

Chapter 18: Cancer in the Context of Global Inequities and Disparities in COVID Times: An Ethical Reflection

Andrea Vicini, SJ

The ethical reflection on cancer stresses that addressing the global cancer pandemic is hampered by the existing inequities and disparities in providing healthcare, to citizens across the planet, which are further exacerbated by the global pandemic caused by COVID-19. Thinking about the future requires us to consider the social, cultural, and religious contexts where inequities limit efforts aimed at preventing, diagnosing, and providing care. Ethically, a multilayered approach that strives to promote research, prevention, and therapies, and that engages individuals, institutions, and populations in collaborative efforts is promising and generates realistic hopes.

Cancer is ubiquitous. Just as cancer cells keep growing, unbound, the presence of cancer in people's lives and in society keeps spreading. Moreover, context matters. In the peripheries of our world, anything that relates to cancer is colored with the specificity of each context. The presence or absence of healthcare institutions, or the limited healthcare resources available within them, have negative consequences on addressing cancer at any stage, from prevention, to diagnosis, to therapy, and to following up on cancer survivors.

For the bioethical tradition, differences in the healthcare systems, as well as in the services that hospitals, clinics, and healthcare professionals can offer, reveal the injustices that people experience. These injustices demand attentive analysis and bold interventions to address and remove the systemic and structural inequities that limit or inhibit access to healthcare.

A critical assessment of our social inequities is necessary by challenging what the late physician and anthropologist Paul Farmer (1959-2022) has

rightly called the “pathologies of power.”¹ Whether one considers poor neighborhoods in our cities and the disarray of healthcare in rural contexts in the Global North or whether one focuses on the status of healthcare systems and instructions the Global South, indignation and outrage should inform our ethical response. Justice is urgently needed because the presumption is that health is a human right. Humankind should strive to pursue health for everyone, everywhere.

To focus on inequities in health means to consider how social injustices affect people’s health and shape how we provide care or how we avoid caring for the health needs of people and of the whole environment. In the U.S. and elsewhere, racial discrimination is one of these tragic social factors that exclude, marginalize, and worsen the health of people and of the whole society.

Scholars attentive to ethical dynamics in society continue to raise our awareness and provoke our response and action. Prof. Elizabeth Williams has been outspoken in allowing us to hear the pleas of Black women suffering from breast cancer, plagued by the too many social factors that make them struggle in poverty.² Aana Vigen too has highlighted how, in the U.S., gender and race inequities burden women.³

In the Global South, the control and domination of colonial powers has inhibited human, social, cultural, political, and economic developments and has deprived nations of their rich human and natural resources. The *pushing out* of healthcare professionals trained in the Global South, because of the limited opportunities for their professional flourishing, and the *pull effect* of rich nations attracting trained healthcare

¹ Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor*, California Series in the Public Anthropology (Berkeley: University of California Press, 2005).

² Elizabeth A. Williams, *Black Women and Breast Cancer: A Cultural Theology*, Anthropology of Well-Being Individual, Community, Society (Lanham, MD: Lexington Books, 2019). See also prof. Elizabeth Williams’s chapter in this volume.

³ Aana Marie Vigen, *Women, Ethics, and Inequality in U.S. Healthcare: “To Count among the Living,”* Black Religion, Womanist Thought, Social Justice (New York: Palgrave Macmillan, 2006); Aana Marie Vigen, *Women, Ethics, and Inequality in U.S. Healthcare: “To Count among the Living,”* 2nd ed., Black Religion, Womanist Thought, Social Justice (New York: Palgrave Macmillan, 2011).

workers to hospital wards in the Global North, exemplify how, in our global economy, the colonial histories continue what has been called the “brain drain.”⁴ Colonization, with its economic exploitation and social dependence, takes new, pervasive forms that keep affecting the quality of care that can be provided in the world’s peripheries.

The global COVID pandemic has opened the eyes of the whole humanity to the urgency of promoting health globally. What affects one person has the potential of affecting everyone. As Pope Francis tirelessly reminds us, everyone and everything is interconnected.⁵ Moreover, in the Global North, the COVID pandemic highlighted our vulnerabilities. As citizens of developed countries, we thought that our technologically developed healthcare could protect us from incoming pandemics. Instead, we discovered our fragility and lack of preparedness, and the inequities that shape our neighborhoods and working places.⁶ Minorities paid the higher price in human suffering with repercussions on the overall quality of prevention, diagnosis, and therapy of other health conditions, including cancer. Among the citizens, particularly those belonging to minorities, one will continue to see the consequences of the changes and restrictions on offering basic health services that were required and implemented during the global pandemic. The COVID global vaccination process continues, but it shows inequities in access to vaccines between rich and poor countries and in setting up the vaccination campaigns.

