Just Healthcare beyond Individualism: Challenges for North American Bioethics

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Medical practitioners have traditionally seen themselves as part of an international community with shared and unifying scientific and ethical goals in the treatment of disease, the promotion of health, and the protection of life. This shared mission is underpinned by explicit acceptance of traditional concepts of medical morality, and by an implied link between individual human rights and the ethics of medical practice long enshrined in a range of World Medical Association (WMA) and other medical codes.[1-4] These have been powerful instruments exhorting individual practitioners to promote health and to defend universal principles in order to protect their patients and the physician-patient relationship even in the face of authoritarian state coercion and imposed national ideologies and policies. There has been widespread support for this approach and this should be intensified.

Modern medical practice, the result of close collaboration between advances in science and technology and their application under the scrutiny of the scientific method, offers much to improve the lives of individuals. Improvements in population health have, however, been less striking. Declarations by the WMA, Amnesty International, and other powerful organizations about the role of health professionals in torture and "crimes against humanity" have also been less effective than hoped for.[5] I suggest that while there may be many potential reasons for these shortcomings, including the propagation of self-interest by the medical profession[6] and lack of credibility of professional organizations such as the WMA,[7] the most important is almost certainly failure to see healthcare in its broadest social context[8-10] and failure to link concern for population health and human rights to actions that challenge those powerful economic and political forces that shape the context in which health and human rights can or cannot flourish.[11,12]

Any proposal for enhancing population health at national or global levels presents major challenges for North Americans and requires a broader concep-

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tion of bioethics (or perhaps "decisionmaking in medicine" as a more complete description) and the role of medicine in advancing health in a rapidly changing world than currently prevails.[13-15] In an attempt to outline these challenges I shall presume that most readers, like me, have been raised in relative privilege within the liberal, western, and scientific world view, conscious at only a superficial level of the different cultural and social contexts of life experiences of so many people in the world, and of the extent to which their own privileged lives are "subsidized" by complex and divisive social forces, both historical and contemporary. It is necessary to acquire an awareness of, and empathy for, how exploitation and racism deny the human identity of 'others' and divide people into 'haves' and 'have nots' within and between nations,[16-20] and to understand reactions to these that manifest in such forms as black consciousness, multiculturalism, feminism, postmodernism and other countercurrents—each advocating changes that call for scholarly and open-minded debate in the endlessly self-revising quest for knowledge.[21]

I shall suggest that justifiably deeply held interests in promoting individual dignity/rights (autonomy) and concern for doing good (beneficence), which have been the major focus of bioethics over recent decades, must become more intensively linked with greater concern about rectifying increasingly divisive inequities at the social level (justice), as all these moral principles are inextricably linked. The need for active endeavors to achieve social justice in healthcare is especially important in relation to longer-term perspectives in all societies. I shall suggest that: (1) a narrow individualistic interpretation of liberal philosophy and its application to morality in medical practice is inadequate; (2) there is a need to link healthcare to a concept of human rights that encompasses more than civil and political rights; and (3) moral responsibility for promoting health must extend beyond the physician-patient relationship, to include institutions and communities with a view to fostering the social solidarity required to advance population health at national and global levels.[22]

Healthcare Ethics

The reasons for the transition from the traditional concept of medical ethics to a new multidisciplinary discourse on ethics are varied and are located within the complex context of profound, generally liberalizing, social change evolving particularly in the United States but also elsewhere since the 1950s.[23-29] The rise to dominance of the principle of (patient) autonomy over (physician) beneficence, fundamentally based on respect for human dignity, has served to promote patients' rights, improve the communication essential for trust in the physician-patient relationship, and reduce the imbalance of power between physicians and patients in the modern technological age, and has allowed pluralistic perspectives to thrive. Debate, however, continues regarding: (1) the appropriateness of the absolute priority accorded to autonomy—even within the United States,[30-32] and (2) the often unacknowledged link between respect for individual autonomy and the responsibility this implies for individuals to others and their society as a whole.[33]

The principle of justice, particularly in relation to the allocation of resources,[34,35] has achieved less prominence. Reasons for this may include the high level of social justice built into health services in some social democracies (e.g., Canada, Britain, and many countries in Europe), but also the high profiles

given to technological interventions at the beginning and end of life in the U.S.A., where intense focus on individual liberty and the free market tends to eclipse considerations of social justice.[36]

