Round Table

Jean Martin

Would Machiavelli now be a better guide for doctors than Hippocrates?

Humanitarianism has ruled medicine from the beginning, but population pressures and the degradation of the planet may require doctors and others responsible for the health system to adopt a more pragmatic approach in future.

For thousands of years the population of the world grew very slowly. There were perhaps 5–10 million people on earth 10 000 years ago, and about 250 million in the first millennium after Christ; 500 million was reached around 1650, 1000 million in 1820, and twice that in 1930. There are now 5400 million of us, and this could nearly double by the year 2050. Population growth is far from uniform, however. In Europe and North America over the past 200 years, from the time that childhood mortality began to fall, families began to control their fertility, and the population in these areas is now more or less stable, growing through immigration, if at all. Such countries are said to have gone through a demographic transition, whereby a fall in mortality is followed after a time by a drop in fertility, leading to a relatively static situation. The same cannot be said for the regions still developing. In spite of a fall-off in some countries, population growth is still very rapid and accounts for most of the almost exponential growth in the world’s population today.

This question has been much discussed, especially in the context of technical cooperation since the 1950s. A number of countries that provide aid — the USA in particular — have strongly advocated the linking of agricultural, technical, and economic development with fertility regulation and family planning activities. This has been criticized by many in the developing countries because of a suspicion that demographic control is intended to prevent these countries from realizing their

Dr Martin is Cantonal physician and lecturer at the Faculty of Medicine, Public Health Department, Cité-Devant 11, 1014 Lausanne, Switzerland.
full potential. Discussion was particularly heated at the World Population Conference at Bucharest in 1974, where the arguments for such control were opposed by the doctrine that “development is the best pill”. It was claimed that if the development effort were sufficiently dynamic, the expansion of economic potential would be sufficient to

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feed everyone, educate the children, and care for the sick without introducing authoritarian measures to restrict the size of families—a problem that would presumably sort itself out in time. The latter argument won the day.

The situation today

What is the state of affairs in 1993, a year after the international Conference on Environment and Development, at Rio de Janeiro in Brazil? Politicians and cooperation officials have been led to a number of conclusions after more than three decades of development work.

The economic and technical developments achieved have not been up to expectations, even though considerable progress has been made in some sectors and in some countries. Everyone deplores the constantly widening gap between North and South. The vast majority of people in developing countries today have little chance of developing their full human potential, and the outlook is not encouraging.

In the industrial regions, where the population is increasing slowly or not at all, there has been growing awareness over the past two decades that industrial development and the consumption of goods and services constitute a threat to the environment. Political and practical activities to limit the damage are not yet as extensive as they should be, though a start has been made at controlling air, water, and soil pollution.

At the same time, some fundamental criticisms have been levelled at the Western way of development, with its built-in drive to growth that makes conflicts and clashes between competing groups inevitable, with its concentration on having to the detriment of being, and with its rampant individualism that erodes the solidarity of the community. Some aspire to a slower, less stressful, and more convivial way of life, in which people could take their time, even if this means making do with their present standard of living, or even doing without some of the privileges now available to the inhabitants of rich countries and the elites of poor countries. The question then is the extent to which the Western model of development can manage to slow down and accept marked limits to expansion without suffering complete disruption.

The environment in developing countries too is suffering, less through industrial development than through increasing demographic pressure, which causes deforestation, erosion, desertification, urban expansion, and pollution. Certain countries have even allowed part of their territory to be used for the dumping of toxic waste from rich nations.

It seems, then, that for all the hopes of national officials and technical cooperation workers in the 1960s the economic growth of underprivileged regions has not even kept
up with the growth of the population. In Northern countries, the harmful side-effects of high consumption are apparent in the excessive use of nonrenewable resources, the accumulation of waste, and the deterioration or destruction of the natural environment. The hopes of a generation ago have been disappointed.

Hard questions

We therefore have some hard questions to ask ourselves, since only the most complacent optimist could imagine that these disturbing trends would be reversed by redoubled efforts in the same direction.

In 1987 the World Commission on Environment and Development (known as the Brundtland Commission, after its Chairwoman, the Prime Minister of Norway) stressed the need to arrange for a type of development that was sustainable (1). The first strategic imperative is to give a renewed impetus to growth, especially in the poor regions, while respecting a number of conditions that would make it sustainable.

In health, for a long time, the aim of increasing the number of treatment options and the quantity and quality of staff and facilities has been seen not only as an indisputable practical goal but as a moral necessity. It is true that for a couple of decades people have been aware that Western models should not be exported to other countries unchanged, but there was a tendency to regard local alternatives as a transitional phase leading towards the “royal road” taken by the industrial countries.

The stagnation of socioeconomic development, in conjunction with the increase in population, make it clear that, unless we want to head for catastrophe even faster, health officials must deal with some very difficult issues. In its report From Alma-Ata to the year 2000, WHO acknowledged for the first time the frightening risk that humanity could destroy its ecological support system (2). About the same time Maurice King, a British teacher of medicine who was one of the pioneers of medical teaching in developing countries, especially East Africa, discussed the terrible dilemmas posed by this situation (3).