A strong commitment to promote healing in the global, multiple contexts where people live is urgently needed. We all long for healing. Hopefully, we all aim at promoting healing in inclusive ways, without excluding anyone and with a preferential option for those in greater need, who are more vulnerable, and for the poor in our midst.

⁴ As an example, see Ruth Groenhout, “The ‘Brain Drain’ Problem: Migrating Medical Professionals and Global Health Care,” *International Journal of Feminist Approaches to Bioethics* 5, no. 1 (2012): 1–24.

⁵ See *Laudato Si’*, nos. 117 and 138 and *Fratelli Tutti*, nos. 96, 138, 259.

⁶ Cristian Timmermann, “Pandemic Preparedness and Cooperative Justice,” *Developing World Bioethics* 21, no. 4 (2021): 201–210.

For over two millennia, the Christian tradition understood healing very broadly. Healing concerns concrete persons, peoples, societies, and cultures. It is holistic. It aims at global flourishing. It reaches out to the depth of our heart, memory, and imagination. It touches our bodies and all our relationships. It includes the social, cultural, religious, and political living environment. Finally, healing concerns the planet too.

Today, we should continue this long healing tradition, maybe in new ways. In the past, historic events and economic challenges transformed healthcare and its presence locally and globally. Contemporary events continue to challenge and change this commitment: from the global pandemic caused by the COVID-19 virus to the global epidemic of AIDS—the acquired immunodeficiency syndrome caused by the human immunodeficiency virus (HIV)—as well as tuberculosis and malaria, to more localized epidemics like those caused by the Ebola virus in some countries within the African continent.⁷ These challenging health crises urge us to renew our commitment to the healing of people and societies by promoting justice in practices, institutions, and social dynamics. These crises, however, do not modify the ultimate goal that we pursue, that is, to promote healthy living conditions on our planet for all human beings and to offer up-to-date high-quality care to all citizens, particularly those most in need. We do not have a cure for many cancers, but we can already promote healing in multiple ways. We could call it a more just “relational and social healing.”

Concretely, in our global context marked by shocking inequalities and unacceptable inequities, the access to new therapies and techniques should not become a further occasion for discrimination. The Roman Catholic insistence on the preferential option for the poor—whoever they are and wherever they live—is prophetic and longs to be implemented.⁸

⁷ On AIDS, see Jacquineau Azetsop, ed., *HIV and AIDS in Africa: Christian Reflection, Public Health, Social Transformation* (Maryknoll, NY: Orbis Books, 2016). On Ebola, see Paul Farmer, *Fevers, Feuds, and Diamonds: Ebola and the Ravages of History* (New York: Farrar, Straus and Giroux, 2020).

⁸ Alexandre A. Martins, “Ethics and Equity in Global Health: The Preferential Option for the Poor,” in *Ethical Challenges in Global Public Health: Climate Change, Pollution, and the*

Moreover, increasingly, in many instances, a diagnosis of cancer is not a death sentence anymore—if diagnosis is prompt and therapies are available. To be affected by cancer is an ordeal, but, with competent and caring help, we can go through it. In many cases, we might heal and survive cancer.

However, other human and ethical challenges surface and burden us. We need to learn how to live with the consequences of successful therapies because sometimes they change our bodies in ways that are quite unpleasant. We need to learn how to deal with the latent anxiety of being a survivor and risking recurrence. In other words, the importance of outstanding cancer research and efficacious therapies should be integrated with a constant attention given to the lived experiences of people, accompanying them in their struggles and ordeals, and joining them in striving for greater social and global justice. Hence, we should consider research, prevention, therapy, and then people's narratives.

Research and Its Applications

Research helps us to understand the complexity of cancers, from their causes to their development. These studies should also contribute to appreciate how people are affected and how we should care for those suffering from cancer. Moreover, civil society should intervene to prevent cancers by addressing the social, cultural, and political factors that influence the occurrence and presence of cancers in today's world and in people's lives. In very specific ways, the chemicals used in homes and

