addressing the structural violence that silently suppresses the voice of millions without access to healthcare. Less obvious than physical violence, structural violence can be defined as the social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential (Farmer, Nizeye, Stulac, Keshavjee, 2006). In the medical world, it is structural violence on a large scale that often determines who falls ill and who has access to care. For example, malaria is a parasitic infection that causes millions of disease episodes and more than a million deaths a year (Brentlinger, 2006). All of these deaths are occurring in the poor sectors of vulnerable developing nations, implicating structural violence. Malaria is preventable and treatable, yet studies showed that an infrastructure of poverty and socio-economic disparity significantly decreases access to control measures. Put simply, some people are denied the access to life saving medicine because they are poor.

The full connotations of structural violence are not effectively conveyed through graphs and statistics, but rather through the gritty details of biography (Farmer, 2005). In 1991, Paul Farmer, an American physician practicing in Haiti learned the story of woman dying of AIDS named Acéphie. She grew up in the central plateau of Haiti, previously known for fertile farmland. In the 1950’s the Haitian Capital drafted a dam project in Washington, D.C. Acéphie’s family was among the thousands of peasant farmers who were displaced to the rocky hills by the rising waters. The people were exceedingly poor as they attempted to till the rocky, non-fertile soil. She was pulled out of a rudimentary primary school at the age of 19 to help generate income for her suffering family. While carrying produce to the local market, soldiers would impose haphazard fines and flirtatiously jeer at the beautiful, young Acéphie. In desperate poverty, she was pleased when a Captain took interest in her, even though this Captain was known to have a wife and several other sexual partners. The Captain mysteriously fell ill and passed away after one month. It turns out he had AIDS. Acéphie found a job as a housekeeper making 30 dollars a month. She was engaged to marry a fellow Haitian man when she became pregnant. Because of the pregnancy, her fiancé left and she was fired from her job. She found herself consumed with managing the symptoms of the AIDS she contracted from the Captain while attempting to care for a child. Political violence hampered her doctors’ ability to open the nearby medical clinic. Everyone in her village assumed she was the victim of some type of sorcery and viewed her as an outcast. Acéphie became weaker and weaker, eventually dying from AIDS. Her daughter was also infected with the virus. Shortly after hearing this news, her father committed suicide.
Subjectively, this situation screams injustice. Objectively, the repercussions of structural violence come as no surprise. Acéphie died from, and should have received medical care for, AIDS. However, her story implies that the broader economic, political, legal, religious, and cultural structures were just as devastating as the virus that killed her. It isn’t often that this awareness translates to formal frameworks that link social analysis to everyday clinical practice (Farmer, Nizeye, Stulac, Keshavjee, 2006). Dr. Paul Farmer hears stories like Acéphie’s daily at his hospital in central Haiti. He sees a plausible positive change in health indicators stemming from the initiation of more virtuous structural cycles, even if they are unrelated to medicine. Structural violence will only cease to become a barrier when it stops being overlooked in the medical community.

The same structure of violence that keeps those countries trapped in underdevelopment, also blinds the eyes of those fortunate enough to do something about it. The opposition to global health equity lies in the skewed mindsets resulting from globalization. Defined as the current phenomenon of growing interdependence of the world’s people, globalization involves the integration of economies, cultures, technologies, and governance (Chapman, 2009). Regrettably, globalization has increased the socioeconomic gap between the fortunate and the less fortunate. This has largely influenced who has access to healthcare. Illustrating the current socioeconomic gap, mega corporations now rival entire countries by making up 50 of the 100 largest economic entities in the world (Heggenhougen, 2004). The economic gap between the top and the bottom 20% of the world population, was 30 to 1 in 1960, grew to 82 to 1 by 1995. The least developed countries, with 10% of the world’s people, have 0.3% of world trade, half their share two decades ago. In 1995, the total wealth of the top 358 global billionaires equaled the combined income of the world’s 2.3 billion poorest people (Keegan, 1996). Haitian factory workers make 28 cents per hour sewing Pocahontas pajamas, while Disney’s U.S. based chief executive officer makes 97,000 dollars for each hour he toils (Millen & Holtz, 2000). These economic disparities wield a poverty structure of destructive influences that negatively affect health equity (Chapman, 2009). The technological and medical advancements of this day and age are substantial. However, local and global economic inequalities mean that the fruits of medical and scientific advances are stockpiled for some and denied to others (Farmer, 2005). The Universal Declaration of Human Rights states that everyone has the right to share in the benefits of scientific advancement (1948). If the ultimate goal is equal access to both healthcare and scientific advancement, the economic gap facilitated by globalization has greatly limited health equity.