Bioethics and the Medical-Industrial Complex

The complex social context in which North American bioethics has developed is, in its totality, specific for the U.S.A. However, a similar profile of change is evident in other countries, with wide application of rapid scientific and technological developments contributing to evolution of the physician-patient relationship from a somewhat paternalistic, personal relationship imbued with (at least some) trust, toward a rights-based, but also more impersonal and adversarial (but accountable) relationship between 'strangers.'[37,38]

American physicians generally deal with a better educated public who distrust medical authority and the power of medicine. The underlying national political philosophy fostering this attitude is that of liberal democracy in which self-determination, civil and political rights, and free trade are highly prized, but socioeconomic rights are limited, government control over healthcare services is feared, and civic duties are underemphasized.[39] Concern about excessive state power, potentially subject to public accountability through the democratic process, however, seems to have been traded for the progressive accumulation of (almost anarchic) power by private corporations that have been freed from accountability by "deregulation"—even though this permits them to diminish the freedom of the market.[40,41] These social changes, their ongoing evolution, and reactions to them, have implications for the universal ethos of medical practice and bioethics in a rapidly changing world characterized by increasing polarization into a core of privileged nations that are growing richer and a periphery of deprived nations that are becoming poorer.[42,43] Manifestations of the core-periphery spectrum within individual nations draw attention to the need to apply advances in both medical science and bioethics for the benefit of whole populations as well as for individuals.

Some Questions

Against this background some questions can be posed from the perspective of a foreign physician admiring of so much in the U.S.A. but skeptical about how universal healthcare goals can be modeled on a highly individualistic political philosophy that neglects community by sustaining a system of healthcare that, despite annual expenditure of over $3,500 per person per year on healthcare (more than 10 times the per capita GNP of half the world's population), fails to provide all citizens with access to a basic minimum healthcare package.

Why is the expenditure on health in the United States (14% of GNP) so maldistributed and the payoff as reflected in health statistics so poor in comparison with other industrialized nations?[44-46] What justification can there be for insurance companies to make massive profits within a medical-industrial complex increasingly shaped by economic and bureaucratic considerations, rather than by concerns for patient welfare? If the answers to these questions are linked to healthcare becoming merely another commodity to be traded at great profit in the marketplace[47] the implications are very adverse for the future of medical practice, for the nations' health, for the example set for other countries,

and even for the so-called freedom of the market, which is distorted and diminished by monopolies and oligopolies.

Why is there such a gap between the size and intellectual strength of a flourishing bioethics enterprise[48] (that has so enriched thinking and discourse about medicine) and its impact on improving patients' health and satisfaction with medicine in the U.S.[49-51] Is bioethics being subtly co-opted into the medical-industrial complex and serving (through a common cultural mind-set) to perpetuate the social injustices associated with U.S. economic values, or is bioethics sufficiently independent to be able both to pioneer reform and reshape healthcare services on the rational grounds bioethics is supposed to encourage?

Is the liberal political philosophy upheld for the nation believed in sufficiently to be applied coherently and consistently? Are the theoretical boundaries between the private realm of personal choices and the public realm of political and civic activities in a liberal society respected in practice? Is there consistency in the overriding of individual choices by state interest in protecting life? If the private and the public realms are considered separate, with the rights of individuals to shape their own lives taking precedence over any public conception of the good life, why isn't there greater respect for freedom of choice, for example, regarding abortion, physician-assisted suicide, and gender roles/relationships? In a liberal, secular, pluralistic society (where church and state interests are supposed to be separated) are some (religious or other) highly valued conceptions of the good being selectively propagated in the public realm in preference to promoting public neutrality? If so and if this relates to concern for the adverse effects excessive individual freedom may have on society, then this should be made more explicit. If state interests in life can be used to override individual interest for the alleged benefit of the public good, why is this not used as an argument for the role universal access to healthcare could play in shaping a cohesive society respectful of autonomous citizens and the common good? Autonomy has been respected and many measures taken to implement its application in practice. Why not the same for justice? Is the Canadian healthcare system more or less just than the U.S. system? Why is there so little serious attention to this question in the U.S. despite the excellent documentation available?[52,53]

