

## TEACHING GLOBAL BIOETHICS

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### ABSTRACT

*We live in a world with enormous disparities in health. The life expectancy in Japan is 80 years; in Malawi, 40 years. The under-five mortality in Norway is 4/1000; in Sierra Leone, 316/1000. The situation is actually worse than these figures suggest because average rates tend to mask inequalities within a country. Several presidents of the IAB have urged bioethicists to attend to global disparities and to broaden the scope of bioethics. For the last six years I have tried to do just that. In this paper, I report and reflect on my attempts to teach bioethics in ways that address global health and justice. To begin, I discuss how I structure bioethics courses so as to move naturally from clinical ethics to health policy to global health. I then discuss ways to address key ethical issues in global health: the problem of inequalities; the nature of the duty to assist; the importance of the duty not to harm; the difference between a cosmopolitan and a political view of justice. I also discuss how teaching about global health may help to shift the emphasis in bioethics – from sensational cases to everyday matters, from autonomy to justice, and from access to healthcare to the social determinants of health. At the end of my paper, I reflect on questions that I have not resolved: how to delineate the scope of bioethics, whether my approach over-politicises bioethics, and how to understand the responsibilities of bioethicists.*

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We live in a world with enormous disparities in health. The life expectancy in Japan is 80 years; in Malawi, 40 years. People born in Japan can now expect, on average, to live twice as long as people born in Malawi. The under-five mortality rate in Norway is 4/1000; in Sierra Leone, 316/1000. Of all the children born in Sierra Leone, more than 30% will die before they are five years old. The maternal mortality rate in Sweden is 5/100 000; in Mozambique, 1000/100 000. This means that 1% of pregnant

women in Mozambique will die of causes related to their pregnancy – a risk that is repeated with each pregnancy.<sup>1</sup>

In two ways, the situation is actually worse than these figures suggest. In the first place, average figures tend to mask inequalities within a country. For the poor and marginalised within a country, the life expectancies are even shorter and the mortality rates are even higher. In the second place, measures of life expectancy and mortality ignore the burden of disease that results from morbidity. Mortality rates do not take into account the pain, disability, and lost opportunity that comes with illness. Measures like ‘disability adjusted life expectancy’ suggest that the disparities between countries are even larger.<sup>2</sup>

And the HIV pandemic has made a bad situation even worse. Of the 36 million people who are living with HIV infection, 75% are living in Africa. In Zimbabwe, about 25% of adults are infected. In Botswana, 35% of pregnant women at prenatal clinics are HIV-positive. If these women do not receive treatment to block mother-to-infant transmission, about 25% of their children (9% of all children in the country) will be born infected with HIV. And many children who are born in good health will lose their parents to the disease. About 12 million children in Africa are orphans because of the pandemic. If the current rates continue, there will be 40 million orphans by 2010.<sup>3</sup>

Several presidents of the International Association of Bioethics have urged bioethicists to attend to the disparities in health that exist within and between countries.<sup>4</sup> They have urged us to look at the whole world and to broaden the scope of bioethics. For the last six years, I have tried to do just that. In this paper, I report and reflect on my attempts to teach bioethics in ways that address global health and justice.

<sup>1</sup> All these figures are from: *The State of the World's Children*. 2001. New York. UNICEF.

<sup>2</sup> See, for example: World Health Organization. 2000. *The World Health Report 2000*. Geneva.

<sup>3</sup> For the latest figures, see the UNAIDS website: [www.unaids.org](http://www.unaids.org). It is possible to find different estimates in the literature, but I do not want to quibble about the numbers. By any estimate, the problem and suffering are enormous.

<sup>4</sup> See the presidential addresses by Daniel Wikler, Ruth Macklin and Solomon Benatar. D. Wikler. Presidential Address: Bioethics and Social Responsibility. *Bioethics* 1997; 11: 185–192. R. Macklin. Bioethics and Public Policy in the Next Millennium: Presidential Address. *Bioethics* 2001; 15: 373–381. S. Benatar. Presidential Address: Bioethics: Power and Injustice. *Bioethics* 2003; 17: 387–398.