The problem lies in the following process. Initially, the productive potential of the earth accommodates population growth, but in the second phase the demands of the population exceed the potential “sustainable” harvest, so that biological and ecological reserves are consumed. In the third phase, human consumption is reduced when the ecosystem collapses, with disastrous consequences in terms of malnutrition, morbidity, and mortality. Such situations already exist in a number of countries because of a combination of political and ecological factors such as war, migration, and desertification.

[Box: Is the care given to an individual sometimes detrimental to the health of the public in general?]

This leads to questions that seem unacceptable. King asks whether there are some programmes that should not be carried out because they would increase the population. In other words, should levels be set for reductions in mortality?

As to the second part of the problem — the use of resources and energy — one would hope that decision-makers and the general public were increasingly aware of the
problem. Big changes that are hard to accept will have to be made in our way of life and our methods of production (4).

In a book describing her experience as a member of the National Consultative Committee on Ethics, the well-known French theologian France Quéré says, in relation to the fact that the saving of lives in immunization campaigns can be an indirect cause of famine, the destruction of forests, and the consequent disappearance of animal and vegetable species: “Different interests collide and the coherence of moral action disintegrates under conflicting pressures” (5).

Although demographic problems were not central to the discussions, the International Forum promoted by WHO in December 1991 at Accra, Ghana, inevitably touched on them indirectly. It emphasized the links between poverty and disease and launched the Accra Initiative for a new health culture to manage all development activity (6).

**The problem of choices**

Should there be an ethical distinction between what is done at the collective level for the health of the population and what is done for the individual patient?

This, for me, is the crux of the matter (7), but it is difficult to express one’s thoughts which may tend to break taboos. The question is: is the care given to an individual sometimes detrimental to the health of the public in general? The answer must be yes. Available resources are always limited, at least in relative terms. In fact the problem has long had to be faced in the developing world while it has largely been hidden in the rich countries, where the ideological conception was to give the whole population access to all types of diagnosis and treatment.

Until the beginning of this century, there were so few medical techniques capable of producing a real improvement in health that there was little difference in prospects between those who had access to a physician and those who did not. It is worth recalling the tragic difficulties encountered by the gynaecologist, Semmelweis, in Vienna in the mid-nineteenth century; he showed that a woman who put herself in the hands of hospital physicians was running a major risk of postpartum mortality, because at that time the physicians did not know how puerperal fever was transmitted.

Later, for half a century, 1940–90, several industrial countries were able to offer their populations a very wide array of treatments, often through some form of health insurance, and enable them to benefit from the rapid advances being made in treatment methods. The situation in these countries today is less reassuring: “two-tier” situations are emerging in which only part of the population has access, under acceptable conditions, to high-level medical care (the USA is the most striking example, some 40 million of its citizens having little or no access to the health system). The reason for this is that with advances in technology health care is becoming more costly, especially in conjunction with the demographic changes that have been taking place. The birth rate is low, the population is aging, and the old need much more care.
The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art, being honoured with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

and medical attention than the young. The low birth rate also casts a shadow on the financing of social security arrangements in the decades to come. Nevertheless, the ideal remains, in principle, of providing all individuals with full medical care.

In an individual case, there are different approaches to decision-making in specific clinical situations. In many places, especially Europe, the decisions are made mainly by physicians in consultation with their patients, in collaboration with other health
personnel, and (as long as the patient’s interests are respected) with those close to the patient. In the USA, interdisciplinary ethical committees (usually in hospitals) discuss such cases in depth. European committees of the same name have a rather different function: their task is to assess research projects or to come up with principles for application at national level.

In the area of public health, decisions are political (or civic) in the best sense of the term. Deliberations should include philosophical, moral, and sociocultural aspects as well as medical ethics. Yet in practice these difficult decisions are seldom made public and are generally found only in implied form in budgetary allocations. Maurice King has had the temerity to state that these decisions will have to be made explicitly.

When we consider an industrial society in which over two-thirds of health expenditure is borne by collective arrangements (health insurance and public budgets), we should bear in mind the following points. The public money available for spending on the health sector is a proportion of the state budget, and, if this remains constant, any increase in the health budget entails a reduction in other sectors such as education and welfare. Moreover, for a given health budget, any increase in expenditure in one area (such as the treatment of a particular group of diseases or patients) entails a reduction in expenditure in other areas (such as treatment and care in the home, psychosocial assistance, and health education programmes). Whichever way we approach it, the problem remains the same: if one of us gets the full treatment, others suffer.

Sustainable health, sustainable development

Since population growth and the galloping consumption of resources are clearly going to overstretch the ecological resources of the planet, King calls on us to choose public health action, where health is understood as a sustainable state. He uses the word “sustainable” with explicit reference to the concerns of the United Nations (1). Recognition of the need to spare the ecosystem destroys one of the deepest convictions of Western civilization—that our ability to control the world will enable us all to develop indefinitely, in unlimited progress. It also dispenses with the notion that the question of equity can be postponed. Unfortunately, the irreversible changes to our environment will make equity increasingly difficult to achieve.

