

Losing the “Human” in Humanitarian: the unethical omission of palliative care due to current humanitarian outcome-based thinking founded on utilitarian grounds

Opinion Editorial

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Pulling bodies out of rubble following a natural disaster. People in personal protective equipment treating those with highly infectious diseases. Too little beds and too many patients in an unpredictable, life threatening setting that could erupt in conflict at any time. These are the images that often manifest when thinking of humanitarian aid health care professionals risking their lives to save others. In these images and in its best expression, humanitarian action, the compassionate response to extreme forms of suffering from organized violence and natural disaster, truly embodies its semantic lineage; what it means to be human.¹ Humanitarian action is built on respecting, protecting and saving lives regardless of geographic location, race, status, or context ultimately affirming the intrinsic value of humanity and systematic expression of empathy and altruism in the contemporary process of globalization.¹ From this deep-seated value for humanity sprouts the three objectives of humanitarian action; to save lives, alleviate suffering, and preserve human dignity.² But what happens when lives cannot be saved? What happens when the gravity of a crisis exceeds all resources available or when curative care isn't even an option to begin with? One would imagine that the remaining two imperatives, to alleviating suffering and preserve human dignity, would then be the focus. For most of us, however, what this exactly looks like in practice is enigmatic. The bodies have been heroically pulled out of the rubble yet the gut wrenching reality remains that there is nothing left to offer the dying. Now what?

Palliative care, or non-curative support is by

definition, the branch of medicine that seeks to protect human dignity and alleviate suffering at the end of life. It is surprising however, considering suffering is inevitable and exacerbated in a humanitarian crisis setting more than any other, that palliative care interventions have been historically left out of the humanitarian ethics narrative. Furthermore, if human dignity, the quality within us worthy of honour and respect, is at a vulnerable peak in the wake of violence, disaster, disease, and at the end of life, it begs the question as to why reference to pain relief and palliation is virtually non-existent in most publically available guidelines published by leading medical humanitarian organizations.^{3,4,5} Granted, when lives can be saved it is clearly the priority to allocate resources accordingly. However, it is this ethical resource distribution dialogue that claims both are unable to coexist in a humanitarian setting has created a false dichotomy between curative and palliative approaches drawing focus away from integrative program planning.³ This dichotomy is evidently false when considering the ethical implications of failing to include palliation, and the feasibility of providing both palliative and curative provisions simultaneously.

If effective humanitarian action is to save lives, alleviate suffering, and preserve human dignity, continuing to exclude palliation in the humanitarian mandate would be to abandon the latter two objectives. Beyond these guiding humanitarian objectives, neglecting palliation is also to fail as health care professionals to uphold the bioethical principles of beneficence and non-maleficence. To provide adequate pain relief to

those who are suffering should be a necessity, not a luxury during an overwhelming health catastrophe and a bare minimum of beneficent care when opioid analgesics are inexpensive and feasible to provide to everyone.^{5,6} When discussing how to meet the Ebola crisis responsibly, physician and clinical ethicist Dr. Philip Rosoff argues that to use a palliative care approach for those who cannot be cured is mandated by an ethic of compassionate concern and should be a priority even in exceptional circumstances such as a wide spread epidemic.⁵ Without palliative provisions, training, and program development, health care professionals working in a humanitarian health catastrophe are forced to swallow this compassion and turn their backs to the suffering of the ill and dying. If there is to be an empathetic humanitarian response to a crisis and to allow health care providers to adhere to the practice of ethical medicine, palliation is paramount. Médecins Sans Frontières physician James Orbinsky articulates on the matter, "... where demands for care dramatically outweigh resources, however, dying patients may be left unattended, or attended by healthcare providers who do not know what to do for them, or worse, who treat patients as if they were already dead".⁷ To treat a person as if they are already dead is to completely neglect the principles of beneficence, non-maleficence, respect for autonomy among all medical codes of conduct and humanitarian morals. This ethical and deeply unsettling dilemma is an enduring reality for humanitarian health care professionals in absence of palliative armamentarium.

Although literature supporting palliative care as an international human right and as an obligation to an effective, compassionate humanitarian healthcare response is growing, in order to implement systematic change the community must draw attention to why this arcane gap is there to begin with.^{8,9} One explanation may be that humanitarian aid organizations view beneficence through a utilitarian lens. For a utilitarian, the outcome of one's action is of the greatest moral importance

where the greatest good must be achieved for the greatest number of people.¹⁰ For humanitarians, that greatest good is to save lives. When dealing with a humanitarian crisis, there is no dispute that to save and help the majority makes sense in net utility calculations however, by solely focusing on population needs, humanitarian aid organizations may overlook the individual, intimate, human experience of death and the beneficence duty to beneficence in their program planning calculations.¹ This is where we sacrifice the true meaning of an empathetic humanitarian response for simply a mechanical one.

One reason humanitarian organizations may fail to define success beyond lives saved may be because there are no clear measurable outcomes for how much pain was alleviated through palliative care or how many people experienced a dignified death. Smith and Aloudat's are keen to point out in the article Palliative care in Humanitarian medicine that "unfortunately, the palliative-curative dichotomy is amplified by sector-wide approaches that privilege the pursuit of quantifiable results".³ Why advocate for a palliation renovation, in which the primary mandate is to acknowledge and benefit the dying, when the number of people saved is the measure of success? The way in which crude mortality rates are used to determine success or failure in a crisis response shows that the preservation of life takes priority over other outcome measures like relief of suffering and the respect for persons.⁴ This utilitarian way of thinking and operating hinders the humanitarians' ability to focus on the needs of an individual. The inability to provide adequate palliation services is therefore not due to resource limitation or the allocation of services towards life-saving care, rather on the lack of deep ethical consideration beyond utilitarian, outcome-based thought.

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Democracy and Health

Research Article

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Background and Definitions

“Medicine is a social science, and politics is nothing but medicine at a larger scale,” said physician Rudolph Virchow in 1848.¹ A pioneer in the fields of public health and social medicine, Virchow believed that ill health stemmed from inequities within populations and society, and therefore required a political solution. Thus began the exploration of the role of politics in medicine and medicine in politics, from focused health policies to larger political institutions. Despite democracy being a fiercely-held value in many countries, especially within the Global North, there is no robust evidence that it causes improved health of citizens.^{2,3}

Theoretical arguments for ways in which democracy can both support and impede health are numerous.^{4,5,6,7,8} However identifying robust correlations between democracy and health are unquestionably difficult. This is due to many confounding factors,⁴ and the inability to create a controlled environment in which to elucidate a true correlation between democracy and health.

Theory of Democracy and Health

On a theoretical level, there are numerous ways in which democracy can support the health of the public, but there are equally as many ways in which it might impede health. These particular factors are often opposite in autocracies, as thus it is useful to juxtapose the two.

Measurement of Democracy and Health

It is important to recognize that in reality, interactions between democracy and health do not perfectly reflect theoretical models such as the one above; thus, we must try to measure the association using data from countries around the world. Many potential confounders to the relationship between democracy and health exist within a country, not limited to: education, demography, income per capita, size of the public sector, quality of health data available, inequality within the country, length of time a country has been democratic, and recent conflicts and disasters, etc.⁹ No empirical studies to date have been able to employ a robust methodology to dissect the effect of democracy from the various confounders.