Instructor:
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Summary of Course

The International Bioethics, Social Justice and Health Seminar is a one-credit seminar scheduled in Fall, Winter and Spring Quarters. Students may enroll in one, two or three quarters of the seminar. Class sessions are two hours. The Winter Quarter class series begins on January 12. The next sessions are as follows: January 26, February 9, February 23, March 9.

The overarching goal of the seminar series is to bring together law, health sciences and other graduate students to discuss a series of problem-based case studies and provide an opportunity for multidirectional, multidisciplinary learning and problem-solving. Our cases will be drawn from current issues articulated in the media and scholarly journals in law, bioethics and global health. Over the course of each quarter, students will not only participate in selecting the topics and developing case studies, but they will have the opportunity to engage in discussion about leading issues in global health from a bioethics and social justice perspective. Using the format of prepared case studies from which to launch an analysis, the problem-solving sessions will allow students to discuss issues based on their own experiences and cultures. There will also be targeted readings assigned for each session that complement the case study.

Course Objectives

By the end of the course, students will be able to:

- Compare and contrast bioethics and human rights standards in different country settings and cultural contexts using international norms and foundational documents in bioethics and human rights.
- Demonstrate and be conversant with the moral, legal and political challenges and perspectives that are relevant to evolving controversies in international research and population health.
- Describe and analyze the bioethics and social justice aspects of health disparities as articulated in case studies from low- and middle-income countries and in marginalized populations in wealthy countries.
- Apply knowledge of international human rights and bioethics in formulating solutions to health problems that impact individuals and populations locally and globally.

Required Readings and Course Materials

The syllabus will be based on studies drawn largely from resource poor countries and wealthy country contexts, in which ethnically distinct populations are marginalized. There will be a series of targeted readings corresponding to the case studies. These will be available on the website along with the case studies for discussion.
Course Grade
This is a credit/no credit course. Credit will be accorded on the basis of active participation in class discussions and group work in selecting a topic and developing a case study with readings. With respect to active class participation, the expectation for each class will be that the student arrives prepared and ready to engage in discussion, having previously briefed the assigned reading and discussion questions.

Disability-related Needs
To request academic accommodations due to a disability, please contact Disability Resources for Students (DRS), 448 Schmitz, (206) 543-8924 (V), (206) 543-8925 (TTY). If you have a letter from DRS, please present the letter to me so we can discuss the accommodations you might need in this class.

January 12, 2015

Case Study 1: Uganda’s Anti-Homosexuality Bills of 2009 and 2012
Six years ago, a Ugandan politician introduced the Anti-Homosexuality Bill of 2009 (Links to an external site.). The bill threatened to hang homosexuals. One month prior to the introduction of this bill, three American evangelists held a conference in Uganda and allegedly preached that homosexuals posed a threat to Bible-based values and the traditional African family.

The U.S. and other countries demanded in 2009 that Uganda’s government drop the proposed law, saying it violates human rights. At the time, the Ugandan Minister of Ethics and Integrity was quoted as saying, “Homosexuals can forget about human rights.”

Faced with the prospect of losing millions in foreign aid, the Ugandan Government indicated that it would back down, slightly, and change the death penalty provision to life in prison for some homosexuals. Ultimately, the bill did not pass.

Prior to the introduction of the 2009 Anti-Homosexual Bill, American evangelists helped set in motion a very dangerous cycle, according to human rights advocates in Uganda. Gay Ugandans described an environment of beatings, blackmail, death threats, constant harassment and even so-called ‘correctional rape’. “Now we really have to go undercover,” said Stosh Mugisha, a gay rights activist who said she was pinned down in a guava orchard and raped by a farmhand who wanted to cure her of her attraction to girls. She was impregnated and infected with H.I.V., but her grandmother’s reaction was simply, “You are too stubborn.”

The anti-homosexuality bill was reintroduced in Parliament in 2012. Contempt for the West and Western diplomacy has fueled the anti-gay movement in Uganda. In 2012, the anti-homosexual parliamentary bill’s author, David Bahati stated, “If there was any condition to force the Western world to stop giving us money, I would like that.” Many governments, including the U.S. and Britain have publicly stated their strong opposition to these bills. The Obama administration said it would use its foreign diplomatic tools, including aid, to promote equal rights for lesbian, gay, bisexual and transgender people around the world. Prime Minister David Cameron of Britain has threatened to cut aid for countries that do not accept homosexuality. African nations have reacted bitterly to this diplomatic engagement, saying it smacks of neo-colonialism.

