



## CHAPTER 20

# Becoming a Global Community: It's a Small World After All

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*“The first step in the evolution of ethics is an enlargement of a sense of solidarity with other human beings.” (Albert Schweitzer, quoted in Benatar & Brock, 2011)*

**WHEN OUR ADVENTURES INTO SPACE** allowed us to see our planet for the first time, we were gifted with the reality that we and other earthly creatures live on a beautiful blue globe turning slowly through space. This truth was evident: we inescapably live *together*. The science and technology that enabled this vision are increasingly connecting us further and in such a way that the impacts of environmental, political, economic, and military events in one part of our planet reverberate across all of it. What we do affects the Earth, which, according to James Lovelock (1979) in his Gaia theory, is a living

entity, too. Our planet appears to have entered a new epoch, the Anthropocene,<sup>1</sup> so named from the Greek word for “human” (*anthropos*) to indicate the negative effect humans are having on the systemic stability of the Earth (Clement, 2021). Along with the lives of other species, we are endangering our own existence, as our planet’s stability is necessary to human health and flourishing.

Our greatest problems—the paramount threats to our survival as individuals, as communities, and even as a species—are global ones: the effects of human activities on the environment and increasing climate change; emerging and resurgent infectious diseases; terrorism; nuclear and biochemical weaponry; and for many, devastating poverty. While our modern sense of “ethics,” from the Greek *ethos* for “way of living,” is about how one should live, it is imperative that we recognize that it is essentially about how we should live together. A morally imaginative shift to a planetary perspective must occur, one in which global solidarity is created, appalling inequities are diminished, and actions that sustain life are actively pursued (Benatar et al., 2003; Benatar & Brock, 2011). The philosopher Peter Singer warns in his work *One World: The Ethics of Globalization* (2002) that our survival may depend on “how we respond ethically to the idea that we live in one world” (p. 13).

Active recognition of our global reality has been with us at least since the 21st century began. As a nurse, and as an academic, in 2001 I began to consider how this reality affected the ethics of nursing practice—including the role of human rights as the moral underpinning of global relations—through writing about it (Austin 2001a, 2001b). I continued to publish on the topic (Austin, 2004, 2008, 2016), including my chapter in the first edition of *Toward a Moral Horizon: Nursing Ethics for Leadership and Practice* (Austin, 2003).

In this chapter, I provide advanced practice nurse leaders with key concepts significant to global health ethics and discuss its interface with human rights. The current state of global governance for health—and the possibilities and predicaments of expanding one’s professional health care responsibilities to embrace the entire world—are explored. I will reference the SARS-CoV-2 pandemic throughout the chapter, given that this deadly viral threat has made our global interconnectedness so evident.

## Essential Values of Global Health Ethics

To start, I will explore various values essential to health care ethics that need to be enacted: human dignity, social solidarity, social responsibility, social justice, and health equity. The central value—human rights—is delineated, and a framework for global health governance is shared.

### Human Dignity

The belief that human beings possess an inherent dignity existed in classical philosophy, such as that of the Roman statesman Cicero in his *De Officiis* [*On Duties*] (44 B.C.E./1913), and was based on the human ability to reason and the possession of free will. It was not until Immanuel Kant's *Groundwork for the Metaphysics of Morals* (1785/2018), however, that human dignity was systematically addressed as a principle relevant to ethics and law. For Kant, the ability to reason meant that we are capable of living an ethical life (Lutz-Bachmann, 2018). A contemporary conception of human dignity, evolving in the twentieth century, closely links human dignity with rights and casts it as the primary assumption underlying our modern conception of human rights (Sensen, 2011). This understanding includes the idea that, as human dignity is innate to the human condition, it is equally possessed by all and cannot be legitimately denied (Adorno, 2009).

In the Preamble to the *Universal Declaration of Human Rights* (UDHR) (United Nations General Assembly, 1948), it is stated that the inherent dignity of all members of the human community (as well as their equal and inalienable rights) “is the foundation of freedom, justice and peace in the world.” Article 1 claims that “[a]ll human beings are born free and equal in dignity and rights” (United Nations General Assembly, 1948). The significance of human dignity is noted across most human rights documents, as well as treaties that ban maltreatment and injury such as slavery, torture, or discrimination. Connecting dignity with rights is imperative as, while human dignity justifies human rights, it is rights which can be legally addressed and protected (Adorno, 2009).

As we share the Earth with other living things, we will need to move beyond respect for only human dignity. The German philosopher and theologian Albert Schweitzer (1875–1965) believed that we are ethical only when all life is sacred to us, not only the lives of our fellow humans. For Schweitzer, ethics was about reverence for life: an understanding, he acknowledged, that “throw[s] upon us a responsibility so unlimited as to be terrifying” (1946, p. 254).