## FROM CLINICAL ETHICS TO GLOBAL BIOETHICS

In teaching bioethics, I have not ignored the more traditional and familiar issues in the field. I address ethical issues that arise in clinical settings. I also address ethical issues about the use of new technologies, the way healthcare organisations function, the aims of health policy, and proposals to reform healthcare systems. But I try to address some of these issues in ways that lead to questions about global health and justice.

In a sense, I try to let the students experience different stages in the development of bioethics. A number of years ago, Daniel Wikler identified the following four stages: (1) discussions of codes of professional ethics; (2) critical accounts of the traditional doctor-patient relationship; (3) ethical evaluations of healthcare systems and healthcare financing; and (4) ethical discussions of population health.<sup>5</sup> Although we could argue about how and where to delineate different stages, I do not want to do that here. I want to note the value of letting students experience aspects of different stages. In the physical sciences, it is less important to acquaint students with the stages in the development of these sciences. After all, some stages have been overturned or outmoded. But in bioethics, the different stages deal with issues that people still face.

So I have tried to include issues and problems that reflect different stages in the development of bioethics. And I have tried to show how ethical concern and reflection, at any stage, can lead quite naturally to issues of global health and justice. At each stage I try to include some issues and case studies that lead the way. I will give one example.

After the students have studied familiar issues about doctors' duties and patients' rights, I use the following case study, a case from a public clinic in New York City:

*A Depressed Patient:* Mrs. Chen was waiting to be seen in the primary care clinic. She was sitting quietly with her daughter, who looked to be about ten years old. It was almost six o'clock when Dr. Marsh called Mrs. Chen's name and introduced himself. Mrs. Chen didn't speak a word of English, but her daughter was fluent. Although Dr. Marsh didn't like to use family members as interpreters, he didn't know what else to do. The Cantonese-speaking receptionist had gone home at five, and so had the hospital interpreters. He didn't want to send the patient away, so he began the interview through the daugh-

<sup>5</sup> Wikler, *op. cit.* note 4.

ter. He asked a few open-ended questions and took in the responses, all with the help of his ten-year-old interpreter. As the story unfolded, Dr. Marsh realised that Mrs. Chen was seriously depressed. He wanted to ask some pointed questions to assess the risk of suicide, but he felt bad about posing these questions through the daughter.<sup>6</sup>

We can raise ethical issues about whether the doctor should use the daughter to try to assess the risk of suicide or whether he should avoid posing these questions. Better yet, we can raise issues about the doctor's responsibility to avoid this choice in the first place. Although some philosophers like to formulate conflicts as airtight dilemmas so that people must choose one side or the other, most of life is not like *Sophie's Choice*. Much of the real work in moral life involves attending to various concerns and finding satisfactory ways to reconcile those concerns.

Of course, we can also raise ethical issues about how the hospital is organised. How should the hospital respond to the needs of patients who do not speak English? How should the hospital organise its resources and use its budget? How should the hospital work with different language communities? These are questions that hospital administrators, and other concerned people, need to address.

There are also questions at the social level. What is society's responsibility for people who live and work in that society? What is society's responsibility for undocumented workers or illegal immigrants? This last question leads to ethical issues at the international level. Not only is it important to address ethical issues at all levels. It is also important to consider how best to integrate individual, familial, professional, organisational, social, and international responsibilities.

Using a case like *A Depressed Patient* helps students to develop important skills and dispositions. Students need to learn to search for satisfactory alternatives when they are faced with difficult choices in particular cases. But they also need to learn to bring the background into focus so as to raise issues about the social context in which the particular cases occur. When they can do that, they will be able to identify ethical issues at many levels, including the international level. To see how ethical concerns extend naturally to different levels and focal points is part of what it means to broaden bioethics.

<sup>6</sup> J. Dwyer. Babel, Justice, and Democracy: Reflections on a Shortage of Interpreters at a Public Hospital. *Hastings Center Report* 2001; 31: 31–36, at 31–32.

## GLOBAL HEALTH AND SOCIAL JUSTICE

When I come to the section of my course that is devoted explicitly to global health, I describe in detail the disparities in health that I mentioned at the beginning of this paper. Merely describing the existing inequalities has a tremendous effect on my students because many of them are only vaguely aware that so many people in the world have such poor health prospects. Although many of my students are relatively uninformed, I have never had a student who was really indifferent to the suffering and ill health of millions of people.