Irony lies in this market capitalist opposing point of view. Even as our world grows smaller and more connected by technology, our definition of a “neighbor” has not expanded much farther past those in our immediate social circles. Globalization conveys the idea that individuals and economies alike have the power to pull themselves up by their bootstraps. Those in fortunate socio-economic positions fail to see the direct and causal relationships between a protected minority enjoying great ease and those billions who go without bare necessities of food, shelter, potable water, and medical services (Farmer, 2005). Because of our ignorance of structural violence, third world countries remain trapped in underdevelopment. What medical professionals must not do is wait for the problem to fix itself.
The lack of solidarity for the suffering stems from deep concepts within human nature. This provides a rationalization of the history of medical ethics and its focus today. In this case, Evolutionary Psychology will be used to take a look at human adaptations and physiological states from a modern perspective. Two important questions the subject has raised have great implications towards health and human rights. What kind of society can we have and what kind of society should we have?

Charles Darwin’s evolutionary theory has taught the intellectual world that humans have adapted on the basis of survival. Starting at this inclination towards survival, the groundwork for human rights is laid in human nature. One could deduce that everyone should have basic rights relating to their proclivity towards survival. Historic proclamations like the Universal Declaration of Human Rights and the Hippocratic Oath originate from the inherent moral code that says humans should not be denied basic quality of life necessities like food, water, safety, and good health.

Francis Fukuyama, an American political philosopher and political economist, explains that this inherent moral code can only be applied to those we would consider our kin. Based on his interpretations of Evolutionary Psychology, this view of kin is limited to our family and small social circles because of evolutionary adaptation (Fukuyama, 1992). He sees human nature as unchangeable, self-interested, and fairly antisocial with the ultimate goal of accumulating wealth to pass down to our own descendants. According to Fukuyama, the only society that we can have is one of small community perspective.

The difficulty in showing solidarity to members of the communities to which one believes they do not belong is founded in human nature. The concept of solidarity can be expressed through the theme of connectedness and love for one another (Dussel, 2007). It is the lack of global solidarity for the causes presented in this document that reinforce ignorance about structural violence. Understandably, neighbors are most often defined as the people across the street, not across borders or oceans. Fukuyama’s theory on human nature explains why startling worldwide health statistics have not roused the medical community to collective action.

“What kind of society can we have? What kind of society should we have?”
A review of current literature surrounding medical ethics published for medical students revealed deep shortcomings in 2004 (Eckles, Meslin, Gaffney, Helft, 2005). The authors extensively searched well-known medical journals using the following terms: ethics education, medical ethics education, curriculum, undergraduate medical education, virtue, philosophy of medicine, and outcomes research. Deficits were found most importantly in theoretical work on the overall goals of medical ethics education. Another study noted that the standard for ethical analysis has typically focused on physician/patient relationship, patient autonomy, and the clinical encounter (Dos Anjos, 1996). Dr. Paul Farmer shed light on more current medical ethical issues (2005). Dominating the literature are end-of-life decisions, medico-legal questions of brain death and organ transplantation, and medical disclosure. The countless people whose life course is shortened by unequal access to health care are not topics of discussion. Without trivializing medical decisions like death and prolonged coma, Farmer pondered the interlining assumption of unlimited care and medical resources. The ethical questions while treating patients in his clinic in rural Haiti are much different. First and foremost, will the patient get any treatment at all? The current focus of medical ethics fails to address the larger context of social injustice because of the unconscious notion of small community. This results from the lack of universal set goals in medical ethical practice and education. If equal access to care is considered to be ethical, what levels of quality can medical ethics aspire if it ignores the population of poor? Also, how effective can theories to further medical ethics be if they are not closing the gap in care between the privileged and the disadvantaged? Medical ethics risks becoming yet another strategy for managing inequality if it fails to address the moral code that implicates all humans should have the right to survival (Farmer, 2003).

The relationship between human rights and medical ethics focus uncovers an internal conflict. Our nature pushes one to care about only the people considered kin, but there is a greater notion of right and wrong that silently rebels against this self-interest. In it lies the hope for broadening the caring radius beyond family and into the greater needs of society.