## Social Solidarity

Social solidarity is the felt sense of belonging to a group or community, united in shared characteristics or common goals, such that a level of interdependence is recognized and a feeling of unity created. It is a “fellow-feeling” that can motivate “we-thinking” and readiness for mutual support (Davies & Savulescu, 2019, p. 134). Social solidarity is active; it is not simply an attitude. A catalyst for solidarity can be recognition of shared vulnerability (West-Oram, 2020); thus, our inherent human vulnerability potentially offers hope for achieving global solidarity. The United Nations (UN), whose very existence is emblematic of solidarity, is evidence of a global willingness to strive for community. It has designated December 20th as International Human Solidarity Day to emphasize the concept’s importance. As the UN’s Millennium Declaration (United Nations General Assembly, 2000) describes:

We recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality, and equity at the global level. As leaders we have a duty therefore to all the world’s people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs. (Value and Principles 2)

Solidarity, involving both rights and obligations (Davies & Savelescu, 2019), plays a major role in any nation’s ability to successfully address a crisis. A sense of global solidarity prompted the UN member states to first adopt the Millennium Development Goals to reduce poverty by 2015 and then, in September 2015, to build upon

these goals by adopting a 2030 agenda for sustainable development (UN Department of Economical and Social Affairs [UNDESA], 2015) with 17 goals (see Box 15-1). Every four years, the UN publishes a Sustainable Developments Goals report, created by a group of 15 independent scientists from various disciplines and institutions selected by the Secretary-General. At the time of this book's publication, the latest report was *The Sustainable Developments Goals Report 2021* (UNDESA, 2021a). Table 20-1 names the UN's 17 sustainable development goals (SDGs) (UNDESA, n.d.).

**TABLE 20-1**

### *The UN's Sustainable Development Goals*

Goal	Description of Goal
1	no poverty
2	zero hunger
3	good health and well-being
4	quality education
5	gender equality
6	clean water and sanitation
7	affordable and clean energy
8	decent work and economic growth
9	industry, innovation and infrastructure
10	reduced inequalities
11	sustainable cities and communities
12	responsible consumption and production
13	climate action
14	life below water
15	life on land
16	peace, justice and strong institutions
17	partners for the goals

The global importance of solidarity became dramatically evident during the SARS-CoV-2 pandemic, with the recognition that the virus must be stopped everywhere if it was to be stopped at all (Mishra & Rath, 2020). Unprecedented collaboration among medical researchers across national boundaries achieved nearly miraculous results in the creation of new SARS-CoV-2 vaccines. The worldwide initiative COVID-19 Vaccines Global Access (COVAX)—led by the partnership of the World Health Organization (WHO),

Gavi (the Vaccine Alliance),<sup>2</sup> and the Coalition for Epidemic Preparedness—was created in 2020 to accelerate the manufacturing of vaccines and ensure equitable global access to them. As I explain below, this initial solidarity response proved, however, to be fragile.

This pandemic presented an opportunity to address the usual exclusion of ethics in the distribution of vaccines due to factors such as the prioritization of profit by pharmaceutical companies and the valuing of life more in some countries than others (Binagwaho et al., 2021). COVAX provided guidelines titled *Fair allocation mechanism for COVID-19 vaccines through the COVAX Facility* to support equitable access to vaccines worldwide (COVAX, 2020). Ideas from bioethicists—such as a vaccine lottery once the “at high risk” were vaccinated—buoyed these efforts (Jecker et al., 2021). Overall, however, ethics did not prevail.

Many vaccine manufacturers refused to engage in the principles of global solidarity. They declined to share knowledge and technology that would have significantly increased vaccine production and availability. Some high-income countries (including many provinces in Canada) provided booster shots for fully vaccinated people at a time when less than five percent of Africans were vaccinated (Moeti, 2021). In an August 12, 2021 article in *Time* magazine, Dr. Adhanom Ghebreyesus, Director-General of the WHO, noted that this situation must make health workers in low-income countries wonder about the meaning of “solidarity.” The reality is that solidarity can require sacrifice to ensure that others are receiving what they need—and such sacrifices may not be forthcoming.

## Social Responsibility

Responsibility is defined as “a moral obligation to behave correctly towards or in respect of a person or thing” (“Responsibility,” 2021). Social responsibility is grounded in the belief that actions at all levels of society—from individuals to communities to governments—should be such that a society’s well-being is supported and not harmed. Does this concept hold when the society is global in its magnitude? The answer depends on one’s point of view.

Those with a cosmopolitan perspective view all humans as citizens of the world, to whom they have a moral duty that is not

limited by proximity nor national boundaries. For instance, Peter Unger, author of *Living High and Letting Die* (1996), argues that giving up one's luxuries to help those who are suffering is essential to living an ethical life. The anti-cosmopolitan, statist perspective is that moral obligations are local and specific, delimited within a community or nation (Toumi, 2014). This is congruent with Rawls's (1971) isolationist theory of justice: National self-determination should be the norm, and other nations must decide their own future. While anti-cosmopolitans see peaceful coexistence as a morally worthy goal (Stapleton et al., 2014), at the core of the philosophy is the belief that morality is always local. In this schema, cosmopolitanism is viewed as impractical and undesirable. Attempts to realize universal values are unjustified, as they are an imposition of one's own account of "the good society" upon others.

Iris Marion Young (2006), an American political theorist and sociologist, developed a social connection model of responsibility and justice based on her belief that "[t]he social relations that connect us to others are not restricted to nation-state borders" (p. 106). She believes that we bear responsibility for structural injustices when our actions contribute to processes that create such outcomes. While such actions are morally distinct from deliberately committing an injustice, a shared responsibility now exists for us all, derived from social connections. This responsibility must be discharged through collective social action. Young offers a guide to determine how one might choose to act in accordance with this responsibility. I will adapt and apply her model to the roles of nurses and their ethical responsibilities for global health later in this chapter.

In a truly global society, social responsibility encompasses all of humanity, and ultimately all living things. Zygmunt Bauman captures, in his *Postmodern Ethics* (1993), the overwhelming scope of our moral responsibility, describing it as "cumbersome, incapacitating, joy-killing," and "insomnogenic" (p. 242). The philosopher Ann Harbin (2014) acknowledges, too, how disorientating and unsettling complex responsibilities requiring moral action can be, especially when one is uncertain that a sufficient response is possible. She reassures us by noting that if one addresses projects suitable to one's capabilities, then there can be a meaningful response to calls to act. This is good advice for

advanced practice nurse leaders and other health care practitioners, given their roles and responsibilities for global health. Ethics in Practice 20-1 below illustrates the importance of engaging one's moral imagination to create a meaningful response to global health issues.