Because most people have some moral sentiment and human concern, describing the state of the world has a powerful effect. When we deliberately and repeatedly focus our attention on the state of global health, ethical issues emerge. The first and biggest issue to emerge is the question of a duty to assist. Do people in relatively healthy and wealthy societies have a duty to assist people in unhealthy and poor societies?

Taking a non-foundationalist approach, I have come to believe that the real issue is not about whether there is a duty to assist, but about the nature, extent, aim, and fulfilment of this duty. To shed light on these issues, I often set out Peter Singer's account of the duty to assist.<sup>7</sup> I begin with his view, not because I endorse it, but because I admire the way it engages the issue and engages the students. Singer starts with the widely held view, and the widely felt sentiment, that we have a duty to assist a child who falls into a pond, if we can do so without sacrificing anything of comparable moral worth. He articulates the principles and ideas behind this common view, and then extends them to the global situation.

The discussion of the duty to assist leads quite naturally to questions about the effectiveness of aid. It is here that scepticism and indifference surface. It is not really indifference. It is a mixture of healthy scepticism, empirical ignorance, and unexamined ideology. Some students make overly general and poorly supported claims about the causes of people's poor prospects, and then conclude that all aid is useless.

When students make such claims, I take the time to examine the root causes of the poor health prospects for so many people. Here I shift from the ethical question about duties to the empirical question about causes. This order may seem backward or even

<sup>7</sup> P. Singer. 1993. *Practical Ethics*. Second edition. Cambridge. Cambridge University Press: 218–246.

illogical. Shouldn't we first get clear about the facts and then take up the ethical question? The best logical order may not be the best pedagogical order. Starting with an ethical concern and question helps to focus the empirical inquiry, and a better empirical understanding may point to a need to reconceptualise the ethical issue. In teaching, as in life, we often go back and forth between ethical and empirical inquiry.

How much empirical inquiry is enough? I have no simple answer to that question. If we undertake too much empirical inquiry, we will never get back to the ethical issues. If we engage in too little empirical inquiry, our ethical reflections will remain abstract and disconnected from concrete situations in the world. So I try to acquaint my students with several key points and several supportable generalisations.

In countries with high rates of childhood mortality, about half of all deaths are due to two immediate causes: diarrhoea and acute respiratory infection. Yet the causes of death are not just microbes. About half of all children who die are malnourished, to a greater or lesser extent. Their malnourishment renders them more susceptible to many diseases, and less able to respond when they do become ill.

This point leads to the following question: what are the root causes of malnourishment? Many students focus on overpopulation and shortfalls in food production, but there is a growing body of evidence that challenges that view. Amartya Sen and others have shown that the problem is primarily a problem of distribution, not production.<sup>8</sup> Famines and widespread malnourishment are often due to features of the political and social structure. Land, income, and power are very unequally distributed, and many social systems fail to provide backup entitlements.

What begins as an inquiry into the immediate causes of death leads to broad questions of social justice. In *The Law of Peoples*, John Rawls gives a summary of the causes of destitution in what he calls burdened societies. He believes that the principal causes of the poor life prospects of so many people are 'basic political and social injustices.'<sup>9</sup> So he focuses attention on war, the rule of law, human rights, divisions of property, class structures, the status of women, and the cultural and moral beliefs that underlie these traditions and structures.

<sup>8</sup> A. Sen. 1981. *Poverty and Famines*. Oxford. Clarendon Press. J. Dreze & A. Sen. 1989. *Hunger and Public Action*. Oxford. Clarendon Press.

<sup>9</sup> J. Rawls. 1999. *The Law of Peoples*. Cambridge, MA. Harvard University Press: 108.

With Rawls' summary in mind, it is instructive to look at examples of countries whose health measures are notably better, or notably worse, than their wealth would lead one to estimate.<sup>10</sup> Consider Costa Rica and Brazil. In Costa Rica, the GNP per capita is \$2740 and the under-five mortality rate is 14 per 1000. In Brazil, the respective figures are \$4420 and 40. Consider Sweden and the USA. In Sweden the GNP per capita is \$25 040 and the under-five mortality rate is 4 per 1000. In the USA, the respective figures are \$30 600 and 8. These examples help to focus attention on class structure, inequalities in income, provision of healthcare, concern for public goods, and other factors that raise issues of social justice. But we need to keep in mind that even the good examples may be adversely affected by international arrangements and transnational forces.