Why has there been so little attention to the right of access to healthcare in a nation that upholds the idea of human rights so vigorously? While civil and political rights are vital, what example does a powerful and wealthy nation set for other nations when the social and economic rights that are also considered to be an essential component of the Universal Declaration of Human Rights are denied to its own citizens, and its monitoring of human rights abuses excludes self-assessment?[54]

Are ethical considerations in the U.S. framed from a universal perspective or are they contextually shaped? What relevance does this have for bioethics elsewhere? What are the scope and boundaries of moral concern in medicine? Should ethical considerations be limited to interpersonal considerations, or should there be more attention to the ethics of institutions (as cogently argued for by Thompson[55,56] and Wolf[57]) and international ethics (as advocated by others[58]). Can a universal ethics of medicine be sustained if the ethos of medicine is eroded?[59] Should ethical considerations focus only on individuals and the present or should consideration also be given to the implications of current practices for whole populations and future generations?

From Treating Disease in Individuals to Improving Population Health

Escalating healthcare costs, disparities in access to healthcare, and the problem of rationing raise questions of social justice relevant to the restructuring of health services to promote and sustain the dignity and autonomy of all citizens, including the poor, and particularly in the longer term. The recrudescence of tuberculosis and the spectre of multi-drug-resistant tuberculosis, even in the U.S., despite great strides in science and the availability of drugs that can cure any individual patient, illustrate the need to view the science and ethics of healthcare in a broad social context.[60-63] The well-recognized responsibility of physicians for the individual good of their patients must be extended to include consideration and acceptance of medicine's social responsibility for improving health at a community level.[64-66]

Broadening the Scope of Bioethics

Bioethics is a relatively young field of professional activity that has arisen and flourished through skepticism and critical attitudes, particularly by philosophers, to traditional, professionally oriented moral decisionmaking in medicine within the narrow framework of scientific and professional medical values. This is not surprising in the turbulent cultural milieu of the U.S. that has generated widespread and intensifying interest in ethics.[67,68] Multidisciplinary interest in medical decisionmaking involving philosophers, lawyers, physicians, nurses, and professionals from the humanities has facilitated and enriched both teaching and practical aspects of an expanded conception of medical ethics—now commonly called bioethics. While this transformation is spreading through many countries,[69] it is not surprising that in countries with different pathways and patterns of social progress the contextual application of the new bioethics is less clear.

But healthcare has also become a focal point within a complex social battle for power, prestige, and wealth, and the relevance of a dominant role for a liberal individualistic approach is being challenged. The need to extend the influence of bioethics in promoting population health is especially apparent in poorer nations, but also applies in industrialized countries. Critics of the "new bioethics" have expressed concern about a perceived overemphasis on conceptual analysis and ethical theory, on the difficulty in bridging the gap between ethical theory and clinical practice, and on the tendency for the focus on individual self-determination to foster selfishness and erosion of such virtues as self-effacing care for others and a sense of duty that when combined with judgment, skills, trust, and rapport with patients enrich the quality of the healing endeavor.[70-83]

Such criticisms, of a medical moral decisionmaking process influenced to a large extent by a secular philosophical approach,[84,85] come from theological,[86] anthropological,[87] social science,[88-90] feminist,[91] cultural,[92,93] and other perspectives.[94-97] These criticisms include: (1) opprobrium for the erosion of faith and the shift from the 'sanctity of life' principle to 'quality of life' calculations; (2) calls for attention to patient narratives of illness and ethnographic considerations; (3) advocacy for developing caring and empathetic approaches; (4) greater concern about pervasive racial and gender discrimination; (5) supplementation (*not replacement*) of the analytical philosophical approach with

existential, phenomenological, and hermeneutic philosophical approaches; (6) greater attention to the concept of a more holistic primary healthcare and biopsychosocial approach to health; (7) pleas for a deeper understanding of challenges to medical practice in cultural contexts very different from those of North America and Western Europe; and (8) for a less "ahistorical universalistic" and more sociological approach to healthcare decisionmaking in widely diverse contexts. While these criticisms are not without their own flaws, they deserve the constructive deliberation that together with ongoing challenges from many academic disciplines will certainly further shape the evolution of what is now called bioethics to encompass valid contributions to medical practice and medical decisionmaking from many perspectives.