### **ETHICS IN PRACTICE 20-1**

#### *A Pressing Need to Engage Our Moral Imagination*

For nurses to embrace a global vision of nursing, we need to reflect upon our collective ethical responsibilities within the global community and reimagine health, nursing ethics, and health care ethics. This will be challenging. Benatar (2005) has identified moral imagination as necessary to a meaningful response to global health issues. Among other influences—such as a focus on technologies and narrow approaches to global health rather than attention to the social determinants of health—Benatar notes that concern for others' severe ill health is not sustained when they are "anonymous and out of sight" (p. 1207) and therefore, perhaps, of less value to us. In a research project funded by the Canadian Institutes of Health Research, the Canadian Program of Research on Ethics in a Pandemic (CanPREP), it was found in a focus group study that economic and humanitarian discourses are evident when the scenario involves an outbreak originating in a low-income country. However, when the outbreak originates in Canada, a dominant response is to keep all resources for Canadians (Thompson et al., 2015). This type of response can be seen in the SARS-CoV-2 pandemic. Nurses are not immune to such a local viewpoint, despite our knowledge that the virus must be eradicated across the globe for Canadians to be safe in turn. Our moral imagination will be necessary to allow us to respond locally in ways that also sustain the global community.

### **Social Justice**

Social justice, "the fair distribution of society's benefits and responsibilities and their consequences" (Canadian Nurses Association, 2010, p. 10), is viewed by the United Nations (UN) as essential to the peace and security of nations. It is further strengthened by the existence of human rights and fundamental freedoms. The notion of "justice" is an ancient one. Confucius (551–479 B.C.E.) is said to have viewed justice as a principle of government and social conduct, as well as an essential virtue

(Duvert, 2018). His view was congruent with that of Plato (428/427–348/347 B.C.E.), who considered justice a duty of the soul that made an individual good and a society harmonious (Bhandari, 2004). While their perspectives seemingly encompass a broad idea of social justice, the reality is that it was not until the late 18th century that fair distribution of benefits to all members of society began to be envisioned by philosophers like Thomas Paine (1791/1998), the author of *The Rights of Man*.

Social justice—that is, justice for the whole of society—is a contemporary idea that involves the fair allocation of resources and burdens among all. This aspiration has yet to be fully embraced, though the UN designated the World Day of Social Justice in 2006. In fact, the platitude “the rich get richer and the poor get poorer” is essentially true in today’s global community (UN, 2006, p. 1). *The World Social Report 2021* (UNDESA, 2021b) reveals that there are 1.3 billion people living in multidimensional poverty, half of whom are children and 105 million of whom are aged 60 or older. Most of the world’s wealth (84%) is held by 10% of the global population; the other 90% share the remaining 16% of wealth. An even closer look reveals that one percent of humans inhabiting the Earth hold over a third (37%) of the world’s wealth (Capeheart & Milovanovic, 2020).<sup>3</sup>

To help ameliorate this inequality, *The World Social Report 2021* includes a reconsideration of rural development and a *2030 Agenda for Sustainable Development*. The need to do so is urgent, given that four out of every five people who face extreme poverty live in rural areas. Many of these areas are experiencing depletion and degradation of natural resources to a severe extent, contributing to climate change and the occurrence of zoonotic diseases, such as COVID-19. “The current strategies and patterns of rural development are failing to meet either the socioeconomic or the environmental Goals of this Agenda” (UNDESA, 2021a). Rural development can be reset to achieve sustainability if it is moved to the centre of attention, instead of being an aside for urban development. Rural inequality can be overcome using ways that preserve the environment, such as “leveraging investments in public services and rural infrastructure while protecting the health of the planet” (UNDESA, 2021a, p. 1).

## Health Equity

Health equity, a component of social justice, is described by the World Health Organization (WHO) as “the absence of unfair, avoidable and remediable differences in health status among groups of people” (2021a, p. 2). It is achieved when everyone can attain their potential for health and well-being. Canada is a healthy nation, but there are inequalities across our country that impact health and require remediation. In 2012, Canada, with other WHO member states, endorsed the *Rio Political Declaration on Social Determinants of Health* (WHO, 2021c), pledging action to promote health equity. The report *Key Health Inequalities in Canada: A National Portrait*<sup>4</sup> (Public Health Agency of Canada, 2018) is a response to that pledge. Health inequalities were revealed to be persistent; some are even increasing. These inequalities primarily affect those with lower socioeconomic status, Indigenous Peoples, sexual and racial/ethnic minorities, immigrants, and people living with functional limitations (such as physical or mental impairments). The Health Inequalities Data Tool (Government of Canada, 2021a) is an online interactive database documenting Canada’s health inequality by province or territory.

Across the globe there are twice as many COVID-19 cases and deaths in deprived areas, such as communities with few resources who do not have access to quality health care services or to information from the internet (for example, information about how to stay safe or how to overcome obstacles in obtaining COVID-19 related aid) (WHO, 2021a). Those who are socially excluded, such as those who are unhoused or migrants, are at higher risk. Further evidence of health disparity exists. On April 1, 2021, it was noted that 86% of the half billion vaccines administered were in high-income countries; 0.1% in low-income countries (WHO, 2021a). As noted previously, some high-income countries were already offering a third dose of the vaccine to people who were fully vaccinated in October 2021. In Ethics in Practice 20-2 below, disparities in health equity related to maternal health care are explored.