Perhaps the most telling example of all is Kerala, a relatively poor state in the south of India. The GNP per capita is around \$1000 and the per capita spending on healthcare is around \$28 per year. Yet life expectancy at birth is 72 years, infant mortality is 14 per 1000, and the fertility rate is 1.7 per woman.<sup>11</sup> Examples like Kerala tend to support Rawls' claim that a 'society with few natural resources and little wealth can be well-ordered if its political traditions, law, and property and class structure with their underlying religious and moral beliefs and culture are such to sustain a liberal or decent society.'<sup>12</sup>

Although it is important to give students concrete examples, I try to be careful not to oversimplify the relationship between health and social justice. Both the concept of health and the concept of justice are multidimensional, and the relationship between these concepts is complex. In the midst of this complexity, I try to highlight two points. First of all, if social institutions ignore very basic needs of whole classes of innocent people, when it would be reasonable to rearrange these institutions so they do respond to very basic needs, then we can presume that these institutions are unjust. On the other hand, there may be injustices that do not impact on health. It is possible for a society to have good measures of health, and even relatively narrow disparities in health, but to be unjust because it violates civil liberties or political freedoms that we consider part of justice.

<sup>10</sup> The following figures are from: *The State of the World's Children 2001*, *op. cit.* note 1.

<sup>11</sup> K.R. Thankappan. Some Health Implications of Globalization in Kerala, India. *Bulletin of the World Health Organization* 2001; 79: 892–893.

<sup>12</sup> Rawls, *op. cit.* note 9, p. 106.

## INTERNATIONAL JUSTICE

When we return to the ethical issue, things look different and more complex. The duty to assist needs to take on a different focus. If certain kinds of social injustices are responsible for the poor health prospects of many people, then we need to focus more attention on assistance that promotes just institutions. This new focus has two consequences. First, forms of assistance that reinforce unjust structures are suspect. Secondly, forms of assistance that exclude the participation of the beneficiaries are suspect. Paternalism in global health is as problematic as paternalism in clinical practice. Assistance should seek to empower those who are often marginalised, and to allow everyone who is affected a real chance to shape the goals and policies of assistance. After all, justice demands respect, empowerment, and some degree of political autonomy.

In practice, I have come to think that the duty not to harm is often more important than the duty to assist. Powerful nations, corporations, and institutions sometimes engage in practices that harm disadvantaged people in low-income countries. In the past, the powerful have colonised territories, fought and financed unjust wars, supported oppressive regimes, reinforced privileged groups, undermined social reform, encouraged unhealthy practices (like the use of tobacco), pressured health-care systems to reduce public expenditures, valued intellectual property above public health, and contributed to environmental problems.

In focusing on ways that powerful countries and corporations harm people with poor prospects, I do not mean to shift all the blame. There is often enough blame to go around. But if justice is an important element, then we need to attend to these matters. Yet the focus on justice requires some clarification. Two different ideas are at work here. One idea is the idea of social justice – the notion of fair and responsible practices and institutions within a society. The other idea is the idea of global justice – the notion of fair and responsible practices and institutions between societies. How social justice and global justice are related is an important question. Different answers to that question tend to specify different conceptions of justice.

The big conceptual divide is between a cosmopolitan view and a political view. Although there may be no pure examples of either view, there are examples where the emphasis is decidedly in one direction or the other. Peter Singer is an example of a philosopher who takes a more cosmopolitan view of justice; John Rawls



is an example of a philosopher who takes a more political view. Let me explain.

Peter Singer is acutely aware of the poor life prospects that more than a billion people face. For over thirty years, he has spoken and written about famine, poverty, and the duty to assist.<sup>13</sup> As I noted before, he argues that people in relatively affluent circumstances – most people in Europe, North America, Japan, Australia, and so on – have a strong duty to assist. In specifying this duty, he sees no moral justification for taking into account distance, community membership, or citizenship.<sup>14</sup> Although he recognises an increased responsibility to care for family members, he views national boundaries as morally arbitrary and remarks on the contingency of being born into a rich or poor country. His view focuses on the fundamental human interests of people, wherever they live.