Health of the Poor, ed. P. J. Landrigan and A. Vicini, SJ (Eugene, OR: Pickwick Publications, 2021), 96–105; Alexandre A. Martins, “*Laudato Si'*: Integral Ecology and Preferential Option for the Poor,” *Journal of Religious Ethics* 46, no. 3 (2018): 410–424; Alexandre A. Martins, *The Cry of the Poor: Liberation Ethics and Justice in Health Care* (Lanham, MD: Lexington Books, 2020), 59–75. See also Stephen J. Pope, “Proper and Improper Partiality and the Preferential Option for the Poor,” *Theological Studies* 54, no. 2 (1993): 242–271; Stephen J. Pope, “Christian Love for the Poor: Almsgiving and the ‘Preferential Option,’” *Horizons* 21, no. 2 (1994): 288–312; Joseph Curran, “Mercy and Justice in the Face of Suffering: The Preferential Option for the Poor,” in *Hope & Solidarity: Jon Sobrino's Challenge to Christian Theology*, ed. S. J. Pope (Maryknoll, NY: Orbis Books, 2008), 201–214.

working places, what people eat, drink, and breathe, where they live and how they work, all these contextual factors intervene in humanity's quality of life and health. While not every environment is potentially cancerogenic, we see what needs to be done to make healthier each social context by limiting and avoiding what affects human health and the health of the whole planet. Scientific research should study everything that can help us to acquire a deeper knowledge of diseases—even geography and history—aiming at helping sick people by offering to them diagnostic tools, accessible effective therapies, and eventually a safe environment. Bioethicists want this to happen and work to make it happen.

Cancer research should also be conducted in ethical ways, avoiding any double standard that differentiates between patients in the Global North and patients in the Global South. Large cohorts of patients might be more easily gathered in the Global South, but the ethical standards required might not be enforced—whether one thinks of accurate and accessible informed consent or studies requiring placebos but with patients unaware they are taking a placebo when comparable efficacious therapies could be given to them.⁹ Moreover, the burden of research that weighs heavily on people in the Global South should translate in concrete benefits for their individual health (e.g., in terms of having access to prevention, diagnostic tools, and therapies) and healthy social environments. It is ethically unacceptable that double standards or exploitation in research practices occur by advocating that these populations do not have access to high quality healthcare services and the little that is offered to them matters. These abuses in research, and in cancer research, should not be tolerated.¹⁰

⁹ Vijayaprasad Gopichandran and Varalakshmi Elango, "Data Ethics in Epidemiology: Autonomy, Privacy, Confidentiality and Justice," in *Ethics in Public Health Practice in India*, ed. A. Mishra and K. Subbiah (New York: Springer Berlin Heidelberg, 2018), 121–138.

¹⁰ For two classic examples, see Marcia Angell, "Ethical Imperialism? Ethics in International Collaborative Clinical Research," *New England Journal of Medicine* 319, no. 16 (1988): 1081–1083; Marcia Angell, "The Ethics of Clinical Research in the Third World," *New England Journal of Medicine* 337, no. 12 (1997): 847–849.

Prevention

Testing for possible predispositions to develop cancer is available, as in the case of the BRCA 1 and 2 suppressor genes.¹¹ Knowing that we have a BRCA mutation means that, in the future, we are at much greater risk of developing breast and possibly ovarian cancer. Being tested for BRCA when our family history shows the presence of breast and ovarian cancers could inform us about our personal or familial predisposition to develop these cancers. Hence, we might want to get tested to identify our predisposition to be affected by these cancers. In these situations, the perception of risk dominates our imagination, emotions, and consciousness. We worry.

Moreover, testing might transform us and, in general, change the notion of patient. Even when we are healthy, testing investigates our predisposition to get cancer. In case of positive results, which confirm we carry a genetic mutation that predisposes us to be affected by cancer, we become patients well before any symptom. Hence, as a form of prevention, cancer testing requires careful assessment and competent accompanying in the decision-making process and in dealing with the testing outcomes.

The possibility to be tested allows us to identify our predisposition, and it can tell us something about our parents and siblings. However, we might not have a therapy able to cure us. People can be tested well before the insurgence of any symptoms. Even so, some want to avoid getting tested. Despite being part of a family marked heavily by hereditary breast and ovarian cancer, Amy Boesky decided not to get tested for the BRCA genes.¹² She has taken other measures to address her increased risk of developing breast and ovarian cancer, including the surgical removal of her ovaries and breasts. For her, the test was not the needed answer to her health concerns. Amy Boesky is not alone in turning elsewhere for the answers that she wants. Since the BRCA tests were introduced in 1996,

¹¹ The acronym BRCA means “BReast CAncer gene.”

¹² Amy Boesky, *What We Have: A Memoir* (New York: Gotham Books, 2010).

surprisingly we have not seen long waiting lines outside the clinics, with women at risk waiting to be tested.¹³

From the point of view of theological bioethics, testing can be a helpful resource that empowers us by promoting the knowledge of our own selves even when therapies are not possible. In this case, access is needed: testing should be made available to all citizens. At the same time, testing might be perceived as invasive and giving us unwilling information. Hence, the possibility of not knowing should be protected.