**ETHICS IN PRACTICE 20-2***Health Inequity Revealed in Maternal Mortality Rates: Ghana and Canada*

In 2017, the maternal mortality ratio in Ghana was 308 deaths per 100,000 live births, gradually falling from 398 deaths per 100,000 live births in 2003 (World Data Atlas, n.d.). In 2018, the Canadian maternal mortality rate was 8.3 deaths per 100,000 live births (Statistics Canada, 2019). A possible cause of this significant discrepancy may lie in the level of available resources. These resources are limited, for example, in northern Ghana, as described by Boakye in her 2021 University of Toronto PhD research study, *Analysis of the Moral Habitability of Obstetric Settings in Ghana*, of three tertiary maternal wards in the region. A critical moral ethnography study, the research involved 30 nurses and midwife participants. Brief excerpts from descriptions by the study's nurse participants follow.

The maternity ward is “characterized by a lack of space and beds, resulting in the admission of patients on the floor and chairs, bed-sharing, and in some instances, patients being denied admissions.” A nurse reveals, “We don’t have oxygen to save life. The predominant role of a hospital is to save life” (Boakye, 2021, p. 98). She says that the ward can be without oxygen for two or three months, but “never do we hear that the hospital car did not have fuel to pick up the CEO [Chief Executive Officer] on his rounds (p. 98).” Another nurse shares that “[t]here are occasions whereby two patients need mechanical ventilation at the same time. There is no way we can actually take the ventilator from one ... hmm actually is a hard decision to take” (Boakye, p. 99). This nurse describes how, if a search for a ventilator in the main ICU fails, “you only fold your arms and see the patient go [slow tone]” (Boakye, p. 99).

Practice for nurses and midwives in these wards exists in “a context dominated by the scarcity of resources, overwhelming and incoherent moral responsibilities, oppressive conditions, and workplace violence” (Boakye, p. 2). These factors constrain their capacity to meet their caring responsibilities and endanger the lives of patients. The suffering and distress these conditions provoke is experienced not only by the patients, but by those struggling to give them care and keep them safe.

## Human Rights and Global Governance of Health Human Rights

Uniting and supporting all of the values covered above—human dignity, social solidarity, social responsibility, social justice, and health equity—is a central, encompassing value: human rights. Human rights are grounded upon the assumption that every human being is born free and equal in dignity and rights. John Locke, the

17th-century English political philosopher, argued that—contrary to his contemporaries’ claims that people are, by nature, subject to a monarch—people are free, equal, and possess natural rights (i.e., right to life, liberty, and property). He further stipulated, in his *Second Treatise of Government* (2003/1690), that these rights exist independently of the laws of any society. For Locke, a nation’s government exists by the consent of its people in order to protect their rights and promote the public good. The people, in turn, transfer some of their rights conditionally to their government and may, in turn, demand a new government if the existing one fails to meet its social contract with them (Tuckness, 2020).

In the 18th century, another English philosopher, the utilitarian Jeremy Bentham, strongly disagreed with this notion of natural rights. He decried them as devoid of meaning, as “nonsense upon stilts.” Rights are created by civil law, he argued, rather than being a condition of birth. Bentham remarked that we might wish inherent rights existed, but just as “want is not supply,” “hunger is not bread” (Waldron, 1987, p. 53).

The dispute regarding the legitimacy of human rights continues today. A contemporary argument, for instance, is made by Sim (2020), who finds rights conceptually confusing and inadequate. He believes that the concept of rights does not contribute much to moral decision making in bioethics and, while possibly useful in the expression of a moral concern, adds little to the understanding of it. Rights, he argues further, may cause moral reasoning to be passed over. However, health care practitioners, for the most part, appear to find human rights to have meaning in practice. Most would agree with Albert Einstein: “The existence and validity of human rights are not written in the stars ... [They] have been conceived and taught by enlightened individuals in the course of history” (French, 1979, pp. 305–306).

Proponents of human rights frame health as an entitlement, not as a commodity. Human rights are informed by ethical principles, which, in turn, enhance the significance of global health ethics. A major distinction between human rights and ethical principles lies in the fact that rights are now a matter of law (WHO, 2015). In 1946, the WHO’s constitution was adopted, creating a fundamental right of individuals to the highest attainable standard of health. Soon after,

in 1948, the UN assigned its member states the responsibility of upholding the entitlements of their people claimed in *The Universal Declaration of Human Rights*, the world's most translated document. Health as a right is described in Article 25:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection (United Nations General Assembly, 1948, Article 25)

In other words, there must be equal opportunity of access to health care regardless of factors such as race, gender, economics, and geographical location. Upholding this right can be challenging for many nations, including Canada, with its remote communities in the far North. Our government acknowledges that inequities in access exist for Indigenous communities and that greater efforts are required to ensure Indigenous control over the design and delivery of their health services (see Ethics in Practice 20-3.)<sup>5</sup>

The human rights paradigm is powerful in its individual and global reach, allowing persons to claim particular rights without nationality being a factor (Gable, 2007). The UN's system of rights (declarations, conventions, covenants) legally binds signatory states. Member states of the UN who have ratified agreements to uphold particular rights are assessed every four or five years to determine their progress in upholding these rights.<sup>6</sup> Canada's performance assessments and reports to the United Nations are freely accessible on the Internet. Table 20-2 lists various UN agreements to which Canada has agreed to be held accountable.<sup>7</sup> For a full list of the UN's human rights documents, see the UN Office of the High Commissioner Human Rights (OHCHR; n.d.).