Must health care be subordinated to other considerations?

During the Nobel Conference on Medical Ethics at Stockholm in 1989, the epidemiologist John Last suggested that the survival of human communities should be given higher priority than the survival of the individual, in cases where such a choice had to be made. This calls into question the categorical assertion in the Helsinki Declaration, adopted by the World Medical Association, that the interests of society should never prevail over the well-being of
the citizen, which is regarded as a basic principle of medical ethics (8).

In a long-term perspective of sustainable care for life, the aim of the health system (which can be summarized as disease control and promotion of well-being) can no longer be considered in isolation. Efforts to achieve such well-being should satisfy the condition of maintaining the ecosystem’s capacity to allow life to continue both in quantity and in quality. If the consequences of some health activity should conflict with this principle, then that activity should be called into question, according to Maurice King. One thinks of the situation in developing countries with their population explosion. But the problem also arises in the North, where differential allocation of resources, diminishing returns, wastage, and pollution are matters of urgency.

One can imagine the violent reactions this type of stipulation will cause among professionals and other health workers who are concerned with the suffering individual they are confronted with here and now. One can imagine their indignation at what seems to be an attack on sacrosanct values. The reaction is comprehensible and worthy of respect; indeed, I personally sympathize with it, being as I am a product of a philosophical family, a civic tradition, professional training, and ethical convictions and reflections.

The relationship between individual and collective interests has a history that stretches back to Plato and Aristotle in the Western cultural tradition (9), but the tension between these interests has never been resolved, and our perceptions of them continually change in the light of circumstances. In a recent issue of the magazine of the University of Geneva, which was devoted to ethics, Alex Mauron writes of the profound changes in the professional ethics of several university occupations, the clearest being “the practice of medicine, for which the good old Hippocratic rules are more inadequate than ever” (10).

Moving forward

We hesitate to grasp the nettle: the premises are so unappealing, challenging deeply held convictions — convictions such as:

- what is good for the individual is always good for the group;
- competition is the best motive force in society;
- people should mind their own business.

Space does not permit us to broach the problems raised by the fact that different cultures have different ideas of equity and justice and different views of what we should aim to attain in life, but if we are to tackle the dilemmas posed in this article we might begin with the following steps.

Perhaps we need an arrangement whereby citizens who are particularly clear-sighted, incorruptible, and concerned for the common good would provide firm, enlightened leadership.

1. Admit that the facts and attendant dangers call for changes, and act to improve the feasibility of those changes.

2. Consider new methods of deliberation and making choices. A number of people have suggested forming brains trusts and committees on global trends and their
Preamble to the Constitution of the World Health Organization

The States Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.
Europe tried for 70 years to bring about equity and solidarity by force; they have finally failed. In spite of the advantages of liberal systems, some of their side-effects show that they are far from perfect and can result in a poor quality of life owing to commercialization, standardization, socioeconomic segregation, and the destruction of biological species and habitats. Something else is needed.

Should we think of an arrangement whereby citizens who are particularly clear-sighted, incorruptible, and concerned with the common good will provide firm, enlightened leadership—leadership that sets clearer limits than exist at present to the individual’s right to resources? Yet we find it hard to believe in a good “republic of the wise” (a good, enlightened despotism). On the other hand, given the complexity of the world today and to come, we can hardly believe that universal suffrage will lead to appropriate decisions before it is too late. How can we find a way of living together that respects the environment and the interests of those who come after us, without falling into the trap of authoritarianism?

**By way of conclusion**

The next few decades will be decisive for the future of the human race, in the way we manage the explosive (and impulsive) situation arising from huge population growth and the prodigal use of resources.

Although they are inadequately prepared to face them, public health officials are now beset with problems arising from the situation in their field. The increasing proportion of individuals who survive, a higher life expectancy, and reduction of the most shocking and avoidable deaths can no longer serve as simple and indisputable standards of progress in health and in society. These developments, desirable in themselves, might spell disaster for future generations through overuse of the land, deforestation and urban expansion.

The challenges to the industrial countries of the North and to the countries of the South are therefore formidable. They are different in practical terms but related in ethical terms. In the North, where the population is more or less stable, the question is how to achieve a distribution of resources and health benefits in accordance with prevalent needs, individual and collective. The limits to the community’s ability to finance the health system call for choices to be made, choices to which health professionals are not accustomed and to which society is hardly ready to respond explicitly.

In the South, there is also the problem of the quality of life in the broadest sense. Some balance or compromise must be found between the number of people in the country, the carrying capacity of the environment, and the opportunities and services that are seen as the right of every member of society. This means on the one hand the vigorous continuation of family planning and birth regulation, in spite of certain political or religious doctrines. For example, the biblical command “be fruitful, and multiply, and replenish the earth” no longer applies, because the earth is close to being full. Moreover, since there is no
The increasing proportion of individuals who survive, a higher life expectancy, and reduction of the most shocking and avoidable deaths can no longer serve as indisputable standards of progress in health and in society.