Many in Africa think that homosexuality is an immoral Western import. Harsh laws against homosexuals and homosexual behavior are common. In fact, more than 36 countries criminalize homosexuality in Africa. In northern Nigeria, gay men can face death by stoning. Beyond Africa, a handful of Muslim countries, like Iran and Yemen, also have the death penalty for homosexuals. However, not all Ugandans believe that laws should be so harsh against homosexuals, although few openly speak out in support of gay people.

Since 2009, several anti-homosexuality bills were introduced in the Uganda Parliament but never passed until 2013. In 2014, a Ugandan court, composed of a five judge panel, struck down the law on technical grounds. This leaves open the possibility that the law could be revived.
Questions for Discussion:
1. What are the ethical issues in the case described in the NYT articles?
2. What specific human rights are being violated in the bills introduced in 2009 and 2012?
3. What are the public health implications of harsh criminal laws like the Anti-Homosexual Bills in Uganda?
4. The Ugandan Penal Code is not an outlier in Africa. In Daniel Englander’s article, “Protecting the Human Rights of LGBT People in Uganda in the Wake of Uganda’s Anti Homosexuality Bill 2009”, what reasons are given as the cause of this discrimination in Uganda and other countries in Africa?
5. What models have been used in other countries to decriminalize homosexuality or homosexual sexual acts? Are there lessons that can be learned, including those from the U.S.?
6. What solutions, both within and outside the country, are proposed to eliminate LGBT discrimination in Uganda and to respect, protect and fulfill their human rights?
7. What solutions, both within and outside the country, are proposed to eliminate LGBT discrimination in Uganda and to respect, protect and fulfill their human rights?

Readings:
Universal Declaration of Human Rights: http://www.un.org/Overview/rights.html (Links to an external site.)
The International Lesbian, Gay, Bisexual, Trans and Intersex Association, or ILGA, 76+ countries where homosexuality is illegal, Available at: http://76crimes.com/76-countries-where-homosexuality-is-illegal/ (Links to an external site.)
January 26, 2015

Case Study 2: Pesticides & Multi-National Corporations

A 2010 report from the World Health Organization’s (WHO) Commission on the Social Determinants of Health (CSDH) concluded that, “social injustice is killing people on a grand scale,” and called for a renewed focus on ending health inequalities within the international health policy agenda. One example is the escalating burden of death and disease in developing countries related to the escalation of tobacco consumption. The Framework Convention on Tobacco Control (FCTC) is the first WHO public health treaty, and it addresses the global health inequalities associated with tobacco use. However, many stakeholders are skeptical about its ability to address the problem through, what might be called, harmonizing policy across international health, development and economy sectors.

Tobacco consumption is related to global health inequities. This case study will focus on the relationship between poor population health, social justice and regulations of the global tobacco industry in low- and middle-income countries (LMIC). Tobacco has become an important cash crop in LMICs. In Pakistan, approximately 73% of total tobacco cultivation occurs in the Swabi district of the North West Frontier District (NWFP). Unfortunately, tobacco is also a heavily pesticide-dependent crop, which makes the plant’s cultivation tremendously dangerous for the farmworkers who cultivate it. Several studies have shown that prolonged exposure to pesticides may cause leukemia, brain tumors, prostate cancer and many more serious diseases in the general population. Protective measures can decrease exposure and decrease disease risk, but many farmworkers do not have the benefit of protective measures. In the Swabi district, there are very high rates of cancer and other diseases, the most in all of Pakistan.

Due to the nature of pesticides and the harm they pose to human safety and health issues, they are heavily regulated both nationally and internationally. Government-imposed limitations on pesticide use present serious impediments to the international trade of tobacco. Under the threat of regulation, tobacco companies respond using various advocacy methods in support of their goals. They are often very successful. The tobacco industry has altered the outcome of two legal cases by hiring ex-agency scientists to write reports favorable to industry positions regarding pesticide regulations for national (EPA) and international (WHO) regulatory bodies.