**TABLE 20-2**

## *Examples of UN Rights Agreements Signed and Ratified by Canada*

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*The International Convention on the Elimination of All Forms of Racial Discrimination* (1969).

<https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx>

*The International Covenant on Civil and Political Rights* (1976).

[https://treaties.un.org/doc/Treaties/1976/03/19760323%2006-17%20AM/Ch\\_IV\\_04.pdf](https://treaties.un.org/doc/Treaties/1976/03/19760323%2006-17%20AM/Ch_IV_04.pdf)

*The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1987).

<https://www.ohchr.org/en/professionalinterest/pages/cat.aspx>

*The International Covenant on Economic, Social, and Cultural Rights* (1976).

<https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

*The Convention on the Elimination of All Forms of Discrimination Against Women* (1981). <https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx>

*The Convention of the Rights of the Child* (1990).

<https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

*The Convention of the Rights of Persons with Disabilities* (2006).

<https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities>

*Note.* The cited dates indicate the year the convention or covenant came into force.

## **The Declaration of Bioethics and Human Rights**

The UN's *Universal Declaration of Bioethics and Human Rights* (UDBHR) is a global document grounded in the reality of human connection and directly related to ethics and human health. It was adopted by the UN's Educational, Scientific, and Cultural Organization's (UNESCO's) General Conference on October 19, 2005 (UNESCO, 2005). In this declaration, the principles of bioethics are presented within a human rights framework. The UDBHR goes beyond protection of individual rights to emphasize the solidarity of the human community, and the equality of all humans in relation to dignity, justice, and rights. The need for pluralism and diversity to be respected is stipulated, as is the need for protection of the environment (Langlois, 2014). Specific goals for universal access to

essential medicines and quality health care, as well as the sharing of science and technology, are noted.

The declaration was welcomed as an accomplishment by many, given that it appeals to human dignity, but combines this appeal with a practical, global recourse to human rights (Adorno, 2009). The profound doubts of those who wonder whether the declaration can have a meaningful impact, given that it is nonbinding under public international law, does not diminish its worth for the non-governmental agencies and health professionals whose work it informs and supports (Faunce & Nasu, 2009).

As the health of human life on Earth is increasingly threatened—with the attendant potential negative effects on other living things rising in equal measure—the human rights paradigm provides advanced practice nurse leaders, as well as other health care professionals and policymakers, with a guide to a meaningful response. It offers them the means to provide a more just allocation of health care resources while respecting human dignity and the necessary ethical constraints of informed consent and confidentiality (Frenk & Gomez-Dantés, 2021). The following Ethics in Practice scenario summarizes the story of a compelling violation of human rights.

### **ETHICS IN PRACTICE 20-3**

#### *The Story of Joyce's Principle*

In September 2020, Joyce Echaquan, a 37-year-old Atikamekw woman and mother of seven from the Manawan reserve in Quebec, was admitted to the hospital in Joliette, Quebec for stomach pains potentially related to her heart condition. Two days later, as Joyce was dying, she recorded her final moments on her phone for Facebook Live. The recording revealed hospital staff insulting and swearing at her as she cried out for help. This horrific scene made national news in Canada. Hospital staff were fired and calls for ending such discrimination, which is prohibited under the *Canadian Human Rights Act* (Government of Canada, 1985), came from across the country (Banerjee, 2021). The Canadian government, based on dialogue with Joyce's family, leaders, and practitioners from both her own Indigenous community and Indigenous communities across the country, as well as government representatives and health system partners, funded the development and implementation of Joyce's Principle (Council of the Atikamekw of

Manawan & the Council de la Nation Atikamekw, 2020). Joyce's Principle "aims to guarantee all Indigenous Peoples the right to equitable access to social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health" (Indigenous Services Canada, 2021). These words were inspired by Article 24 of the United Nations *Declaration on the Rights of Indigenous Peoples* (UN Department of Economic and Social Affairs, 2007), which sets out, among other rights, "the right to access, without any discrimination, to all social and health services." The application of Joyce's Principle is one means to promote ethical health care for the Indigenous Peoples of Canada.

## Health for All: The Role of Global Health Governance

To achieve "health for all," guidance and leadership at a global level are required. Global health governance can be defined as "governance that involves the structural and normative aspects of managing the determinants and outcomes of global health," with human rights playing an integral role (Gable, 2007, p. 534). A global government has yet to come into being, although over the past three centuries, joint efforts have evolved to address health issues that reach beyond national boundaries. These efforts began with international standards for sanitation and trade-related health issues.

Additionally, non-governmental agencies were created to respond to emergencies and conflicts (e.g., the International Federation of the Red Cross and Red Crescent Societies, commonly known as the Red Cross). Such agencies evolved into institutions formed at the end of World War II in hopes for a better world (e.g., the World Bank [1944]; the United Nations [1945]). Since 1948, the WHO has been the primary institution with normative and legal authority over global health, setting the agenda for addressing urgent health crises. The World Health Organization has an online "health emergencies list" that notes disease outbreaks, disasters, and humanitarian crises where the organization has a role in supporting nations to respond and recover (WHO, n.d.).

Such crises are set to escalate, according to warnings from other global organizations such as the World Economic Forum (WEF) (Sridhar & Gostin, 2014). The WHO identifies these crises as: (a) the

climate crisis; (b) health care delivery in conflict/crisis areas; (c) health care equity; (d) access to treatment; (e) infectious disease/pandemic prevention; (f) unsafe products; (g) underinvestment in health workers; (h) adolescent safety; (i) threat of anti-microbial resistance/access to low-cost medicines; (j) health care sanitation; (k) the need to improve the public trust in health workers; and (l) capitalizing on technological advancements (Advisory Council, WHO, 2020).