A rational framework for analyzing and dealing with the imperialism of dominant perspectives is provided by Minow's lucid exposition of the 'dilemmas of difference' in American culture and law, of how these have grown "from the ways in which this society assigns individuals to categories and on that basis determines whom to include and whom to exclude from political, social and economic activities," and the unstated assumptions that underlie these dilemmas.[98]

Health and Human Rights

The idea of access to healthcare as a universal human right has gained widespread credibility in recent years. Basic good health is indeed seen as "one of the indispensable conditions for the expression of personal autonomy" in a liberal society.[99] It should however be noted that the conception of liberalism in the United States differs significantly from the liberalism of social democracies in Canada and many European countries where, unlike the United States, the concept of human rights includes socioeconomic rights.[100] Opposition to the idea of the right to access to healthcare in the United States has been challenged recently by the American Association for the Advancement of Science's project to influence healthcare reform by promoting the right of all citizens to a level of healthcare commensurate with their country's wealth.[101] This was a commendable (but also long overdue) attempt by a prestigious organization to state with conviction the role of medicine and healthcare in the U.S.A. As stated in the preface of this publication:

> Health care is first and foremost a social good dedicated to the improvement of the health and well-being of the entire community, not a private commodity. A great deal more than individual needs and advantage is at stake. Health care reform involves the renegotiation of the social covenant defining social obligations and commitments between the government and the society and between members of the society. The nature and humaneness of the society in which current and future generations will live will depend on decisions made regarding the structure and standards of the healthcare system. A determinant will be whether the reform process primarily protects the insurance coverage and benefits of groups that are amongst the "haves" or, consistent with a human rights approach, accords priority to improving the health status of "have nots". Another question is whether a commitment to the common good can outweigh the influence of the "medical industrial complex" in setting the agenda for reform.[102]

Recent failed attempts to reform American healthcare are thus distressing. Explanations for the failure that focus on proximate causes and (relatively) medicine-specific historical considerations are insufficient.[103] Reflection is also required on the history and nature of American culture and politics to reveal the difficulty in achieving a conception of human rights that goes beyond civil and political rights in a society that has elevated the admirable concept of individual liberty to a level that (with the best of intentions for individuals) seems to undermine the concept of community to the detriment of both society at large and many of its citizens.[104-107]

The liberal-communitarian debate that has gained prominence in the past decade (in response to both practical failures in the implementation of liberal policies and to perceived deficiencies in liberal theory itself) seems relevant here.[108-112] Emanuel has argued that it is the inadequacies of the political philosophy of liberalism (in particular the idea of neutrality regarding the common good) as applied to medicine that accounts for the inability to resolve many of the ethical dilemmas currently being faced in healthcare.[113] The communitarian critique of liberalism poses challenges to four central tenets of liberalism, each of which has implications for healthcare. These are: (1) the concept of the self as a presocial, autonomous, self-determining individual, (2) the concept of community as made up simply of such individuals, (3) the priority of individual rights (civil and political) over any particular conception of the (common) good (implying neutrality in the public realm), and (4) the distribution of resources predominantly through the pursuit of free trade (conceived of as if free and not as in reality distorted by powerful political forces). However, communitarians should not all be stereotyped into the same mold, as the critique spans a range from radical to cautious communitarianism.

It is also necessary to understand liberalism as a spectrum that ranges from libertarianism to welfare liberalism.[114,115] Elegant responses from liberals, for example, Buchanan,[116] Rosenblum,[117] Gutmann and Thompson,[118] and Gutmann,[119] illustrate the power of the political philosophy of liberalism to deal constructively with communitarian criticisms. In the absence of any adequately developed communitarian theory, these liberal responses show that it is not liberal theory in its fullest sense that is necessarily deficient but rather the seemingly narrow, individualistic interpretation of liberalism that has been implemented in practice. Walzer's description of liberalism as a self-subverting doctrine that requires periodic communitarian correction to reinforce pursuit of its community values,[120] Buchanan's elegant and penetrating analysis of the communitarian critique of liberalism,[121] and Mulhall and Swift's explication of the liberal-communitarian debate[122] identify much common ground for building a deeper understanding of liberal values and making progress toward achieving community goals.