These new and difficult problems will clearly put global solidarity to the test. There is reason to believe that the seemingly irresistible growth in population and the increasing influence of fundamentalist movements in certain regions are due in part to people feeling that they have no control over their lives or over the future of their communities. Industrial countries have much to answer for here, and whether they like it or not they should see to it that human society in global terms becomes more equitable. They should in particular lower their standard of living in relative terms; in any case, assessing the quality of life in terms of the accumulation of goods only is a procedure that belittles human achievement.

The title of this essay mentions Machiavelli. Whatever his popular reputation, Machiavelli represents a certain detachment (some would say objective cynicism) and above all a long-term view of the common interest. That interest is threatened by today’s laissez-faire approach — and the short-sighted application of the simple principle of “benevolence”. Machiavelli was a pragmatist, ready to dispense with certain obligations if doing so would advance the cause of his country. Is it perhaps this kind of approach that health professionals must learn to adopt and/or adapt in future?

We have no ready-made formula for what should be done to ensure timely, intelligent, and firm management of the resources and population of the planet. In the wake of Alma-Ata, initiatives such as the Accra Forum of December 1991 or the Rio Conference on Environment and Development of 1992 may produce some results. But a wider transformation in the attitudes and habits of individuals and nations seems indispensable.

Today, there is no sign of such a change of heart in international relations. National or regional egotism is still the motive force in most negotiations. How, then, can we achieve a global consensus on the course to pursue to ensure the health and well-being of people on the one hand and the protection of the environment on the other?

Why do we find it so difficult to draw practical conclusions from the obvious fact that we are all in the same boat? For our children and future generations, the earth will be the only possible basis for life; we must therefore treat it with special care. The population of the planet must be sensitized and educated to this end, and politicians and scientists must give the matter their most serious consideration. Time is short.

References


## Discussion

**Pinit Ratanakul**

---Blaming and punishing the poor achieves nothing---

Dr Martin’s argument in favour of a new approach to ethics in health care is unconvincing, being based on excessive generalization, unfounded assumptions, statements taken out of context, and the linking of factors that are, in fact, not clearly related. Moreover, his blame-the-victim syndrome and the lifeboat ethics that were discredited in the USA 15 years ago are unacceptable.

It is wholly unwarranted to assume that the environment in developing countries is suffering primarily from demographic pressure, rather than from greed, consumption and exploitation by governments and international commerce. It is also unwarranted to refer only to high consumption in the North as the cause of the destruction of nonrenewable resources and the environment without pointing out that governments, in support of industry, have failed to regulate wastage, protect natural resources, and invest in renewable materials. Thus in the USA many people have called for environmental protection, yet the government has resisted and has even failed to enforce certain regulations.

Why does Dr Martin accuse humanity in general of destroying its ecological support system when so much of the blame should be placed on governmental and business interests? Why are demographic changes given as the explanation for the two-tier health care system in the USA when it is documented that the factors responsible are greed among doctors and drug companies,

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The author is Director of the Center of Human Resources Development at Mahidol University, 45/3 Ladphrao 92 Bangkapi, Bangkok 10310, Thailand.
profiteering by hospitals and insurance companies, large-scale wastage, fraud, excessive medicalization, and a failure of the democratic system to ensure the well-being of all the people? The USA is the only developed country without a national health care programme.

Dr Martin is mistaken in assuming that an increase in health budgets inevitably requires reduced spending on education and welfare. Why is the possibility of reducing the money spent on armaments and political patronage not mentioned? Why does he say that population growth and consumption are clearly going to place an impossible strain on the ecological resources of the planet, when countries have only reluctantly begun to do research on alternative resources and to regulate and invest in new sources of energy?

As regards the suggestion that the survival of human communities should be given priority over that of the individual, one wonders which communities are referred to. History shows that it is usually people without power who are asked to make sacrifices.

It is also worth noting that the part of the Helsinki Declaration mentioned by Dr Martin was made in the context of the abuse of human experimentation. The assertion that the interest of society should never prevail over the well-being of the citizen was not an allusion to the use of high-technology, high-cost procedures to save lives.

Dr Martin says we are all in the same boat, but this is manifestly not the case. Rather are we in different kinds of boat. People in the developed countries will certainly not want their life expectancy to fall and their maternal and child mortality to increase. When Dr Martin says that the desire of people to save their lives spells disaster for future generations he can only mean people in the developing world. Can it be right to criticize health care programmes in the South for their foreseeable demographic effect, when the countries of the North waste more resources than the Third World possesses?

Dr Martin says that a long-term view of common interest is threatened by today’s laissez-faire approach and the short-sighted application of the simple principle of benevolence. Is it because of too much or too little benevolence that we are confronting problems such as famine and destruction of the environment? Do the common people control their social, political and economic destiny to such a degree that they can be blamed for all of the problems we are facing?