In addition to WHO, there are other UN organizations that develop independent institutional policies and programs to address health within their respective spheres of influence. These include the UN International Children's Emergency Fund (UNICEF), which advocates for ways to give children a good start in life; the United Nations Development Program (UNDP), which helps countries eradicate poverty, decrease inequalities and exclusion, build resilience, and achieve the UN's Sustainable Development Goals; and the United Nations Population Fund and Activities (UNPFA), which focuses on reproductive health (Meier et al., 2020).

Given that health is a factor across critical areas of government from foreign and security policy to trade agreements, health diplomacy plays a large role in the endeavours of the World Health Organization. Indeed, in our interdependent world, health challenges require cooperation of nations through political negotiations and solutions. Such discussions take place at the World Health Assembly, the Human Rights Council and, at times, the UN General Assembly (WHO Eastern Mediterranean Regional Office [EMRO], 2021).

The SARS-CoV-2 pandemic has exposed our need for radical global solidarity if solutions are to be created and humanity's survival is to be ensured. Achieving harmonized action on this deadly threat has promise for facilitating meaningful response to other perils, such as climate change (Taghizade et al., 2021). The UN's Conference of the Parties (COP), who have signed the United Nations Framework Convention on Climate Change (UNFCCC; United Nations, 1992), a treaty in force since 1994, meets every five years. In November 2021, (delayed one year due to the SARS-CoV-2 pandemic), the UN Climate Change Conference (COP26) was held in Glasgow to assess progress since the 2015 Paris Agreement and to

repledge to increasingly ambitious climate goals. Given the enormity of the consequences if global temperatures rise to two degrees Celsius or more above preindustrial levels, COP26 was viewed as highly critical not only to global health, but to the globe itself. Representing Canada, Prime Minister Justin Trudeau pledged to meet these climate goals:

- price on carbon, currently \$40 per tonne, to rise to \$170 per tonne by 2030;<sup>8</sup> cap on oil and gas emissions with goal of net-zero by 2050;
- global methane pledge to lower emissions 30% below 2020 level by 2030;
- protecting 25% of Canada's land and oceans by 2025 (Vasquez-Peddie, 2021); and
- net-zero emissions in Canada's electricity grid by 2035 (Government of Canada, 2021b)

In addition to government agencies, and other organizations that were created to improve global health, public-private collaborations are being developed in an attempt to address global inequities.

### **Public-Private Collaborations: The World Economic Forum**

The World Economic Forum (WEF), was created in 1971 as a not-for-profit foundation. Headquartered in Geneva but best known for its annual meeting in Davos, Switzerland, its aim is to leverage entrepreneurship in the global public interest while staying grounded in the values of moral and intellectual integrity. It has centres dedicated to addressing various areas in the business world, including (a) industry transformation; (b) media, entertainment, and sport; and (c) the mobility of people and goods. Past achievements include the 1988 Davos Declaration (in which Greece and Turkey agreed to reduce tensions), and the 1995 meeting of national trade ministers that eventually led to formation of the World Trade Organization (WTO) that same year.

WEF has various platforms, including a "Platform for Shaping the Future of Health and Healthcare." One focus of this platform is that of global health, with such areas of interest as global health governance, data collection and communication, health and

climate change, and preparing for pandemics.<sup>9</sup> Related health projects include the development of precision medicine (i.e., more personalized and targeted approaches) and genomic data policy.

The founder and executive chairman of the WEF, Klaus Schwab, co-authored a 2021 publication with Peter Vanham entitled *Stakeholder Capitalism: A Global Economy That Works for Progress, People and Planet*. They stated that “stakeholder capitalism,” (i.e., capitalistic approaches by businesses and political leaders) should be the basis of the global economy and used to address world challenges, such as rising income inequality, the monopoly market powers of large corporations, and exploitation of natural resources (Schwab & Vanham).

The WEF is both highly influential and substantively criticized: it brings together political leaders, business leaders, and nongovernmental organizations to consider key world issues, but makes decisions without accountability to an electorate or to shareholders (Delivorias, 2016). The WEF appears to be based upon the belief that businesses do better at solving problems than do governments.

## The Global Elite

According to Forbes, a new billionaire was created, on average, every 17 hours in 2021, with the world’s wealthiest altogether richer than the previous year by five trillion US dollars (Dolan et al., 2021). Members of this plutocracy tend not be from “old money”; rather, they are innovators and entrepreneurs who share a global perspective. Their sense of community with one another tends to be stronger than with people from their own countries (Freeland, 2011). Most of these innovators and entrepreneurs have at least one philanthropic foundation, which usually focuses on finding innovative ways to solve global problems and is often related to health. Journalists Bishop and Green, in their book *Philanthrocapitalism: How Giving Can Save the World* (2008), note that the elites’ way of giving is strongly influenced by their way of doing business. In *Winners Take All: The Elite Charade of Changing the World* (2018), Giridharadas states that billionaires use philanthropic giving to clean up their reputations—and avoid taxation. These actions may blur the reality that these richest humans in the history of the

world “own” the future (Giridharadas, 2018). Ethics in Practice 20-4 below describes some examples of the roles played by the ultra-rich in “fixing the world,” and introduces some questions about the implications of their actions.