Whereas liberalism in the United States has allowed some individuals to flourish at the expense of others and without adequately pursuing a sense of community, the inability of liberalism to achieve its broader goals in other countries[123,124] and the debate between liberals and communitarians set the scene for greater attention to the crisis of liberal internationalism described by Hoffman[125] and to the need to build a concept of international justice capable of contributing to peaceful global development. This is a vital task at a time when marginalization of billions of people threatens to undermine all in the long term.[126-128] Statements by Western economists that "two thirds of the

world's people are superfluous"[129] profoundly undermine the cherished concept of human dignity, mock the concept of universal human rights, and could propagate hideous exploitation and degradation, even within medical practice if this identifies with such economic thinking.

The fundamental cultural and social forces that contribute to human rights violations and the role and the limitations of human rights education have been described in the Latin American context, where linkage of human rights education to justice is seen as a means of achieving reconciliation.[130] The recent Commonwealth Medical Association's project on the role of medical ethics in protecting human rights represents a very small but potentially important step toward addressing these issues at a wider level. It takes as its starting point the fact that physicians are among the first to become aware of human rights abuses and that: "the ethical regulation of their professional conduct is, therefore, an important, though little recognized, component of the observance and enforcement of human rights." In formulating a set of guiding principles linking medical ethics and human rights the CMA has also acknowledged that: "the quest for political, economic and military power has polarized the world into a small, stable, privileged core of people and a large, growing, marginalised periphery," and "it is increasingly recognized that exploitation of the human and material resources of developing countries threatens the health and dignity of those societies and ultimately the well-being of all."[131]

The CMA goes even further in pointing out that the inability of many people in the world to enjoy the benefits of basic human rights is clearly linked to those economic forces that have arisen through complex global economic and political patterns of change, and that health, human rights, and justice for all can only be approached through probing and transforming those forces that drive the acquisition and use of economic resources. I should like to propose that it has been the failure to acknowledge this that has been a major impediment to the promotion of human rights at a global level.[132] Some introspection seems appropriate at this point.

Examining Ourselves

Recognizing Privilege

Those who live, work, and think in rich material and intellectual environments understandably tend to take for granted their wealth, democracy, and civil society.[133,134] They may have little direct knowledge or understanding of how their societies have acquired the resources that enable them to lead comfortable lives. They are also remote from the "world of victims"[135] and from the difficulties faced by colleagues who are endeavoring to sustain universal professional ideals and accessible services in poor, nondemocratic, and oppressive countries in which a myriad of overt and covert forces influence and obstruct them. These divergences in perception are abundantly clear to those from the 'Third World' who participate in international meetings on 'human rights' and observe how colleagues from privileged societies often speak from their own socially determined perspectives with inadequate understanding of complex contexts beyond their own.

Humility, empathy, and a broad intellectual approach are necessary (1) to understand fully the pervasiveness of powerful economic and political forces

that have shaped the past and will shape our future,[136,137] (2) to overcome somewhat imperialistic expectations of others in vastly differing societies from whose cultural perspective we can also learn, (3) to understand the contextual implications of "universal theories," and (4) to acknowledge that privilege and power acquire legitimacy by generating moral obligations that go beyond exhortation and the elaboration of theories to include exemplary action.

Recognizing Coercion

Those who live in democratic societies also need to recognize that pervasive ideological forces that coercively affect healthcare professionals in oppressive countries also operate (albeit in a more subtle and less oppressive fashion) in their world. As Ericson has stated,

> Even in democratic societies a constant alertness . . . is needed to resist pressures to subordinate all institutions that shape the human spirit and to place them under the control of those who want to dominate the social order. Although there are profound differences between the extent of personal freedom within Western democracies and one-party communist societies (and these distinctions should not be minimized) it is nevertheless true that the future of the free mind is threatened by converging forces in both these rival systems. In the Communist States and the Western nations, technological structures and bureaucracy instil in the individual citizen a feeling of helplessness and hopeless passivity. Both social systems are advancing towards corporate structures that efface individuality and freedom of expression. Both are managerial societies that tend to equate virtue with conformity, pliability and administrative efficiency . . . (even) teachers of ethics are reduced to functionaries controlled by a corporate mentality concerned most of all with 'success' as measured in quantitative terms.[138]