I agree with Dr Martin that the world’s population needs to be controlled. But most demographic studies indicate that the best way to achieve this is not to allow people to die prematurely but to give proper attention to the educational and economic development of women and to provide care for the aged. In his search for the root causes of our present difficulties, Dr Martin is on the right track when he mentions national and regional egotism. If he had spent more time on how to resolve this problem his article would have been of greater value.

Immense social harm would undoubtedly result if an elite had the power to choose who should live and who should die; twentieth-century history alone should have taught us that. One of the hallmarks of civilization is the conviction that each human life is precious. The ethics of benevolence or compassion have not failed us. There is no justification for Dr Martin’s proposals. Probably not even Machiavelli
would have approved of his argument, for it is certainly not in our common interest in the long term to have a compassionless world with people in different kinds of boat.

Under Machiavellian ethics, people would exploit rather than serve each other, to the obvious detriment of health care. Medicine, on the other hand, is rooted in high moral values, without which the most vulnerable people would not survive.

Prema Pandurang

— Flexibility, perhaps; Machiavellianism, never!

Dr Martin highlights certain disturbing factors in the management of resources and population, relating to population growth, resource depletion, conflict between the individual and society, ethical implications of health programmes, the elaboration of strategies acceptable to all countries, and other things.

While affluent countries have more or less steady populations with low fertility and long life and have environmental problems, the developing countries face immense demographic pressure on resources and the environment. Many countries are affected by air pollution, desertification, deforestation, climatic change, and other adverse factors in varying degrees. Not surprisingly, countries strenuously uphold and defend their national cultures and identities, and are unwilling to see them sacrificed in the interest of humanity at large. In this context it is not feasible to create a universally acceptable health programme.

In India the Ayurvedic system of traditional medicine is a holistic approach to the development of the personality, providing preventive, promotive and curative health care. Treatment focuses on the patient, whereas in Western medicine it focuses on disease. Holistic herbal medicines, efficacious against many chronic conditions and having none of the harmful side-effects commonly associated with some powerful allopathic drugs, are now being accepted in Western countries, where many people evidently wish to adopt natural remedies.

The alarm expressed about depletion of natural resources, consequent on population pressure, is often unfounded. As Mahatma Gandhi said, “There is enough for everyone’s need, but not enough for everyone’s greed”. Making use of natural resources for a living is one thing, exploitation is quite another. Natural resources become exhausted only when plundered. In all fair dealings there is a give-and-take process. There need be no depletion of natural resources if judicious use is made of them. We have to try to ensure that the natural environment is not destroyed by major developmental projects such as the construction of power stations.

Health care should never be sullied by crooked and dubious practices.

The experience gained in the industrialized countries should not be overlooked in the Third World.

In India, health development is considered to be vital and there can be no question of cutting back on work in this field.

Professor Pandurang is with the Sree Chakra Foundation, Raja Mandiram, 984 Trichy Road, Coimbatore 641045, India.
Needs-based health programmes are given priority, with adequate manpower, infrastructural facilities and other inputs. There should be no conflict of interest between the individual and society, and no delays in making medical facilities available to the poor.

Of course, Western medicine is highly respected in India, as is its father, Hippocrates, not least for his code of conduct for the medical profession. Machiavelli, on the other hand, was the personification of crookedness and deceit, and cannot be regarded as a better guide to doctors than Hippocrates. To accept that proposition would spell doom for the noble profession of medicine.

Do the ethics of medicine as enunciated by Hippocrates need to be revised? There is no point in adopting an inflexible position on this question. If, for instance, a patient in the terminal stage of a disease cannot put up with the suffering any longer and pleads for his life to be ended, the doctor in attendance should comply if legally possible, irrespective of what is laid down in medical ethics. That is the maximum extent to which Hippocrates should be set aside. Health care should never be sullied by crooked and dubious practices.

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Debabar Banerji

— The South should not heed lethal sermons from the North

To consider that pragmatism is preferable to humanitarianism is surely an extreme example of Machiavellianism. Dr Martin evidently does not think that some values are, or should be, eternal. He praises Maurice King and ignores the torrent of arguments against King’s ideas. Halfdan Mahler equated them to a proposal for mass euthanasia of children in the South.

The propensity to indulge in mass murder seems to be deeply embedded in the psyche of rulers in Western countries. In the last two centuries, it has been manifested as the genocide of the native inhabitants of the Americas, the slave trade, the brutalities of colonialism and imperialism, the Gulag, the horrors of two world wars, Hiroshima and Nagasaki, apartheid, the holocaust, and carpet bombing and defoliation in Viet Nam.

Even when examined from an ahistorical and apolitical angle, Dr Martin’s argument is seriously flawed: he looks at problems from the wrong end of a telescope. The question is not one of the primacy of requirements at the collective level over those at the individual level: rather it concerns the distribution of resources between the North and the South and between the elite classes and the broad masses in individual countries, and also the overwhelming political and technological domination of the North over the South. The arguments of people like Dr Martin reflect the desire by rulers in some countries of the North to impose their will on the South, so as to promote their commercial and political interests.