Some countries have regulations that require the establishment of maximum residue limits (MRLs) for pesticide crops. However, Phillip Morris determined that MRLs were not required and should not apply across all countries. The corporation encouraged industry regulators to advocate for high MRLs without any supporting scientific data about human safety. In Pakistan, MRLs in the NWFP exceed the international average by 48%, the highest of any country. Furthermore, a member of the National Assembly from Swabi acts as a representative for farmworkers in the district; the representative is also an owner of a tobacco company.

Questions for Discussion:
1. Should the global tobacco industry have the power to influence and create public health policy? To what extent should they be limited and to what extent should they take part in the process?
2. What conflicts of interest arise in this debate?
3. Philip Morris says that it supports a wide range of charitable programs in the communities where they source and manufacture tobacco, including development, education and environmental protection projects. These might fall under the category of corporate social responsibility. Does this excuse any of its behavior in Pakistan?
4. Phillip Morris also promotes the idea that to be effective, tobacco regulatory policy must be evidence-based, apply to all tobacco products, and take into account the views of all legitimate stakeholders, including public health authorities, government finance officials, and members of the tobacco supply chain. What are the ethical issues?
5. What ethical issues exist when tobacco farmworkers have job-related health issues and do not have the legal structures with which to realize their rights? Do you think that Pakistan’s recent signing of the FCTC will have any impact on farmworkers rights?
6. If you were a consultant to the WHO, what would you recommend for updates to the FCTC?
Readings:


(SKIM) WHO Framework Convention on Tobacco Control (Links to an external site.) (2005).


Optional:

Philip Morris International, Pakistan (Links to an external site.). Country Overview & Smoking and Health page.

February 9, 2015

Case Study 3: Death with Dignity

In November 2014, Brittany Maynard, a 29-year-old woman suffering from terminal brain cancer, ended her life. She chose to die by taking a lethal dose of prescribed medication. She made use of Oregon’s Death with Dignity Act that allows eligible residents to self-administer a lethal dose of medication, prescribed by a physician, to aid in dying. In order to do so, she had to move to Oregon and set up residence. Her home state of California does not allow physician-assisted suicide.

Oregon is one of three states in the United States that allows physicians to assist in suicide; the other two states are Washington and Vermont. In Oregon, only adult patients who are deemed mentally competent and who are diagnosed with a terminal illness, with only six months or less to live, are eligible to request, from their physician, a lethal dose of medication. The patient must initiate the request by first making an oral request, and then after a mandatory waiting period, a written request. There is another waiting period before the physician can prescribe the lethal dose. During this process, the patient can change their mind and back out at any time. The patient can also choose not to take the prescribed medication. Any physician, pharmacist, or healthcare provider may refuse to participate. For those who do participate, the law provides the health workers involved with immunity and liability protection.

Just to be clear: Physician-assisted suicide (PAS) is not euthanasia. The 11th edition of Merriam-Webster's Collegiate Dictionary defines the term euthanasia, which derives from the Greek for "easy death," as "the act or practice of killing or permitting the death of hopelessly sick or injured individuals...in a relatively painless way for reasons of mercy." The key difference between PAS and euthanasia is the agent administering the lethal dose. In PAS, the lethal dose is self-administered. The patient administers the medication, not the physician. A physician does not even need to be present at the time the patient takes the dose. In contrast, with euthanasia, the healthcare worker administers the medication. Euthanasia is illegal in all 50 U.S. states.

While the movement to legalize euthanasia in England began in 1935 with the founding of the Voluntary Euthanasia Society personalities like H. G Wells, the movement gained momentum in the United States
in 1938 with the founding of the Euthanasia Society of America (renamed as the “Society for Right to Die” in 1974).

There has been an ongoing effort to distinguish between active and passive euthanasia. While active euthanasia refers to the hastening of death by the administration of external agents, passive refers to withholding or forgoing necessary treatment in the management of an illness. Simply stated, one is an act of commission, while the other is that of omission.

Different religions and cultures have viewed suicide in different ways. Ancient Romans, who dishonored themselves or their families, were expected to commit suicide to maintain their dignity and, frequently, the family property. Islam and Judaism condemn the taking of one’s own life. Catholics committed to the dignity of each human person must insist: "Kill the pain. Not the patient." Catholic moral tradition holds that it is impossible to achieve some good effect without causing a bad effect as well, hence coining the doctrine or principle of double effect.