John Rawls is also well aware of the scope of human destitution. He notes that our world is marked by ‘extreme injustices, crippling poverty, and inequalities.’<sup>15</sup> And he emphasises a duty to assist, a duty aimed at helping people attain political autonomy and just institutions. Although he recognises that national boundaries are often historically arbitrary, he thinks that to focus on their arbitrary nature is to focus on the wrong point. In the absence of a global government, people need political divisions in order to exercise autonomy and create just social institutions.

So Rawls thinks of global justice in international terms, and focuses on the laws and institutions a people should adopt for dealing with other peoples. In his view, the principles that should govern interactions between societies are not the same as the principles that should regulate institutions within society. And so the duties we owe people in other countries may not be the same as the duties we owe fellow citizens. Although Rawls recognises a duty to assist people in other countries, he distinguishes this duty from a principle of distributive justice (like the difference principle) that should hold within a society. Rawls rejects a cosmopolitan view and expects that we will need somewhat different moral principles for families, civic associations, societies, and international relations.

In dealing with matters of global health, should we take a more cosmopolitan or a more political view of justice? I am not sure. I

<sup>13</sup> P. Singer. Famine, Affluence, and Morality. *Philosophy and Public Affairs* 1972; 1: 229–243.

<sup>14</sup> Singer, *op. cit.* note 7, pp. 232–234.

<sup>15</sup> Rawls, *op. cit.* note 9, p. 117.

tend to evaluate a theory by the work it does for us. Does it direct our attention in needed ways? That is, does it focus our attention in ways that, upon reflection, we recognise as 'better'? Does it conceptualise problems in ways that are helpful? That is, does it employ concepts, discourses, and frameworks in ways that help us to 'better' understand and deal with the problems we now recognise? I put the word 'better' in quotation marks because I doubt that any meta-theory will be able to specify what counts as better. What is better will usually depend on a reflective and historical judgement about many factors. But at this point, I am not ready to make a judgement with any confidence. I think we have a lot of work to do in evaluating and specifying accounts of justice that are adequate to the problems of global health.

### BEARING ON BIOETHICS

What effect should broadening the subject of bioethics have on the practice and discipline of bioethics? I hope that emphasising global health will help to change what we focus on and how we construct case studies. But I'm not so sure that we need to radically change the concepts we employ. I will try to explain.

The tendency in bioethics is to focus on sensational, high-tech cases. Hundreds of ethicists commented on the case of Mary and Jody, the conjoined twins who were operated on in England. Hundreds of ethicists have written about the ethics of human cloning. These are important issues, to be sure, but we tend to neglect the more everyday issues, even when those issues affect millions of people. There is a need to shift and broaden our focus. Teaching about global health may help to bring about that shift.

Attending to global health might also help to shift our focus from healthcare to health itself. Health is the good we value. Healthcare is important in many ways, but it is only one factor that may contribute to health. We have rediscovered two things that should have been obvious. More healthcare is not always better, and many factors besides healthcare profoundly affect health.<sup>16</sup> When we focus more on health, we will need to consider both average measures of health and inequalities in health.

<sup>16</sup> For an example of when more is not better, see: D.C. Goodman et al. The Relation between the Availability of Neonatal Intensive Care and Neonatal Mortality. *New England Journal of Medicine* 2002; 346: 1538–1544. For a discussion of social determinants of health, see: M. Marmot & R. Wilkinson, eds. 2000. *Social Determinants of Health*. Oxford. Oxford University Press.

If bioethics needs a new focus, does it also need new concepts? I have never thought that three or four abstract concepts were adequate for seeing and dealing with bioethical problems. But consider the wide range of concepts available to us: autonomy, beneficence, justice, rights, duty, responsibility, respect, dignity, equity, dominance, exploitation, exclusion, marginalisation, solidarity, compassion, care, hope, and so on. We do not need a new set of concepts in order to address ethical issues in global health. Indeed, unless new concepts resonate with some aspects of moral life and practice, they would not have any meaning for us.

