CMAJ Essay Prize winner

AIDS, Africa and indifference: a confession

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ß See related articles pages 481, 483 and 528

> Not everybody wants to be a saint.
> — Jonathan Hullah, MD, in Robertson Davies, *The Cunning Man*[1]

The activities of the World Trade Organization (WTO) do not normally attract much attention from the medical community. However, the defence by manufacturers and governments of patent protection for antiretroviral drugs — despite the catastrophic HIV/AIDS crisis in Africa — ensured that the November 2001 meeting of the WTO in Doha, Qatar, would be different. At issue was the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), common rules for protecting proprietary interests in ideas, processes and products (including pharmaceuticals), and for circumventing those rights in the case of a "national emergency." In the days after the conference all sides seemed to be, for the time being, satisfied. An African delegation believed its proposal that "nothing in the TRIPS Agreement shall prevent Members from taking measures to protect public health" had carried the day: it had won wording to this effect, including a specific reference to HIV/AIDS as a disease that could constitute a "national emergency."[2] On the other hand, the final document took pains to point out that this position was only a clarification of the WTO's existing agreement on intellectual property rights, obliquely suggesting that all this furor was a matter of misunderstanding rather than disagreement.

Before the conference, other conflicts had flared over the role that drug manufacturers might play in stemming the tide of HIV/AIDS in sub-Saharan Africa. The Oct. 17, 2001, issue of *JAMA* offered Amir Attaran and Lee Gillespie-White's answer to the question, "Do patents for antiretroviral drugs constrain access to AIDS treatment in Africa?": a clear No.[3] Their analysis of existing antiretroviral patents in African countries suggested that few such patents were actually in place and that "geographic patent coverage [did] not appear to correlate with antiretroviral treatment access."[3] Instead, they fingered insufficient international aid to fund therapy as the biggest culprit in maintaining the status quo. Nongovernmental organizations (NGOs) such as Médecins Sans Frontières and Oxfam wasted no time firing back.[4] Patents *do* matter, they contended: the most practical and sought-after formulations have been strategically patented, while drugs left unprotected typically are impractical in resource-poor communities (e.g., owing to increased need for monitoring).[4] Arguing that the drug companies were using the research published in *JAMA* as justification for further inaction (and querying a $25 000 grant from Merck to Gillespie-White's institution), Médecins Sans Frontières unflaggingly pressed on with its Access to Essential Medicines campaign in the lead-up to Doha.

What are we to make of these clashes between NGOs and academics, between impoverished nations and an institution of global commerce? Everyone agreed in 2001 that the infection of 28 million Africans with HIV is a public health disaster of epic proportions. Clearly, a Herculean effort will be required to combat the disease, involving international health organizations, drug manufacturers, governments and local health care workers. I am absent from this list.

I have never been to Africa. I am not black. I do not have HIV. I am a middle-class man (married, 2 kids) living a middle-class life (family medicine resident) in a middle-class neighbourhood (London, Ont.). By virtue of my work, I have cared for people — transiently — who have HIV/AIDS. But, as politically incorrect as it may sound, I am not connected to the tragedy that is AIDS in Africa. And, as crass as it may sound, I do not have to be. Perhaps, as part of my effort to be reasonably well-informed about the world, I cannot avoid hearing about it. Perhaps, as a physician who spends much of his time considering how best to help people who are sick, I cannot avoid thinking about it. But I can avoid doing anything about it, and no one will call me to account for my inaction.

This is the downside of globalization: self-interest is still paramount. Cheaper televisions, cheaper bananas, cheaper running shoes. At best, we can make arrangements that are mutually beneficial. But tragedy is not an easily exported commodity, and we prefer that it be handled behind national borders. In wealthier nations, we look after our own: Americans pledged $1.2 billion to New Yorkers in the 2 months following the terrorist attacks of Sept. 11, 2001, that left thousands dead.[5] The US Agency for International Development budgeted $320 million to target HIV/AIDS in Africa in 2001, a disease that had killed an estimated 2.3 million people on that continent over the preceding year.[6,7]

Where can we turn for help in sorting out our responsibilities in the face of human disaster? "Ethics" was a word I heard frequently during my medical education. I approached it warily, with the jaundiced eye of a former graduate student in the humanities, all too conscious of the ways by which words can become ends in themselves. "There are no right answers!" was a common invocation intended to break down our reticence. I appreciate the pedagogical point, but the notion that there are no right answers is a dangerous partial truth. The mistake is to conclude that we cannot have a rational discussion about better answers, nobler answers, more virtuous answers.