#### **ETHICS IN PRACTICE 20-4**

### *The Role of the Ultra-Rich in Fixing the Health of the World*

The global elite are said to be using their wealth to explore ways to solve world problems, particularly those related to disease and lack of access to the necessities of life. Bill Gates, for instance, is contributing to the Bill & Melinda Gates Foundation to find cures for the diseases killing millions of children in low-income countries.

Arrangements such as these raise a series of difficult questions. Is a wealthy person's actions to prevent or cure a disease of their choosing the best strategy to improve world health? Would a better way be to donate the funds to WHO and contribute to a planned, needs-based global response? Wealth donation can make a significant positive difference in the health and well-being of lives around the world if it is informed by a genuine understanding of the targeted global problem.

A recent example of the potential discrepancy between the priorities and knowledge sets of the global elite and the health care establishment occurred in October 2021, when the UN World Food Program director, David Beasley, challenged the ultra-rich to help solve world hunger. Elon Musk, *Time's* “Person of the Year” for 2021 and one of the wealthiest people on Earth, announced that he would sell US \$6 billion of Tesla stock (2% of his wealth) and donate it to the UN, provided they could prove that the sum would solve world hunger. Beasley replied that it would not solve world hunger, but could save 42 million people from starving (Gollom, 2021).

In other words, while Musk's financial donation could do much to address the immediate needs of those on the brink of starvation, the situation is also more complex. Global food insecurity is a longstanding problem, and one that requires comprehensive, integrated, and long-term responses. These responses might be difficult for non-professionals to foresee, assess, or accommodate.

## **The Roles and Ethical Responsibilities of Nurses in Global Health**

The COVID-19 pandemic has revealed the worldwide need to ensure that nurses are supported in developing and sustaining their capacity to respond to this type of deadly public health threat while continuing to provide other essential health services (WHO, 2021b, p.

vi). The WHO's *Global Strategic Directions for Nursing and Midwifery 2021-2025* (WHO, 2021b, April 6) addresses the urgency of investing in these occupations and outlines strategic directions in four areas:

1. *Education*: to ensure that practitioners have the necessary attitude, knowledge, and competencies to meet national health priorities and that health systems' need for their services is met or surpassed;
2. *Jobs*: to promote the creation and sustaining of positions for health workers, with effective recruitment and retention in place and international mobility and migration ethically managed;
3. *Leadership*: to encourage a substantial increase in the number and authority of nurses and midwives in senior health and academic positions and uphold continued development of the next generation of leadership;
4. *Service delivery*: to enable health workers to work to the full extent of their education and training in safe and supportive service delivery environments.

The report suggests that investments be made in strategic areas, such as overtime and hazard pay, safety measures (e.g., personal protective equipment and training), and mental health services. A critical global nurse shortage is identified in the report through findings indicating that 65% of UN member states have under 50 nurses/midwives per 10,000 population and that a needs-based shortage of 5.9 million nurses exists (WHO, 2021b, p. 11).

Gender disparity persists in top health management. In the global health workforce, 70% of health care workers are women. Within the nursing profession, 89% of nurses are female, as are 93% of the midwives. Nevertheless, only 25% of the senior roles in health organizations are held by women (WHO, 2021b, p. 15). As health is one of the highest priorities on the UN's 2030 sustainable development agenda, the need for nursing and midwifery leadership is particularly pressing. Health organizations require nurses in senior roles, with accompanying input into organizational design. Nurse leaders are also needed in government departments, given the significant importance of health and health care throughout government policy (Catton & Iro, 2021).

Rosa et al. (2020) acknowledged that while the expertise of advanced practice nurses (APNs) can contribute significantly to achieving the Sustainable Development Goals, and to the promotion of universal health coverage, to date APNs are underutilized in global health care. These authors maintain that expanding the scope of practice of nurse practitioners globally and making strategic use of nurse practitioners across nations is critical to global health. They note that education of interdisciplinary partners, policymakers, and the public regarding the capacity of APNs is required, as are appropriate role titles and remuneration reflective of this level of service.

Efforts are underway to realize this enhanced role for nurses. Programs such as the Global Leadership Mentoring Community of nursing organization Sigma Theta Tau International—in which mentors and mentees are brought together across seven global regions to promote leadership capacity, understanding of global issues development, and the building of networks (Rosser et al., 2020)—can contribute to the evolution of the role of APNs in global health. The Global Nursing Leadership Institute (GNLI) program of the International Council of Nurses (ICN) has the potential, as well, to facilitate an increase in the number of nurses in senior leadership roles (ICN, 2020, August 20). Notably, in the GNLI 2021, there was an emphasis on health disparities and on the impact of the SARS-CoV-2 pandemic on preparation of nurses for participation in local to global levels of policy actions.

While the need for enhanced participation and leadership from nurses on the global stage is clear, for many nurses, across all levels of practice, considering ethical responsibilities from a global perspective can be unsettling. Simply coping with the demands of everyday practice can be challenging, particularly within pandemic parameters. Nurses, however, understand and embrace ethical responsibilities in their nursing roles. What is required now is for nurses to develop a global state of mind: to understand local actions as situated within a global community. A global attitude has always been foundational to the health disciplines: the best care and treatment possible are to be introduced without discrimination to race, religion, political affiliation, enemy or friend status, or any such

attributes of recipients. Although the moral space is changing, the core values of nurses remain constant.