Although we do not need a whole new set of concepts, we do need to develop case studies related to global health. As any teacher of bioethics knows, case studies have many advantages. They hold students' attention; they bear on real problems; and they require analysis. But case studies can also be limiting. They sometimes ask students to make a choice between ready-made alternatives, rather than encouraging them to create and construct better approaches. They sometimes take the social context as a given, rather than encouraging students to critique the context in which the case occurs. The task is to develop and use case studies in ways that retain the advantages but overcome the limitations. To begin, we need to develop rich, detailed case studies that bear on global health.

I want to give an example of a case study that I use, but first I need to give a little background. Low- and middle-income countries have seen large increases in the rates of obesity, diabetes, and hypertension. A recent article in *The Lancet* notes that '50% of Egyptian women are overweight, and Egypt now has a diabetes rate equal to that of the US. Diabetes is also just as high in Mexico, where the rapidity of the increase in obesity has been remarkable.'<sup>17</sup>

The case study I use is from the Kingdom of Tonga, a nation of about 100 000 people in the South Pacific.<sup>18</sup> Tonga, like other Pacific nations, has experienced rising rates of non-communicable diseases. One important cause of the increase is a change in diet. Tongans have increased their consumption of imported foods that include fatty meats and simple carbohydrates. They eat less traditional foods like fish, taro greens, and yams, and more imported foods like mutton flaps, chicken parts, and bread.

<sup>17</sup> F. McLellen. Obesity Rising to Alarming Levels around the World. *The Lancet* 2002; 359: 1412.

<sup>18</sup> M. Evans et al. Globalization, Diet, and Health: An Example from Tonga. *Bulletin of the World Health Organization* 2001; 79: 856–862.

But what accounts for this shift in diet? Surveys suggest that the shift is not due to a change in taste preferences or to a lack of nutritional knowledge. The authors of a recent study report as follows:

The data indicate that the Tongans were aware of the various nutritional values of the foods they consumed. It is also clear that simple preference was not the motivating force behind the frequent consumption of imported fatty foods and simple carbohydrates. Instead, healthier low-fat Tongan sources of proteins, such as fish, generally cost between 15% and 50% more than either mutton flaps or imported chicken parts, and in many areas mutton flaps and imported poultry were more easily purchased than fish or indigenous chicken. The same can be said of imported simple starches, such as bread and rice, in contrast to the locally available taro.<sup>19</sup>

Clearly, economic factors are contributing to the shift in diet.

The problem in Tonga seems to have a simple solution. If people prefer more healthful traditional foods but have increased their consumption of less healthful imported foods because these foods are cheaper or more readily available, there are two solutions. Tonga could place tariffs on the less healthful imported foods, or subsidise forms of fishing and farming that produce more healthful traditional foods. The problem is that each of these solutions may conflict with Tonga's plan to join the World Trade Organisation (WTO) and to abide by the General Agreement on Tariffs and Trade (GATT). Of course, the rules of global trade are not fixed points. They often need to be critiqued and emended.

### THREE PROBLEMS

In teaching global bioethics, I have struggled with three problems about bioethics and bioethicists. I have found ways to broaden the scope of my course in bioethics, but I have not found a natural and justifiable way to limit the scope. I have found ways to address issues of justice, but I have struggled with the questions of whether my approach over-politicises the field of bioethics. I have found ways to address issues of responsibility, but I have not clarified the kind of moral and political engagement that is appropriate for bioethicists. I will try to illustrate each of these problems.

<sup>19</sup> Ibid, p. 859.

We can and should broaden the field of bioethics, but I am not sure how we should limit the field. I will give one example to illustrate the problem. When I look at the countries with the highest rates of childhood mortality, I am struck by how many of these countries have been ravaged by wars. The ten countries with the worst rates of under-five mortality are: Sierra Leone, Angola, Niger, Afghanistan, Liberia, Mali, Malawi, Somalia, Democratic Republic of Congo, and Mozambique. Most of these countries have been ravaged by wars – wars between factions, wars with neighbours, wars fuelled by the Cold War.

In teaching about global health and bioethics, I have noted the effects of war. I have even addressed issues like the development and use of biological weapons, the effects of nuclear weapons, the role of medical personnel, and so on. But I have said that the general problem of just and unjust wars is outside the scope of bioethics. Yet I worry that I am inadvertently giving students the message that ethical concerns can be divided neatly into academic fields or, worse, that the problem of war is not our concern. That would be a high price to pay for trying to preserve the boundaries of bioethics – of a field that is new, expanding, and interdisciplinary.