Some believe that assisted suicide and palliative care are not only distinct, but they are radically opposed to each other. Palliative care controls physical, mental, and emotional pain through medication and psychotherapy, while assisted suicide reduces suffering through the hastening of death, which is believed to undermine pain control methods.

End-of-life care options in the U.S. include hospice and palliative care, as well as life-sustaining treatment. However, patients have the right to refuse medical treatment. Suicide is not illegal, but assisted suicide is in all but three states that allow PAS. Currently, Death with Dignity laws that would allow PAS have been introduced in California, Colorado, Connecticut, Iowa, Kansas, Missouri, New Jersey, New York, and the District of Columbia.

Questions for Discussion:
1. What is the primary ethical issue for death with dignity? Are there secondary ethical issues?
2. What is the difference between euthanasia, physician-assisted suicide, and palliative care?
3. Do you think it is justified for someone to avoid pain and desire death, while upholding their right to autonomy?
4. Is there scope for misuse of a law that allows physician-assisted suicide/death (PAS)? If so, what do you think is the best approach to prevent it?
5. Do you think the safeguards put in place by DWD (Death With Dignity) laws are sufficient to protect patients? To protect physicians?
6. Opponents of PAS are concerned that PAS laws would target vulnerable groups, such as poor people, people on Medicaid, or minorities. Does the data collected to date support their claims?
7. Opponents of PAS are concerned that allowing PAS has the potential to snowball into permissiveness for euthanasia. Do you think this is a valid concern?
8. According to Oregon’s DWDA demographic data, who has made use of the DWDA? Are there any ethical implications regarding individuals or groups of individuals making use of the law? Are there other data that Oregon should be collecting?
9. What is the essence of the Mancini and Catholic Bishop’s articles? To what extent do you think they are justified?

Readings:
Intro Info:
* Suicide, Euthanasia, and Physician-Assisted Death
http://ic.galegroup.com/ic/ovic/ReferenceDetailsPage/ReferenceDetailsWindow?displayName=Reference&zid=5cb440ad9a2dda9f9aa1249c9a51e15a&action=2&catId=&documentId=GALE%7CEJ1771600106&userGroupName=gottitans&jsid=e520b8d3f3fa2f6268ad5a92e9d1f165 (Links to an external site.)
February 23, 2015

Case Study 4: Right to Try Laws in U.S. States

Colorado has recently instituted what is commonly referred to as the “Right to Try” law. More recently Louisiana, Michigan, and Missouri have passed similar Bills. This law allows terminally ill patients to obtain experimental drugs without federal approval. Currently, FDA approval takes an average of 11-14 years for a new drug, so the “Right to Try” Act could greatly affect whether patients are able to acquire potentially life-saving drugs.

The Sides of the Issue:

a. Pro-“Right to Try” Law

Supporters of the law call it a ray of hope for dying patients trying to navigate the red tape of guidelines for obtaining drugs outside of clinical trials, which usually requires federal approval. Although the bills admittedly have little legal traction, supporters insist that states could push the envelope on clinical trials to speed up the work of federal drug regulators.

Supporters also insist that that the right to try is a fundamental, basic right of human life, and that Colorado patients will have access only to those drugs that have passed the safety phase of clinical trials.
b. Anti-“Right to Try” Law

Opponents call the law a “feel-good campaign” but insist it has no real teeth, because it doesn’t require drug companies to provide drugs outside federal parameters, and there is no inclination that pharmaceutical companies will.

Nationwide, people suffering from terminal illnesses for which available treatments are not working can apply for a Compassionate Use Exemption to be included in a clinical trial. During 2013, the FDA approved all 550 exemption requests, accepting almost all those who apply.

Critics of the Act point out that the FDA approval process exists to protect patients from harm, and that truly miraculous drugs are few and far between.

c. Posture of the Statutes

It is far from clear whether such statutes will pass muster when challenged. Although no Colorado court or controlling federal court has addressed the question, the D.C. Circuit has found unequivocally that terminally ill patients have no fundamental right, under due process, to experimental drugs.

The FDA has not adopted any particular position regarding the “Right to Try” Act. However, the agency is concerned with any efforts that would be inconsistent with its congressionally mandated authority to protect the public from therapies that are neither safe nor effective.

