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Medicine and society

The "ethical imperative" of global health service

by Edward O'Neil, Jr., MD

Why should we care? That is the essential question, and one that has fueled a contentious debate for generations. Millions around the world die every day of treatable illnesses that stem largely from extreme poverty. Yet, in strident and acrimonious tones, certain pundits tell millions of their adoring listeners why all people—particularly the poor—should pull themselves up on their own. Any money or aid we send the way of the global poor, they say, will surely be stolen, wasted or, as Senator Jesse Helms once said, "thrown down foreign rat holes" [1]. The sport of blaming the poor for their poverty and sickness is not new, and the mythology that "explains" poverty has long dominated our public discourse.

For those who comprise the future of the medical profession, this question, and our collective response to it, carries a particular moral relevance. We can no longer train our young physicians to become strong clinically but inept socially, lacking true knowledge of the world. That description, however, fits generations of physicians who bequeathed to today's medical students an honorable profession with a miraculous ability to cure, yet hobbled by an Achilles' heel: that our knowledge and talents serve those who can afford them. Somewhere along the journey from 18th-century ignorance to modern competence we missed the bigger picture. We failed to recognize that clinical excellence, though valuable in its own right, is diminished substantially if it remains out of the reach of most of the human family. Paul Farmer once wrote that "excellence without equity" looms as the central challenge facing the medical profession, and he is no doubt correct [2]. Our challenge, which falls mostly on the shoulders of today's medical students, remains finding ways to bridge the gaps between those in rich and poor countries.

Profound inequalities

Even a cursory look at our world reveals profound inequality in health and longevity. Every single day, 28,000 children under age 5 die of treatable illnesses, while 10,000 Africans die every day of just three treatable diseases—AIDS, tuberculosis and malaria [3, 4]. Nearly half a million women die in childbirth in developing countries at rates 10 to 100 times that of those in the rich countries, while nearly *30 years* separates the life expectancy of those in the richest countries from those in the poorest [5]. More than 1.1 billion people live on less than $1 per day, while another 1.3 billion live on less than $2 per day. Somewhere, someone dies every eight seconds of AIDS [6].

One would think that a profession of smart and compassionate individuals would have long ago addressed such inequality. Yet, despite some encouraging recent trends, we have addressed these disparities with only a fraction of our potential. In 1984, Timothy Baker, MD, of Johns Hopkins University found that just 1 in 300 doctors and 1 in 1,000 nurses were active in global health at the time [7]. More recently, the Association of American Medical Colleges found in a 2006 survey that 27 percent of U.S. medical students reported having taken electives abroad, compared to just 6 percent in 1984 [8, 9]. It seems that today's medical students take their global health responsibilities far more seriously than we ever have before.

Moral impetus to act

Perhaps we should turn first to medical students when we seek answers to the essential question, why should we care? It is a question I hoped medical students and physicians would never ask, but one we must answer. Physicians can trace an ethical ancestry back over two millennia to Hippocrates. Our charge is, and always has been, to care for all people. Rudolph Virchow, the 19th-century physician, perhaps best articulated the role of the physician in the larger world order when he said, "physicians are the natural attorneys of the poor" [10]. Who else will care for them and advocate on their behalf as we might? Albert Schweitzer, once described by President Kennedy as the towering moral figure of the 20th century, added that we have an "ethical imperative" to care for all people, not just those in our traditional realm of concern [11]. Schweitzer abandoned three prosperous careers in Europe to go to medical school and then spent most of the next 50 years working as a physician among some of the poorest people in the world in West Africa. The world noted Schweitzer's feat with the 1952 Nobel Peace Prize, an honor that may well loom ahead for Paul Farmer. Similarly, Dr. Tom Dooley became an American icon during the 1950s through his health service work in Southeast Asia and was the inspiration for the U.S. Peace Corps [12]. We are fortunate to have such crucial role models who speak to the heart of the medical ethic, where the art of medicine intersects with the highest aspirations of man.

For those who need a further moral impetus to act, we find answers in a variety of world religions, to which more than 4 billion people claim some adherence. Christianity, Judaism, Islam and almost every other faith share worldviews rooted in social justice. Each commands its adherents to care for the poor while creating a just world order. A branch of Christian thought called liberation theology compels its adherents to follow the scriptures and *act* to free the poor from their oppression. Similarly, the expanding paradigm of human rights informs us that each person has a birthright to life, health, education, freedom and the dignity that comes from membership in the human race. In light of the above, the role of the physician is clear: we are called to bring about a just world order, in large part by improving the basic health of the world's most vulnerable people.

From a practical perspective, the call for us to act is equally strong. The idea that one group of people can remain isolated from any other group should have long ago expired. Severe acute respiratory syndrome (SARS) should have destroyed any

remaining illusions. The next plague, the one that will inevitably follow AIDS, is just one short airplane flight away.