Recognizing Subversion

The American Association for the Advancement of Science (AAAS) many years ago expressed similar concerns regarding the appropriation of science for parochial purposes:

> Science, the instrument which produces power is being consciously exploited for industrial, military and economic purposes . . . there is little recognition of the internal needs of science or of its purposes as a discipline of the human mind. . . . There is some evidence that the integrity of science is beginning to erode under the abrasive pressure of its close relationship with economic, social and political affairs.[139]

About 20% of the world's research scientists and engineers work entirely on military research and development. If only physicists and engineering scientists are considered this percentage rises to 50%—a sobering insight into the extent to which scientists are co-opted into projects associated with human aggression. The ongoing relevance of these concerns and their global implications are reflected in the National Academy of Sciences' document, *Responsible Science*,[140] and in The Toronto Resolution.[141]

Co-option into Ideologies

Physicians in some countries have been justifiably exhorted and expected to stand against the overtly coercive ideologies of their governments and unjust institutions (even at the risk of their lives) in defense of the rights of their individual patients, for example, in South Africa[142] and Chile.[143] I should like to suggest that physicians in other, more privileged societies cannot be complacent. They too are co-opted into powerful, albeit more covertly coercive, social systems that influence thought.[144] It can be argued, on grounds analogous to the role of physicians in South Africa and Chile, that their power and privilege also generate moral obligations to take similar stands against the powerful ideologies operative in their societies. This is necessary not only to defend the rights of people in their own nations but also to ensure that their own nations' policies do not include political domination or military and economic exploitation that may deprive billions of access to even the most basic of human rights.[145-150]

The enormous responsibility of privileged health professionals (in wealthy and in poor countries) to understand these social forces and to help convert a rhetoric about universal human rights into reality for billions of marginalized people in the world must surely be as openly acknowledged and pursued as the obligations of those who must defend individual human rights in oppressive countries. Selective moralizing from positions of privilege and power lacks credibility, at least at the intellectual level. The potential danger alluded to here, of philosophers and ethicists in wealthy nations being covertly co-opted into national ideologies or the medical-industrial complex, needs to be recognized and resisted.[151-153]

For example, with regard to contributions from bioethicists to the problem of rationing in healthcare Seedhouse has suggested that by accepting their context, and working within it, bioethicists act to legitimize the context either by making it look ethical through endorsement or by becoming part of the fabric of the context. He proposes that

> there are two potentially productive pathways open to bioethics, neither of which are being pursued by most bioethicists at the moment. The first is to stand outside the system and not take it for granted—to do political philosophy in the traditional sense. The second is to take healthcare systems for what they really are—that is, to see them as tribal systems, to grasp their nature as it appears to those within that culture and then—if this is felt desirable—to change the system by using the ways of the culture . . . to work in a partly logical, partly emotional fashion . . . in a way that acknowledges history and culture (and so to be logically corrupt in a way accepted by that tribe). The alternative for bioethics is stagnation and, ultimately extinction.[154]

His expressed preference is to try to examine the system from outside. Buchanan's recent article is a masterly example of this approach.[155]

The concept of intellectuals and academics becoming apologists for the dominant culture within which they live or work is largely undisputed in relation to some contexts, for example, Russian psychiatry. However, suggestions that this may also apply within the western world (for example, to the way in which British and North American anthropologists once served colonial ends

despite their perceptions of themselves as mediators trying to diminish the effects of imperialism, more recently the role of social anthropologists in promoting apartheid,[156] and of medical anthropologists in relation to the dominant biomedical model of healthcare[157]) are intensely debated.[158–160] There is, however, no place in such debates for the personal vendettas that have marred their scholarship. Agich's discussion of the conflicting aspects of the ethicists role in the clinical setting is a model of a scholarly approach to the debate on the 'objective' and 'subjective' aspects of the observing/witnessing roles.[161]

Summary and Some Proposals

In the 19th and early 20th centuries medical morality was largely concerned with unarticulated aspects of professional virtue and with openly discussed conflicts of interest between practitioners (fee-splitting, self-referral, advertising etc.). In the first two decades of modern medical ethics, these gave way to preoccupations with application of liberal political principles to the practice of medicine, for example, to fostering patient autonomy with all the associated implications this has for interventions at the beginning and end of life,[162,163] and for participation in medical research.[164]