Questions for Discussion:

1. Should terminally ill patients have the right to access experimental drugs?
2. Describe the process of bringing a drug to market. What criteria need to be met to do so, and why are they important?
3. Discuss the pros and cons of FDA deregulation.
4. How is “right to try” different than compassionate use (the FDA EA program)? Discuss the ethical considerations for both.
5. Critics say the law will not help dying patients. How could one measurably evaluate this policy? What, specifically should be measured? Would it be worth giving patients hope, even if it meant worse health outcomes?
6. If patients are able to get experimental drugs on request, does this undermine the concept/ethical understanding of placebo controlled trials?

Readings:


http://www.cadc.uscourts.gov/internet/opinions.nsf/4349D96374DCCAFB852574404556B8/$file/04-5350c.pdf (Links to an external site.)


Clayton R. Portell, Live or Let Die: Will the Courts Recognize in Terminally Ill Patients a Fundamental Right to Choose Non-FDA Approved Drugs or Does the FDA’s Stringent Approval Process Carry Sufficient Merit?, Indiana Health Law Review:5 (1), 2008, Available at:
March 9, 2015

Case Study 5: Human Trafficking

Human trafficking is a form of modern slavery where people profit from the control and exploitation of others. It exists throughout the world, including the U.S. Traffickers use force, fraud and coercion to control people for the purpose of engaging in commercial sex or forcing them to provide labor against their will. Traffickers use violence, threats deception, debt bondage and other manipulative methods to trap victims, all of whom share one experience—the loss of freedom.

Human Trafficking is big business. Polaris states on their website that it is a $150 billion industry worldwide. The International Labor Organization estimates that there are 20.9 million victims of human trafficking globally, including 5.5 million children. Fifty-five percent are women and girls.

In the U.S., Polaris operates a National Human Trafficking Resource Center Hotline and in 2013 they received calls about multiple human trafficking cases in all 50 states and D.C. No official numbers of human trafficking victims exist in the U.S. However, it is estimated that 100,000 children are in the sex trade industry each year. Estimates of adults and children run into the hundreds of thousands for sex and labor trafficking in the U.S.

Human trafficking violates international law and the American Constitution (13th Amendment). The U.S. Trafficking and Violence Protection Act of 2000 strengthens the prosecution and punishment of traffickers. However, the organization Polaris says that the numbers of reported victims continues to increase in the U.S.

The personal toll on the individual victim is enormous. There is physical and mental trauma. The psychological impact can often outweigh the physical damages. Health providers have an opportunity to intervene if they are educated about identifying signs, informing victims and immediately referring if possible. Law enforcement can also play an important role in identifying victims and perpetrators and acting to protect the victims and arrest the perpetrators.

Polaris has rated all 50 states and the District of Columbia based on 10 categories of laws that are critical to a basic legal framework that combats human trafficking, punishes traffickers and supports survivors. Delaware, New Jersey, and Washington have perfect scores, meaning they have laws fulfilling all 10 categories. Even so, human trafficking is still prevalent in the Seattle-Tacoma area.

Questions for Discussion:
1. What populations are most vulnerable to human trafficking and why?
2. What is the Stockholm Syndrome? What are the health impacts of human trafficking?
3. What are the ethical and human rights considerations in human trafficking?
4. Concerning the Ohio perpetrator in Priscila A. Rocha’s article, why wasn't he prosecuted?
5. What states are the lowest rated by Polaris in the 10 categories of laws?

7. If the Trafficking and Violence Protection Act of 2000 (TVPA) was amended to include psychological coercion to the list of punishable crimes, how would this change standards for the courts? (Any bright-line rule?)

8. What can be done to better promote the health and well-being of victims?

9. What actions can be taken to strengthen the criminalization of human trafficking?

Readings:


Polaris Project website: http://www.polarisproject.org/human-trafficking/overview (Links to an external site.)


The Advocates for Human Rights, Health Consequences of Trafficking, http://www.stopvaw.org/health_consequences_of Trafficking (Links to an external site.)


Optional Reading:


Trafficking and Violence Protection Act of 2000, http://www.state.gov/j/tip/laws/61124.htm (Links to an external site.)