Eventually, if the course of human history offers any lessons, even the poorest countries will develop. Population growth slows mainly by improving the health of the poor [13]. The sooner we embrace all of humanity, the better our prospects for long-term survival will be.

Through many conversations with health professionals throughout the United States on such matters, I have come to a clear realization. Those who write and talk about the dream of global health equity can make people think, but can't make them care. It is only through direct involvement with the poor in the developing world (or here at home) that medical students and others in the medical profession at large will find reasons to care and, ultimately, find ways to change the health of the world's most vulnerable. Gustavo Gutierrez, the father of liberation theology, once advised people to forget the "head trip" of studying the problems of the poor and take a "foot trip" to work among them [14]. Only through such engagement, he argued, can we begin to understand the complex realities that have long conspired to rob the poor of their agency, their health and their very lives. Only then can we begin our personal journeys of lifelong action.

A global journey

Like so many others who have long worked in global health, my journey began as a fourth-year medical student, in my case working on the wards of a mission hospital in Tanzania. What I experienced there opened my eyes to a world I never knew existed and radically changed my life's path. Over the ensuing years, I sought answers to the most perplexing questions that arose during those first few months in Africa. Why did such needless suffering and dying go on during a time of medical miracles? How could we get more doctors, nurses, medical students and other health personnel to actively engage the problem? I channeled my energies into writing two books that answer these questions, and were recently published by the American Medical Association [15, 16].

Through the history of our profession the ethos of Virchow, Schweitzer and Farmer has been admired by most yet practiced by few. Our collective future resides largely in the hands of the medical students of today. Bono, Bill Gates, Jeffrey Sachs and Paul Farmer can lead and inspire, yet ultimately it will be the combined acts of many that hold the power to transform our profession, from narrowly focused clinical excellence to broadly distributed social justice, a full embrace of all that is the best of what our profession can be. You can and must lead the medical profession to a more rational and clear-eyed view of the world and our collective role in it. Ultimately we reap what we sow, and continued inattention to the plight of the global poor will lead us all to a bitter harvest. You can change this, and I urge you to do so.

References

1. Leaders—Aid and Trade. What the President giveth… . *The Economist.* March 28, 2002: 12
2. Farmer PE. The major infectious diseases in the world—to treat or not to treat? *N Engl J Med.* 2001;345:208-210.
3. United Nations Development Program (UNDP). *2005 Human Development Report.* New York, NY: Oxford University Press; 2005:1.
4. Sachs J. *The End of Poverty, Economic Possibilities For Our Time.* New York, NY: Penguin Books; 2005.
5. United Nations Development Program (UNDP). *2002 Human Development Report.* New York, NY: Oxford University Press; 2002:152.
6. Mullan F, Panosian C, Cuff P, eds. *Healers Abroad: Americans Responding to the Human Resource Crisis in HIV/AIDS.* Washington, DC: National Academy Press, Institute of Medicine; 2005.
7. Baker TD, Weisman C, Piwoz E. US physicians in international health: report of a current survey. *JAMA.* 1984;251:502-504.
8. Panosian C, Coates TJ. The new medical "missionaries"—grooming the next generation of global health workers. *N Engl J Med.* 2006;354:1771-1773.
9. Association of American Medical Colleges. *2006 Medical School Graduation Questionnaire, All Schools Report*. Available at: http://www.aamc.org/data/gq/allschoolsreports/2006.pdf:20. Accessed November 2, 2006.
10. Farmer PE. *Infections and Inequalities: The Modern Plagues.* Berkeley: University of California Press; 1999:12.
11. Brabazon J. *Albert Schweitzer: A Biography*. London: Victor Gollancz; 1975.
12. Fisher JT. *Dr. America. The Lives of Thomas A. Dooley, 1927-1961*. Amherst: University of Massachusetts Press; 1997.
13. Sachs J, for the Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development.* Geneva, Switzerland: World Health Organization; December 20, 2001.
14. Brown RM. *Gustavo Gutierrez, An Introduction to Liberation Theology.* Maryknoll, NY: Orbis Books; 1990:50.
15. O'Neil EJ. *Awakening Hippocrates: A Primer on Health, Poverty and Global Service.* Chicago, Ill.: AMA Press; 2006. Summaries, reviews and Paul Farmer's foreword are at the NGO Omni Med's Web site at http://www.omnimed.org. *Awakening Hippocrates* challenges health providers to respond to global health inequality. It summarizes the "forces of disparity," outlines many of the responses of the rich world, including foreign aid and profiles seven exemplary health providers, including Albert Schweitzer, Tom Dooley and Paul Farmer to inspire people to serve where most needed.
16. O'Neil EJ. *A Practical Guide to Global Health Service.* Chicago, Ill.: AMA Press; 2006. *A Practical Guide* offers step-by-step instructions on how anyone can serve in poor regions in the U.S. and abroad. It includes a database of more than 300 organizations looking for volunteers and a cross-

referencing index so that anyone, including medical students, can quickly find the organizational match that is right for them.

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