In the past decade, however, commercialization and corporatization of medicine within an increasingly dominant economic paradigm of thinking is turning medicine into a medical-industrial complex in which economic and conflict of interest considerations are becoming dominant.[165,166] Normative aspects of traditional virtue and compassion are being eclipsed and self-interest is being fostered. The medical profession seems to have lost its soul, with greed being turned into a virtue under the influence of powerful medical corporations that are not democratically accountable and that have been transformed from institutions serving the means of providing expanding healthcare services, to an end in themselves—the accumulation of wealth through the exploitation of human vulnerability in illness.[167] The medical profession seems unwilling or unable to use its institutional strength to reverse these trends.

Yet, the need for social justice in the delivery of healthcare is being acknowledged and there is increasing urgency both to reclaim much that is being lost in the practice of medicine, and to redefine what is considered necessary for the provision of preventive, promotive, and curative healthcare services that meet individual and community needs.[168–176] To ensure that those who participate in the provision of healthcare are motivated by long-valued virtues will require intense and sustained intellectual and social opposition to those powerful social forces that may undermine the ideals of medicine. These forces result in the overt co-option of health professionals at the individual level into "crimes against humanity," or their covert co-option at national levels into activities that deprive millions of access to basic human rights. For example, a powerful ideology that commodifies medical care in a marketplace in which healthcare professionals are dominated by the procedural and business priorities of corporate managers is replacing the ethos of medicine with a business ethos that adversely affects individual patients and whole populations.[177–181]

Given the power and influence of the great American nation, it should not be surprising that the example it sets through the way it structures its healthcare services has a profound symbolic and material impact (positive and negative) on the practice of medicine in many other countries. This applies not only to

scientific and ethical issues that have received much attention, but also to social and political aspects of healthcare. The legitimation of medical care as predominantly a marketable commodity is undermining the ability of less affluent nations to sustain or develop appropriate healthcare services for their citizens in very different sociopolitical contexts. Even in some social democracies such as Canada and Britain healthcare systems are fracturing under this influence.[182,183] In a middle income country such as South Africa struggling toward a democracy embracing respect for individual liberty, human rights, and more equitable access to healthcare, and education to begin to reverse the legacy of apartheid, it is becoming almost impossible to sustain or build a strong public healthcare service.[184]

The challenge for those concerned with justice in the delivery of healthcare and with sustaining moral behavior in medical practice is to provide rational and coherent arguments for just healthcare (as Buchanan has done[185]), and to find ways of supplementing philosophical ethical debate with restructuring of healthcare services within which teaching methods and exemplary practice could propagate a science and art of healthcare that addresses more humanely the health of individuals and of whole populations. This will require recognition that while individual preferences, values, and perceptions are pervasively influenced by the particular social and institutional structures within which they operate, and in turn influence these, healthcare services as social constructs can be progressively reshaped through a social activism and clear exposition of the rationale for change. This process involves acknowledging that implementing sound ethical values within nations, and worldwide, must include some courageous collective action and new approaches to our understanding of achieving moral behavior as an enterprise influenced as much by practice as by theory.[186-191]

Many countries lag behind North America and Europe in debating individualistic bioethical issues in a multidisciplinary milieu and in offering these deliberations to public scrutiny. However, there is also a gap in wealthy countries between ethical concern at the individual level and the institutional and population levels at which ethical debate and action is required. Hopefully, this will change as the deficiencies of extreme forms of liberal individualism are unraveled, liberal and communitarian responses are formulated,[192-198] rights become recognized as embedded within relationships,[199] interpersonal ethics is supplemented by institutional ethics,[200,201] new metaphors of medicine are forged,[202] and international relations are transformed.[203,204] As physicians in the U.S. seem to be unable to respond adequately to the call for social justice in healthcare, North American bioethicists are challenged to take a leadership role by recognizing their responsibilities to populations, national and global, and using their intellectual and moral power to help shape equitable healthcare systems in their own countries. Through this example and other efforts they can contribute to sustainable development programs that could hopefully improve health and human rights worldwide.