Dr Martin has chosen to ignore that, during the last three decades, experts from the North have taken almost all the countries of the South along the Malthusian path of considering population growth as the cause of poverty, rather than the other way round. Now he joins people like King who prescribe mass euthanasia of children in the South (1), despite rebuttals by Mahler (2) and many others (3), as the only way to achieve

The author is with the Nucleus for Health Policies and Programmes, B-43, Panchsheel Enclave, New Delhi – 110017, India.
sustainable development of the planet. The database for writing such a drastic prescription is very weak indeed. What we are seeing is a highly irresponsible panic reaction, a demonstration of quackery in public health. Why is Dr Martin so timid about writing prescriptions for the North, where 15–20% of the world’s population consumes 70–80% of its resources? He roars like a lion about the countries of the South but only squeaks like a mouse about those of the North.

It is too simplistic to presume that public health interventions are responsible for the present demographic and ecological crisis, and it is folly to imagine that the tide of disaster can be turned if the brave new Machiavellian men of the North stop international public health interventions.

Martin’s patently ethnocentric thinking explains why he does not take into account the refusal of the countries of the North to make adequate contributions to ecologically sustainable development, the grossly unjust North-South terms of trade, the haemorrhage of resources from the South to the North, the economic, social, political and military domination of the North over the South, and the sharp contrast between the elite classes and the vast masses in the countries of the South.

Jean Martin’s views represent a tendency that emerged after Alma-Ata, when the peoples of the South dared to make a declaration of self-reliance, social control and intersectoral action in matters of health. A retreat from Alma-Ata began shortly after the conference with the notion of selective primary health care (4), a contradiction in terms, which, disgracefully, has even been acclaimed at certain international conferences. So as to retain their prerogative of telling the South what to do, some countries of the North laid down a barrage

of international initiatives that were technocratic, imposed on the masses, dependence-promoting and scientifically untenable — the antithesis of what was envisaged at Alma-Ata.

The population problem of the South is much more serious than Dr Martin seems to think and it requires much deeper study than he and others have undertaken. The victim-blaming, Malthusian approach should give way to well-judged strategies aimed at encouraging oppressed people to have smaller families. Viable programmes should be devised to improve socioeconomic conditions, and the Alma-Ata approach to primary care should be implemented. The time has come for the North to have a deeper understanding of the threat posed by rapid population increase in the South in a wider intersectoral context. However, if the North has a death wish and continues with Malthusian outbursts and its profligate consumption of decreasing resources, so be it: the poor of the world have little to lose but their poverty and degrading lives.

Vangie Bergum

— Beyond both Hippocrates and Machiavelli: a vision of cooperation

Martin’s article confronts us with certain harsh realities: the consequences of overpopulation, the economic disparities between North and South, the failure to attain human potential, especially in the developing countries, and the destruction of the natural environment, leading to famine, poverty and disease. No one can stand outside these realities, irrespective of how secure the anthropocentric vantage point may seem. The world is our home and we cannot endlessly exploit it. Instead of comparing the potential for destruction of the environment of a child in the industrialized countries with that of a child in the developing world, perhaps we should consider how to build a world that is home for all children, a place where they can feel safe and develop fully.

Education encourages people to think more in terms of building satisfying lives than about having numerous children.

In health care we tend to think that more scientific and technological knowledge means fewer surprises, fewer diseases that cannot be prevented or cured, less behaviour that cannot be predicted, and fewer situations that cannot be controlled. Yet all this seems to lead to the untenable position that effective health programmes may have to be abandoned because they increase population. There is an alternative, however, namely to ask questions outside the sphere of technological reasoning. Does the use of technology to keep a fetus alive for five months in the body of a brain-dead mother help us to understand the preciousness of human life? (1). How does the withdrawal of vaccination programmes for children where infectious diseases are endemic help us to understand that people should not be treated as a means to an end? How can we contemplate death and finite resources without losing our human perspectives in risk-benefit balance sheets? Such questions raise issues about the relationship between the measurable and the unmeasurable. The more we take an instrumental view that fragments and polarizes, and even helps to maintain the tension between individual and collective interests, the more we are immobilized by these questions. However, once we see that instrumental reasoning fails to give a true picture of human beings we have the possibility of using our rationality for our benefit.

When people promote their own ambitions at the expense of the public interest or become so self-absorbed that participation in politics declines, bureaucracy takes over and individuals feel powerless. Powerlessness, indeed, is implicit in Martin’s remark that time is short.

Central to dominant ethical theories is the principle of autonomy and the image of the ahistorical, self-sufficient, atom-like individual. This is associated with human rights campaigns and also leads people to see their own self-fulfilment as a right. While the vision of autonomy may be sound in a market context, it is less so in relation

Dr Bergum is Associate Professor, Faculty of Nursing, University of Alberta, Bioethics Centre, 222 ANR, 8220 – 114 Street, Edmonton, Canada T6G 2U3. She is currently Visiting Research Fellow, Queen Elizabeth House, 21 St Giles, Oxford OX1 3LA, England.
to the way people, especially women, live their lives. Mothering provides a good example, since it takes women out of themselves, not in a self-effacing manner but in a self-defining way that springs from connections with and concern for their children.