There is a radical alternative. Give up worrying about academic territories and disciplines; give up teaching courses on ‘bioethics.’ Maybe I should teach a course on ‘ethical issues about the life-prospects of people in low-income countries.’ And then I would be free to deal with everything that bears on the topic. Such an approach would be even more interdisciplinary, but it would also be beyond my ability.

The second problem that I have struggled with is the question of whether my approach over-politicises bioethics. My approach does politicise bioethics, but not in the wrong way. Think about how strange it would be to consider questions about right, good, value, responsibility, and care, but only by and for individual people. We would ignore ethical questions about groups, professionals, organisations, policies, structures, and arrangements that bear on health, life, and death.

Philosophers often address both ethics and politics in similar terms. Aristotle is an interesting example. Many of the ideas he develops in *Nicomachean Ethics* lead naturally to the issues he addresses in *Politics*.<sup>20</sup> He begins with the idea of the good, but recognises how much a good human life depends on associations,

<sup>20</sup> See: Aristotle. *Nicomachean Ethics*. Book I, Chapters 1–2. Aristotle. *Politics*. Book I, Chapter 1.

including the association he calls a 'polis.' He says that the polis 'came into existence for the sake of living, but exists for the sake of living well.'<sup>21</sup> So he does not try to separate the study of ethics and politics. He would not, I think, try to separate bio-ethics from bio-politics.

The third problem is the one that has troubled me the most. I wonder about what forms of moral and political engagement are appropriate for bioethicists. I wonder about what forms of engagement are appropriate for me. I have heard good discussions about engagement in the context of clinical ethics, but we need to address the question in the context of global health. In both contexts, bioethicists need to oppose flagrantly wrong practices that they encounter, and they need to engage themselves constructively to prevent indirect harms. But the form and degree of responsibility needs to be worked out.

Let me give one example from clinical ethics. Several years ago, I was leading an ethics discussion for medical students who were doing rotations in obstetrics and gynaecology. In the course of the discussion, the students told me about some instances in which residents did forceps deliveries, without medical indications, because the residents wanted to gain experience and develop their skills. All the cases involved poor women at public hospitals.

I seized the moment and discussed the ethical issues with the students. We discussed whether this form of learning was morally justified, given the possible benefit to future patients. For good reasons, we concluded that the practice was not justified. We then discussed the students' own responsibility. This was an emotionally charged but good discussion about the students' role, their obligation to speak up, and the ways they should engage themselves. I went home feeling good about the discussion, but bad about myself. I thought about those poor women and their babies. I wondered about my own responsibility as an ethicist and teacher.

I ruled out two extremes. I should not turn every failing I hear about into a crusade. Nor should I simply say that my job is to analyse issues and to get students to think about them. The matter of the forceps deliveries was a serious matter, with systematic features. So I encouraged the students to take action, and I arranged to meet with them again. But that was not enough. I spoke to the director of education in obstetrics and gynaecology, and we worked out a plan: to discuss the matter with the chief residents and to visit the hospitals where students reported problems.

<sup>21</sup> Aristotle. *Politics*. 1252b.

Other people who are involved in clinical ethics have faced similar issues. They have worked out judgements, taken actions, developed guidelines, and reflected on the role of ethicists. But what is our responsibility in the context of global health? Here I feel overwhelmed. The matters are serious and systematic, but they are also diffuse, indirect, and embedded in large practices and policies. I see ways in which international institutions, individual countries, healthcare systems, pharmaceutical corporations, and even my own medical centre contribute to the poor prospects of many people abroad. (Don't those 'free' lunches that the drug companies provide for residents contribute to the cost of HIV drugs?) I also see many ways in which countries, systems, corporations, departments, and people could help to ameliorate the poor health prospects of people at home and abroad.

I wonder about my responsibility as a citizen and human being. But more than that, I wonder about my responsibility as a bioethicist who teaches global bioethics. I know that it is not enough to say that the students and I had a good discussion, and that I helped them to think about the issues. But what should I do and what would be enough? I find the question very difficult. I struggle with the very question that I try to address in my teaching: what is our responsibility in a world with enormous disparities in health?

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