Discernment allows us to reflect on, and decide, what is reasonably and realistically the best option. Bioethicists wonder, however, whether, ultimately, we lack in providing moral guidance. Moral critical reasoning should integrate personal stories, experiences, and situations to identify what is right. Competent, discrete, and respectful accompaniment should help us in our discernment and decision making.

Testing might also transform healthcare by emphasizing medicalization. Promoting health could appear to depend heavily on test results instead of being also influenced by how and where we live, by what we breathe, drink, and eat, and by our lifestyle. A more inclusive and holistic approach to personal and social health is appropriate and fruitful.

Therapies

New drugs and therapeutic strategies to treat cancer are needed. This simple and evident statement is quite challenging in healthcare contexts in the Global South, where diagnostic resources might be limited and where it might not be possible to provide the necessary therapies to all patients. In the global context, to think about cancer therapies presents systemic and structural ethical challenges. As Daniel Daly stressed, we should examine whether our structures are vicious or virtuous and, accordingly,

¹³ As examples, see Victor R. Grann, Priya Patel, Anubha Bharthuar, Judith S. Jacobson, Ellen Warner, Kristin Anderson, Eiran Warner, Wei-Yann Tsai, Kimberly A. Hill, Alfred I. Neugut, and Dawn Hershman, "Breast Cancer-Related Preferences among Women with and without BRCA Mutations," *Breast Cancer Research and Treatment* 119, no. 1 (2010): 177–184; Steven A. Narod, "Should All Women with Breast Cancer Be Tested for BRCA Mutations at the Time of Diagnosis?," *Journal of Clinical Oncology* 30, no. 1 (2012): 2–3.

we should identify transformative strategies that could help in fostering virtuous dynamics, structures, and systems.¹⁴

Hence, we should avoid any reductive approach that betrays the complexity of providing cancer treatments. When we discover that we are affected by a cancer, we should be able to identify the type of cancer, its source, stage, and aggressivity, and have access to targeted therapeutic approaches. The hardship of demanding therapies should lead us toward an improved quality of life and, if it is possible, a restored health.

Surviving Cancer: Narratives and Support

People affected by cancer ask us to be present, competent, and compassionate. They want us to listen to their stories and struggles. They hope they will be understood, supported, and helped. Bioethicists hear their call and aim at promoting their well-being. In this interaction, which is shaped by personal narratives, three aspects should be stressed: the growth in awareness, the ability to address tensions, and the importance of participation and change.

Awareness

Cancers affect a very large number of persons and families around the world. For many others, testing will uncover their predispositions to get sick. Are we aware of the daily struggles of these people? This awareness is our responsibility, and it should shape our actions in today's society.

As bioethicists, becoming more aware does not depend only on us, on our own abilities, commitments, and strengths. We are not alone in this. First, cancer patients and cancer survivors can become our teachers by making us more aware of what they are enduring. Bioethicists should join them in strengthening our collective awareness of the ethical issues related to cancer.

Second, many people and organizations help us in raising our awareness about what prevention requires and what treatments demand. They are

¹⁴Daniel J. Daly, *The Structures of Virtue and Vice* (Washington, DC: Georgetown University Press, 2021).

breaking the silence and the shame around cancer. They want us to take more control of our health, how we live and work, as well as our living conditions on Earth.

Tensions

Awareness might lead us to change, often with tensions. In interacting with patients, we might deal with contrasting healthcare models: alternative or traditional forms of healthcare vs. today's Western approaches. The Mayan medicine, for example, interprets diseases and their causes by relating everything to the "heart." Moreover, for the Mayan people in Central America, the single, the family, the whole creation, and even the divine are part of a whole. A disease indicates a broken harmony within the self and with the cosmos. The traditional cures aim at recreating harmony. One could also discuss African traditional healing approaches¹⁵ as well as Asian contributions.¹⁶ Western medicine, on the contrary, is high tech. It relies on tests, screenings, drugs, and invasive procedures. We are quite far from these more harmonic worldviews. Hence, tensions can occur between diverse worldviews and visions of healthcare.

Globally, in our pluralist, multicultural, and multireligious world, we all struggle with vulnerability, fragility, and sickness. We all long for healing and need efficacious treatments. But we address these needs differently because of our diverse visions of our body, society, and cosmos. Within this diversity, extra efforts are required to achieve a profound and respectful understanding and a constructive dialogue.