Efforts should be made to strengthen relationships and commitments and to provide opportunities for dialogue and for meetings between people from different cultures and backgrounds, so as to forge a common purpose. It is desirable to move away from institutions wedded to domination politics, and to adopt a cooperative vision in which equity, ethics, justice and human-centred values prevail. This is beyond Machiavellian or Hippocratic guidance.

Benevolence means doing good for other people. A better approach might be to strengthen and support people's ability to choose what is best for them. This implies relationships that foster mutual growth and development, and a move from positions of domination on the one hand and inferiority on the other, to ones of collaboration and cooperation. The improvement of literacy rates, especially among women, is important, and indeed education in general encourages people to think more in terms of building satisfying lives than about having numerous children. Clearly, it is also essential that birth control methods be available. On this basis, women and men should be able to learn how to keep their children alive, and population control should follow from the realization that each individual can achieve her or his potential.

Ethical considerations are central to the human condition. In order to deal with the issues raised by Dr Martin it is imperative that all people should be able to participate in decision-making that affects their lives. What seems to be required is a complex struggle on the intellectual, spiritual and political planes in which debate in the public arena merges with that in hospitals, schools and other institutional settings. The matters in question certainly need to be addressed with urgency and commitment.


Hassan Hathout

— Development is the proper tool for population control

As Dr Martin illustrates, the winds of change blowing over traditional medical ethics come from outside, and if present trends continue a shift from humanitarianism to pragmatism is inevitable.

Concern over population explosion in relation to resources is legitimate. However, Western views on the matter reflect only part of the truth. The birth of a baby in the USA imposes vastly more stress on the world's resources than does a birth in the Third World. Although historical precedent and common sense indicate that development is the cause and not the outcome of reduced fertility, the developed countries place a disproportionately high emphasis on fertility regulation in the Third World. Why is this? It has been estimated

Dr Hathout is with the Islamic Center of South California. His address is 101 N Grand Avenue 2, Pasadena, CA 91103, USA.
that eight great-grandparents in the West are likely to share only four or five descendants, whereas the corresponding figure is over 300 in much of Africa. Official sources in the USA have expressed the view that demographic factors could be the seeds of revolutionary actions, including the expropriation or limitation of foreign economic interests. Poverty, population growth and large proportions of young people in populations could create pressure for development, induce reviews of foreign investment terms, and even boost the military if conscription is seen as a viable alternative to unemployment.

Sometimes the impression is created that the developed nations are already waging a preventive war against the Third World. Is it not ironic that the more aid the poor countries are given the poorer and more indebted they become? Increases in gross national product lag far behind the cost of servicing debts, let alone paying them. The ruling elites prosper, allying themselves with foreign capital and maintaining the status quo. Major democracies support dictators who participate in joint ventures with the West. The dictators keep the masses quiet, maintain an open door for multinational investment, and improve the climate for foreign investment through tax laws and labour repression (f).

The medical profession needs to understand the root causes of events in order to face them rather than taking the easy way out and sliding into Machiavellianism, otherwise termed pragmatism. Communism apparently having been defeated, victory over capitalism is now a pressing necessity. Both communism and capitalism went wrong in postulating irreconcilable conflict between the individual and society: communism crushed individualism while capitalism extolled it. Unbridled individualism is camouflaged selfishness, and so are its blown-up projections of nationalism and racism. At the global level it leads to exploitation by industrial countries of developing countries. At the national level it works for the benefit of the few at the expense of the many, and it is noteworthy that in the USA some 40 million people cannot afford health insurance, while education, health programmes and social amenities are grossly underfunded.

The obsession with unlimited growth is untenable: the planet cannot support it. The trickle-down economy is not enough for the sustenance of the world's population. In the global village it is necessary for the individual and society to be in mutually beneficial equilibrium, not in conflict. The role and function of capital should be redefined, and its voracious appetite should be assuaged neither by violation of the environment nor by the further exploitation of poor countries if collapse of the whole system, to the detriment of rich and poor alike, is to be avoided. If we remain locked into the conflicts of North versus South, rich versus poor, white versus black, and master versus servant, the prognosis will be bleak.

Dr Martin asks whether care given to an individual is sometimes detrimental to the health of the public in general, forgetting, perhaps, that the general public is made up of individuals. It is neither acceptable nor ethical to suggest a cessation of vaccination in poor countries while other countries dump food surpluses, use them as a strategic
weapon, spend vast sums on military equipment, promote extravagant consumerism, and wage wars in defence not of life but of life-styles.

The proper tool for population control in overpopulated areas is development. Furthermore, it is important to recognize that the countries with zero or negative population growth are the major consumers of resources. Thus in the USA, 6% of the world population consumes a third of global production. The same countries also present the principal threat to ecosystems.

