Editorial

Through the looking glass

Bioethics as we know it today began about a decade and half after the end of World War II as a loosely defined movement to 'humanise' medical education and practice, in which there was an over-emphasis on technological and scientific progress. The goal was to cushion the powerful leaning towards specialisation and science that had started to dominate the education of health practitioners and simultaneously maintain equilibrium between these developments and human values. The objective of bioethics at that time was the ideal of the scientifically competent yet humanistically responsive practitioner. The fervent application of scientific medicine and the specialisation it required was viewed, and correctly so, as deleterious to the human dimensions of medical education and care. What was required was an antidote – and in this way the infusion of human values and the humanities in health sciences education was conceived.[1]

Today, the field of enquiry of bioethics has moved on to assume much broader proportions, especially in terms of its social impact. The fundamental reason for this is that bioethics is about health and therefore about life and death. Bioethics is about our bodies, procreation and birth, suffering and well-being, and very importantly about who controls decisions about our health.[2] Therefore at the heart of bioethics is justice and fairness, and whether the focus on dilemmas and actions is narrow or broad, we cannot escape issues of justice and injustice. If this were not the case, bioethics would lack foundation and integrity and, in effect, be impotent.

South Africa's history of oppression and prejudice, which even permeated the medical fraternity, resulted in us as a society becoming acutely aware of how social and political arrangements affect health. Our past compels us to reflect on the distribution of power and privilege, and how our health care systems, previous and present, raised and continue to raise concerns about justice. And through all our reflections, the reality of the image, although tough to accept, resonates unambiguously: our system of health care lacks justice and compassion.

So, what do we see? We are witness to the deprived and unfortunate (the majority in this country) being denied access to health resources on a daily basis. And if we don't look away, we see our people being trundled off to services that are understaffed, poorly equipped and overwhelmed by the needs of those who cannot afford even minimal care. And if we continue looking, we see the abuse of power at various levels of the political hierarchy, attempting to silence those who are strong and brave enough to fight for the centrality of justice in health care.

And of course, we don't have very far to look to see the huge disparities in access between the affluent and the poor to health care. Former Chief Justice Chaskalson in 1998 said:

> '*We live in a society in which there are great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water, or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them, and to transform our society into one in which there will be human dignity, freedom and equality, lies at the heart of our Constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring.*'[3]

Ames Dhai
Editor

A decade later, and more than a decade after the adoption of the South African Constitution, the question that begs an answer is 'How much has changed?' It has been stated that the economic structure of a nation is probably the most important determinant of the health of its people. It has also been stated that income inequity in the nation, i.e. the gap between the very rich and the very poor, has a profound effect on the health of its people because of *inter alia* stress and its biological effects on the distribution of risk factors. While the importance of advising individuals on the avoidance of risk factors must most certainly be emphasised, that this is not the most efficient way of improving population health cannot be disputed. The effects of the usual dos and don'ts pale in comparison with the effects of society's structural factors on population health, including the amount of hierarchy as measured by income distribution. It is worth noting that those countries that achieve highly in the 'Health Olympics', as measured by soaring life expectancy figures, have a more egalitarian societal structure than the 'low achievers'.[4] South Africa so far can be viewed as an 'under-achiever', with life expectancy for the average South African being just under 50 years of age. Justice Chaskalson's words cannot be ignored. For as long as there are huge disparities in wealth in this country, our Constitutional[5] goal will remain an aspiration on paper only. The same would apply to other 'enabling' laws. The National Health Act[6] starts off its preamble with a recognition that the injustices, imbalances and inequities of the past need to be addressed and a society based on democratic values, social justice and fundamental human rights needs to be established in the quest to improve the quality of life and free the potential of all in the country. However, the experience so far has been totally contrary to our well-meaning and highly ethical and human rights-based laws. We have watched the most powerful in the country corroding justice by blatantly refuting non-maleficence principles and the best interests of those in need. Incompetence, corruption and lack of leadership at the level of public facilities

have failed to render necessary services, not only in the context of the health sector but also in sectors responsible for delivering social services that determine health outcomes. Some health practitioners have used the same system to justify and condone unethical acts and unprofessional conduct. Those who have striven for justice have been bullied and victimised, and others have been caught up once again in the 'dual loyalty' phenomenon, something that we, as South Africans in a democratic order, should not have to be subjected to yet again. Even our professional bodies have not been spared the onslaught of power abuse, with the law being manipulated to eliminate independence and effectiveness. Politics has interfered with ethics. Politics has attempted to determine ethics.

But we have seen also that power abused is power that cannot be sustained, and celebrate the welcome transition from Mbeki to Molanthe and Tshabalala-Msimang to Hogan. In their pursuit for delivery of just and fair health care Barbara Hogan and her Deputy Minister, Dr Molefi Sefularo, have a long and arduous path to tread in reforming the messy moral mess left behind by the former Minister of Health. Their journey is made even more perilous by the fact that justice in health care cannot be achieved in totality in an unjust, unequal society where the disparity between the very rich and the very poor continues to swell. What happens when the 'honeymoon' period of our euphoria is over? Gazing through the looking glass, I see our South African society as one of optimism and hope, confident that resilience and positive political will triumph and the social contract that is health care will eventually be realised.

1. Pellegrino ED. The origins and evolution of bioethics: Some personal reflections. *Kennedy Institute of Ethics Journal* 1999; 9.1: 73-78.
2. Teays W, Purdy LM. *Bioethics, Justice and Health Care*. Australia. Wadsworth, 2001: 1-5.
3. *Soobramoney v Minister of Health, KwaZulu-Natal* 1998 (1)SA765 (CC) at paragraph 8.
4. Bezruschka S. Societal hierarchy and the Health Olympics. *CMAJ* 2001; 164(12): 1701-1703.
5. The Constitution of the Republic of South Africa. Act No. 108 of 1996.
6. The National Health Act No. 61 of 2003.