Healthcare professionals in poor and nondemocratic countries need encouragement and support in upholding the rights of their individual patients, and in shaping appropriate healthcare systems in their countries. Those in wealthy countries need to be sensitized to, and to take on, their wider moral responsibility to strive beyond the limited perspectives of their nations in the quest for high ethical standards in the delivery of healthcare services, and through this

for the progressive achievement of human rights and health at a global level. Bioethicists and bioethics institutions have a crucial role to play in helping the healthcare profession to renew and strengthen its vocational commitment. Loss of public faith in the ability of physicians to achieve this for themselves places a particular burden of responsibility on the bioethics establishment.

A report from the United States Office of Technology Assessment documents the extent to which bioethics initiatives are developing worldwide, and it advocates the need for incorporation of bioethical analysis into national policymaking.[205] This, together with the global agenda for bioethics proposed in the Declaration of Ixtapa[206] and a proposal (Appendix) that has been accepted by the WMA as a working document,[207] could form the bases for steps toward more open and honest debates on disparities within nations and between nations and for approaches to these that are both locally and globally relevant.

In this brief overview I have only been able to allude (I recognize somewhat simplistically, and optimistically) to the potential for an expanding and increasingly important global role for bioethics in a complex world in which social, economic, political, and health issues are intimately related. Considerable scholarship from a diverse range of intellectual sources is enriching our understanding of health and disease and could influence the way in which medicine will be practiced in the future, but much remains to be done to convert 'knowing good' to 'doing good.'[208]

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22. I hope that my concerns will be viewed in the context of an ongoing attempt by a physician to "stand outside his discipline and world view" and see perplexing social problems as symptoms arising in an unjust world that is undergoing profound changes—changes that are reflected in the much admired transition taking place in South Africa which, with all its turbulence, has a positive message for the world. The concerns and criticisms I shall express regarding bioethics and medicine in the U.S. relate to the system within which these operate and not to the many fine colleagues in both fields whom I hold in high regard and affection, and from whom I have received so much intellectual stimulation and friendship over the years. Having experienced the impact of being included by some in the stereotypic picture of "Apartheid medicine" in South Africa—perhaps an inevitable consequence of living in this society—I am aware that in taking a broad view I risk offending colleagues by portraying a somewhat monolithic image of American medicine and bioethics. This is certainly not my intention and I regret any offense I may cause in my attempt to provoke greater interest in the pervasiveness of exploitation and in the symbolic and material influence of the U.S. medical and bioethics enterprises on a global scale.
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APPENDIX

Proposed World Medical Association Statement on Health and Human Rights

Whereas the World Medical Association:

A. Recognises that:

1) We live in a divided world, a world in which 23% of the world's population lives in affluence on 85% of the annual global economic output, while 77% live poorly, often in misery, on 15%;
2) These disparities have deep roots in centuries of complex human development and progress that has regrettably been associated with military and economic conflict and exploitation;
3) The gap continues to widen as human and material resources flow from poor countries into the rich;
4) These disparities and their causes aggravate population growth, human misery and ecological degradation in all countries;

5) Vast resources are wastefully expended year after year on militarisation worldwide;

B. Notes that healthcare professionals have:

1) Traditionally seen themselves as part of a global medical community with shared goals for the protection of life and health;
2) Formulated codes of ethics that reflect the universal nature of these professional obligations;
3) Committed themselves through their nations to support universal human rights, including health for all;
4) Responsibility towards the common good as well as their individual patients;

C. Acknowledges that

1) The principle of justice requires access to health care in all countries as a basic human right without which people will suffer individually and communities collectively;
2) We live in an interdependent world in which modern communication and transport systems inform us about and expose us all to individual and collective threats to human health and survival.

The World Medical Association urges all health care professionals and their professional associations to:

1) Acknowledge that their responsibility for individual and population health should not be subverted by political and other ideologies either in wealthy or in poor countries;
2) Expose and contest actions taken by their respective governments that may adversely affect the health of individuals or populations, at home or abroad;
3) Assist professional organizations in other countries in their efforts to achieve this; and
4) Accept the challenge to work towards creating national and international concepts of the practice of medicine that will contribute to the health of populations as well as to the health of individuals.