A helpful way to rethink ethical responsibilities related to the social roles of nurses is offered by the American political theorist and social feminist Iris Marion Young (2006). In her social connection model, she provides an answer to an important question: How do we choose the best ways to use our limited time, resources, and creative energy to respond to a challenge? For Young, the challenge is that of injustice; for nurses, our challenge will be related to health needs, as well. Each of us, as a nurse and moral agent, must decide for ourselves what we can and should do by considering our capacities, circumstances, and opportunities in relation to a need that we identify. The four areas that follow can be helpful in making such decisions:

- *Interests*: Where are your interests? What aspect of health, health promotion, or health care most interests you? Healthy communities? Family support groups? Research on a particular disease?
- *Power*: What potential exists for you to act on or influence processes related to your interests? Where does your capacity to encourage positive change lie? Soft power, such as having a voice or a particular form of influence? An ability to organize and get others involved? The capacity to provide insight or education on a health issue?
- *Privilege*: Are you privileged in some way? Can you make that privilege work to improve health or health care for others?
- *Collective ability*: Does your membership in a group or organization connect you to others so that you are able to act with them collectively?

Contemplation of these areas may assist you to identify how, as a nurse, the ethical responsibilities of this time may be met. The following Ethics in Practice situation gives an example of how a global threat can bring communities together.

**ETHICS IN PRACTICE 20-5***A Global Threat Brings Us Together and Tears Us Apart*

On March 16, 2020, a **BBC News**, Washington article by Tom Gerken appeared with the headline: “Coronavirus: Kind Canadians start ‘caremongering’ trend.” “Caremongering” describes a public movement, organized via social media, to arrange acts of kindness to members of one’s local community at the onset of the **COVID-19** pandemic. Some examples of caremongering are delivering baby food to a single mom; grocery shopping for those particularly vulnerable to the virus; and providing gift cards to someone unemployed due to workplace closure. Such acts of kindness occurred across the globe, not only in Canada. Health care workers worldwide—despite potential severe risk to themselves and their families—did their duty by caring for those ill with the virus, and they received the world’s gratitude (Lane, 2020). Many cities set designated daily times for citizens to show their appreciation through cheering, singing, clapping, or pounding pots with a spoon.

Over time, however, a more disparate response emerged. Some reacted to the pandemic with scaremongering, not caremongering. In both low- and high-income countries, health care workers became targets of harassment, threats, and acts of violence (Bhatti et al., 2021; Cukier & Vogel, 2021). Health care practitioners, patients, and ambulances were prevented from entering and exiting hospitals (Rabson, 2021a). This threat was so significant that the Canadian government moved to amend its Criminal Code to specifically address it (Rabson, 2021b). Fear and anger were stoked by myths perpetuated via social media (e.g., the **COVID-19** vaccine was created to control the population through microchip tracking; it alters **DNA**; or it causes infertility and miscarriages) (Mayo Clinic, 2021). This occurred despite the **WHO**’s efforts to provide clear, informative public advice on the vaccines and on getting vaccinated (**WHO**, n.d.). This information campaign was supplemented by a weekly video and audio series in which experts explained the science related to **COVID-19** via the **WHO**’s YouTube, Instagram, Facebook, Twitter, and LinkedIn channels.

While the pandemic revealed to the world that solidarity was essential to our survival, it revealed, too, that achieving and sustaining a safe, collaborative global community will be a great challenge; a challenge we—and succeeding generations—must strive to accomplish.

**Conclusion**

Martin Luther King, Jr., in his last work, *Where Do We Go From Here: Chaos or Community* (1967), advises us that our “great new problem” is that we—“unduly separated in ideas, culture and interests”—must find a way to live peacefully together in a “world house,”

as “we can never again live apart” (p. 177). He tells us that “science has provided us with adequate means of survival and transportation, which makes it possible to enjoy the fullness of this great earth. The question now is, do we have the morality and courage required to live together ... and not be afraid?” (p. 192). Perhaps what is most important is that we welcome this question and those that come with it: How do we live harmoniously together? How can we be responsible to and for one another? How do we cultivate the moral courage to live the answers? As the UN reminds us in their motto: *This is your world.*

### **QUESTIONS FOR REFLECTION**

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1. *What elements of global health and global health ethics do you believe should be included in Canadian undergraduate nursing education? In advanced practice nursing education?*
2. *Imagine that you are a member of the ultra-rich global elite. Would you invest any of your wealth in endeavours to improve global health? If the answer is “yes,” how would you go about doing this? What would your focus be?*
3. *What, in your opinion, is the most pressing global health ethics issue today? Identify the factors that inform this choice.*

## Endnotes

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- 1 The International Union of Geological Sciences, which names and defines epochs, has yet to formally approve “Anthropocene.”
- 2 “Gavi” comes from the full name, the Global Alliance for Vaccines and Immunization.
- 3 For further information, refer to the 2021 *Global Multidimensional Poverty Index (MPI)*; United Nations Development Programme (2021). <http://hdr.undp.org/en/2021-MPI>
- 4 This involved a collaborative effort by the Pan-Canadian Public Health Network, the Public Health Agency of Canada (2018), Statistics Canada, and the Canadian Institute for Health Information in partnership with the First Nations Information Governance Centre. The resulting portrait of the state of health inequalities in Canada is available through the Health Inequalities Data Tool, an online interactive database. See Government of Canada (2021a).
- 5 Also see Chapter 5 in this book.
- 6 UN human rights instruments may not be ratified by a nation, even if initially signed (e.g., the United States signed *The International Covenant on Economic, Social, and Cultural Rights* in 1977 [under President Carter], but has never ratified it.
- 7 See Government of Canada (2020).
- 8 The proceeds are returned to provinces/territories meeting federal requirements; in Alberta, Saskatchewan, Manitoba, and Ontario, rebates are issued to citizens.
- 9 See <https://www.weforum.org/platforms/shaping-the-future-of-health-and-healthcare>

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