Peter Singer, well-known Australian Philosopher, puts a scientific theory behind this hope of broadening the context of solidarity. Singer states that it is a mistake to say that evolutionary theory shows that people cannot be motivated by a desire to help others (Singer, 2000). He uses blood and organ donation as an example that there exists in our nature something that makes humans want to care for each other. He believes the construction of a cooperative society not only should be attained but can be attained through the intrinsic morality of human nature. The ultimate societal goal, according to Singer, is for a society to reach a place of fulfillment to promote benefits for everyone. He argues that once basic individual needs are met, altruistic concerns, instead of just more economic growth, will bring happiness and fulfillment.

Singer’s theory gives scientific grounds to a human rights concept that was once dismissed as religious idealism until the more recent decades. Although society will always have an inclination towards self-interest, it is not impossible for humans to broaden their concept of solidarity. In fact, one could argue that fulfillment will only come with the initiation of these more virtuous social cycles. The medical ethical focus shows that medical professionals are lacking the training to enable them to address anything beyond the individual disease or injury. Now comes a desperate need for education to broaden societal paradigms and awaken the innate altruistic motives of medical professionals.
Once educated on broadening worldview, an interdisciplinary medical ethics course would be an effective advocate for involvement in pre-existing organizations involving doctors meeting global health needs. Doctors Without Borders, Mercy Ships, Partners in Health, and Doctors on Call for Service are amazing Non-governmental organizations making grassroots changes and bandaging wounds one individual at a time. Dr. Sainsbury is personally involved with Doctors on Call for Service, teaching emergency medicine to African physicians in the Congo and Rwanda. He often asks other doctors to join him, and is often disappointed by the lack of willingness to consider these suffering people ultimately worthy of their time and energy. The options for involvement are many, but the volunteers are few compared to the resources and needs. A medical ethics course would be a solid step towards improving solidarity between the fortunate minority and the unlucky majority.

Founder of the Liberation theologian movement, Gustavo Gutierrez once said, “If I define my neighbor as the one I must go look out for, on the highways and byways, in the factories and the slums, on the farms and in the mines -- then my world changes” (Gutierrez, 1988). The presentation of global health statistics and structural violence education will lead medical professionals to a caring threshold. According to Singer’s theory on human nature, it is possible and ultimately beneficial for medical professionals to not only redefine their neighbors, but cross this threshold into positive action. This will occur with the addition of an interdisciplinary medical ethics course in medical school and in continuing medical education contexts.

CALL TO ACTION

In 1966, Martin Luther King Jr. accurately stated, “of all forms of inequality, injustice in healthcare is most shocking and inhumane” (Edwards, Rohack, 2009). Forty five years later, and medical professionals are still lacking the solidarity necessary to decrease global health disparity. An interdisciplinary medical ethics education course will bring reality a step closer to the “basic health care for everyone” ideal set in our inherent moral code and the Universal Declaration of Human Rights.

The time has come for medical education institutions and associations to support this global health equity movement. Educated in global health issues and no longer hindered by self-interest, medical professionals have the potential to prevent horror stories like Acéphie’s and make the world a better place. This will inspire others to do the same.
History says, Don't hope
On this side of the grave,
But then, once in a lifetime
The longed-for tidal wave of justice can rise up
And hope and history rhyme.

Seamus Heaney,
“Voices from Lemnos”
I can speak from experience the crossing of the caring threshold mentioned in this paper. As a Kinesiology major, and aspiring nurse, I found myself familiar with a narrow minded view of a health professional career. But then I traveled to India and Thailand last summer and I met orphans and lepers and prostitutes and mothers and fathers and sisters and brothers no different from me. They suffered from diseases and ailments just like anyone else here in America but I saw there were economic, political, social, and cultural structures that kept them from receiving care like I could. The mentality of “us vs. them” was broken as I saw my hands in the oppressors and my face in the oppressed. When other doctors and students become fully aware of these structures driving the disparity and the need, I’m convinced their concept of community will be widened. I believe a reconstructed medical ethics curriculum in medical school and continuing education would effectively and efficiently bring medical professionals to this caring threshold. If we are truly to remain “ethically grounded” the world’s suffering people must be worthy of our thought and effort.

This paper was written by Erin Vroom for KINE 470 Media and Technology class at California Polytechnic State University in San Luis Obispo, Spring 2011.

Watch the video and find more information on Erin, Medical Ethics, and Health and Human Rights by visiting www.erinvroom.com

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