The highly specialized medical technology deployed to treat cancer implies extra tensions too. We need to decide about whether or not to test, to know about one's predisposition to get cancer, and to choose to pursue aggressive therapies or set limits to experimental techniques; and to

¹⁵ Stan Chu Ilo, ed., *Wealth, Health, and Hope in African Christian Religion: The Search for Abundant Life* (Lanham, MD: Lexington Books, 2018). See also Rose Mary Amenga-Etego, "The Practice of Traditional Medicine and Bioethical Challenges," in *Bioethics in Africa: Theories and Praxis*, ed. Y. A. Frimpong-Mansoh and C. A. Atuire (Wilmington, DE: Vernon Press, 2019), 113–130.

become aware that we might have reached the point where we should let go and stop therapy after therapy.¹⁶

How do we deal with these tensions? First, we need to clarify our goals and pursue them with concrete choices adapted to our own context and our worldview. Second, we need to define our way of proceeding (e.g., to be informed about testing and therapies to discuss them in helpful ways). Third, after we have decided how to proceed, we should be able to confirm what we plan to choose or revise it by relying on the help of healthcare professionals, friends, family, support groups, and communities.

Finally, to address tensions within society and in our web of relationships, dialogue is a precious virtue that needs to be nurtured and strengthened. It can help us to address disagreements and differences.

Participation and Change

How do we foster awareness and ability to address tensions? In studying bioethical issues, Lisa Sowle Cahill focuses on participation, justice, and change as essentially human and intrinsically Christian and Catholic needed approaches.¹⁷ Associations supporting cancer patients exist in many countries. They exemplify and embody care as well as medical, legal, ethical, and relational accompaniment. They are instances of efficient, efficacious, and caring participation. They should be strengthened and multiply. They highlight the transformative power of human creativity, care, and compassion.

Conclusion

Whether in research or healthcare practice, cancer is challenging and evendaunting. It could become an opportunity to continue changing how we think about health, bioethics, and social and ecclesial life, and how we

¹⁶ Atul Gawande, "Letting Go: What Should Medicine Do When It Can't Save You?," *The New Yorker*, July 26, 2010, www.newyorker.com/magazine/2010/08/02/letting-go-2; Atul Gawande, *Being Mortal: Medicine and What Matters in the End* (New York: Metropolitan Books, Henry Holt & Company, 2014), 149–190.

¹⁷ Lisa Sowle Cahill, *Theological Bioethics: Participation, Justice, and Change* (Washington, DC: Georgetown University Press, 2005).

believe and think theologically,¹⁸ and how we live as citizens of the world. Cancer slows down and often halts our lives, and our ingenious, generous, loving, and virtuous commitment to promote health.

A cancer diagnosis tells us that cancer is not outside us but within us, and it becomes part of who we are. As Mayan indigenous people would say, cancer is around us but also in our “hearts.” While we strive to improve prevention, diagnoses, and therapies, if we listen to the Mayan people, they invite us to connect also with our “heart,” with our deepest self. It is not only outside, in our world and environment, but it is also inside, in our “heart” that we will find what might threaten us and what could contribute to making us sick. At the same time, it is not only with what is outside our bodies but also what is in our “hearts” that we will promote healing. In other words, what threatens us and what heals us are both in our own contexts and within us—in either case, within our reach.

Whatever will help us to be our true self—as individuals and as a society—will also lead us to deal with the challenges of being sick, suffering from cancer, and hopefully recovering from it. Hence, we might want to pay attention to our external context—to healthcare institutions and systems, to social structures and political arrangements—and, at the same time, to our “hearts.” Many don’t, and many others do not know how to do it. They turn to us for help and guidance. Together, we can help one another to be healed as much as possible, as individuals and as a society, both in the present and in the future.

At Boston College, **Andrea Vicini**, SJ, is Chairperson, Michael P. Walsh Professor of Bioethics, and Professor of Theological Ethics in the Theology Department and an affiliate member of the Ecclesiastical Faculty at the School of Theology and Ministry. MD and pediatrician (University

¹⁸ Jake Bouma and Erik Ullestad, ed., *Cancer & Theology* (Des Moines, IA: Elbow, 2013); Leonard M. Hummel and Gayle E. Woloschak, *Chance, Necessity, Love: An Evolutionary Theology of Cancer* (Eugene, OR: Cascade Books, 2017).

of Bologna), he is an alumnus of Boston College (STL and PhD) and holds an STD from the Pontifical Faculty of Theology of Southern Italy (Naples). He taught in Italy, Albania, Mexico, Chad, and France. He is co-chair of the international network Catholic Theological Ethics in the World Church. His research and publications include theological bioethics, sustainability, global public health, new biotechnologies, and fundamental theological ethics.