The Code of Ethics of the medical profession in Canada,[8] like many other such codes, focuses on the relationship between physicians and individual patients. There is a passing exhortation to "accept a share of the profession's responsibility to society in matters relating to public health," but this clearly seems directed at domestic matters. Defining ethics within a framework of duties and rights (as many are inclined to do) works in a clearly delimited community where people are required to interact with one another and must find mutually agreeable ways of doing so. However, disasters seen at a distance require something different — something capable of generating compassion from across an ocean.

There are forms of discourse that permit us to think in these terms. Some of us turn to the philosophical tradition, from Aristotle to Alasdair MacIntyre, for reflection on virtue. Others seek direction in religious scriptures, such as the New Testament story of the good Samaritan (Luke 10: 25–37), who breaks free of the constraints of culture and race in the face of human need. This is not to say that virtuous action necessarily relies on such traditions; however, they highlight the inability of modern medical discourse — the languages of pathophysiology, epidemiology and genetic determinism — to word-find when confronted with human tragedy.

Of course, as Robertson Davies so wryly observed, "Not everybody wants to be a saint." More truthfully, few aspire to such a state, whether their vocation is religious or medical. There is a small cadre of physicians who commit themselves to working on the international front lines, and I envy their self-sacrifice, the "rightness" of their lives. But my envy, or guilt, or shame will not make the world a better place or make one shred of difference to someone dying of AIDS in Uganda.

I keep returning to the poignant question posed by the essayist Wendell Berry: "How will you practice virtue without skill?"[9] I thought that I was responding to this question during weary nights in uncomfortable call rooms, acquiring the skills that would allow me to make my contribution to society, to turn noble ideals into action. But AIDS in Africa, a crisis that is so classically medical, slides nonetheless through the therapeutic templates I learned so painstakingly. Perhaps if I restricted myself to talk about reverse transcriptase and protease inhibitors I might be on more familiar ground, although our tendency to place AIDS care in the hands of a knowledgeable few leaves me adrift just the same. Move on to other factors such as national health budgets of $8 per capita, patriarchal power structures that leave women with few choices, and civil violence that cripples countries' abilities to act, and I am out of my league. I suspect that if I were airdropped into a Soweto township I would be next to useless.

Hand-wringing is not a particularly constructive enterprise. As I reflect critically on my own response, a few starting points emerge: skeletons of thought, pointing a shaky finger, requiring substantial "fleshing out." I offer them briefly, inviting comment:

1. As medicine in Western democracies becomes increasingly reliant on biomedical engineering (both pharmaceutical and technical), physicians become increasingly incapable of practising effectively without those costly supports. It is unclear why we tolerate such obvious discrepancies in medical infrastructure around the globe, and why we seem bent on widening that gap.
2. As we reflect on the staggering health needs of developing countries, it becomes apparent that the North American medical research machine is in desperate need of retooling. The questionable value of spending millions to prove the marginal benefit of ever-more expensive therapies (which, once they are proven, become medicolegally obligatory) is a case in point. Naturally, we cannot expect leadership from the pharmaceutical industry, whose livelihood is at stake. There may not even be much public support for this (not from the "diseased" public, at any rate). However, investment in projects that find their principal application outside our own borders could be one measure of our compassion.
3. Obviously, there is a deep need for international money to fund programs to combat HIV/AIDS in developing countries.[10] Governments should be exhorted to do their part: Canada's last federal budget committed $500 million over 3 years to a trust fund for sustainable development in Africa,[11] and politicians should be encouraged to amplify this trend. On the other hand, physicians should look carefully at their own ability to make independent contributions as wealthy individuals in a wealthy society.
4. We must remind ourselves that a strictly medical approach to HIV/AIDS will be inadequate. The feasibility of large-scale antiretroviral therapy (which has been instituted on a very small scale in a number of developing countries[12]) is not at all clear. It may be that the most critical interventions will be nonmedical in nature (e.g., culturally relevant public health education aimed at curbing the transmission of HIV), a fact that should both humble us and motivate our cooperation with others.

It is hypocritical for me to write, from the comfort of my suburban backsplit, about the horror of Africans dying by the millions of AIDS. Perhaps I am not qualified to write at all. Perhaps only they can write who have seen the grim realities first-hand, who have suffered the heat and the

heartbreak in an effort to bring healing to the dying. Yet perhaps I am someone who must write, representing as I do the many thousands of physicians in this country who live in the tension of believing that things ought to be otherwise, and chastising themselves for doing so little.

Even our best efforts, coming as they do from a position of power and privilege, may not afford us the distinction of saintliness. But sainthood is not the goal. Instead, we need to shake off the inertia of the overwhelmed and take our first, feeble steps on the road to responsibility.

This article is the winner of the 2001 *CMAJ* Essay Prize. For details on this year's competition, see page 466 of this issue or click on Essay Prize on the *eCMAJ* home page (www.cmaj.ca).

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Competing interests: None declared.

Acknowledgement: I thank W.E. Osmun for his comments on the first draft.

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