Priorities have to be redetermined if human existence is to be sustained. Resources should be used to nurture the planet and satisfy need rather than greed; self-restraint and the avoidance of wastage should be fostered. These goals are likely to be achieved only if a spiritual dimension and a moral purpose are injected into the politicoeconomic system. Perhaps a new breed of politicians is needed. The medical profession should give a lead by demanding change.


Povl Riis

— Only democracy and debate can provide tolerable solutions

Many national health services have focused on the economically competent individual, rather than on society as a whole. Health professionals often seem to believe that their budgetary requirements should be beyond scrutiny and in no way linked to expenditure on defence, education, social welfare and so on. They also tend to overlook the drain which the health economy represents on ecological systems. Ironically, the injustices in health care and the global overconsumption of resources could eventually lead to a kind of equity—one of suffering.

In the conflict examined by Jean Martin, between the individual or self on the one hand and the mass of people, or non-self on the other, patients have fought for the right to be at the centre of health service endeavours. However, the notions that what is good for individuals and their families reflects sound health policy, and that the individual’s right to autonomy is sacrosanct, are not sufficient as ethical principles for a fair and ecologically sound health policy.

Balance between individual and societal needs is necessary in decision-making on health matters at all levels. Changing the balance is a delicate process, because imponderables such as personal values and political attitudes have to be accommodated. Any attempt to shift the balance by central decree is almost bound to succumb to political opposition. The only way ahead is to promote debate in order to mobilize the many silent collective interests and reach a position where people understand that the right to autonomy has to embrace personal choice that is in the interest of society as a whole.

In recent times, market forces have come to be seen by many people as a kind of panacea, not only in commercial affairs but also in the caring sectors, notably that of health. However, if they are used in the health field other than as a means of choosing between competing methods for
fulfilling people’s needs, as defined in responsible public health systems, the losers will continue to include the poor, the chronically ill and the old. The balance point between market forces and public responsibility for health care is economically crucial in the welfare state.

It is essential to uphold the high moral values such as equity and social responsibility.

Dr Martin interprets a central passage of the Second Helsinki Declaration as representing a strong emphasis on the interests of individual citizens as opposed to those of society, but in fact the statement in question relates only to humans as research subjects and to the unacceptability of coercion or risky experiments in this context, even if apparently justified from the standpoint of society. This protective principle could hardly be applied to health policies on a much wider front. People have always been obliged to accept that society takes precedence over individuals, as patients affected by scarcity of resources, as taxpayers, as conscripts, and so on.

As regards ways of coping with the impending collision between individuality and collectivity, the suggestion that brain trusts and committees be formed to consider global trends and their practical and ethical consequences has already been adopted in various areas. If this matter is pursued further, messages will not only have to be very reliable, but will also have to be presented by figures who are both nationally known and locally credible. The messages need to be repeated in various forms and over a considerable time, since attitudes on life and death are not easily altered.

The proposal to rely on enlightened despotism based on clear-sighted, incorruptible and concerned citizens could well produce disaster. History shows that only democracy, despite its inadequacies, can provide tolerable solutions in the long term. Change can only be achieved via citizens and their freely elected political leaders. There are positive signs, for instance a growing acceptance of the need to eliminate inequity and abuse of the environment. Young people are increasingly aware that overpopulation and pollution are a threat to their lives.

The ideology for change cannot come from Machiavelli or from a cynical downgrading of programmes aimed at preventing suffering and early death in the developing countries. It is essential to uphold the high moral values, such as equity and social responsibility, and to act in accordance with the principle that freedom is a sum of individual options that do not reduce other people’s choices.

The two factors of overwhelming significance are overpopulation and overconsumption. Both the numerator and the denominator of the world’s resource balance will have to be reduced.

Cécile De Sweemer-Ba

— Progress requires wide social debate

That a debate on the ethics of health care exists is a reflection of the age we live in, when people seem to be increasingly

Dr De Sweemer-Ba is with the Centre for International Cooperation in Health and Development (CCISD), Faculty of Medicine, Laval University, 2180 chemin Sainte-Foy, Quebec, Canada G1K 7P4.
regarded merely as resources. In many developing countries, especially in Africa, health and social services have apparently become luxuries unworthy of meaningful government support.

Dr Martin’s reasoning does not seem applicable in Africa, where the idea of the welfare state is virtually dead, social Darwinism is heralded as the great purifier of society, and the free market rules all. Humanitarianism may influence the work of African doctors but does not appear to be a criterion used by the economists of the International Monetary Fund who decide the fate of the health systems of indebted nations and prefer doctors’ unemployment to continued government contributions at levels proportionate to the populations served. Collective care, which is largely preventive, is funded from abroad in the main and is under threat as external aid diminishes. Individual modern care is increasingly left to the free market, and some countries have introduced partial cost recovery in government health facilities. The free market rations care in favour of the urban elite and the upper middle class. Despite the good intentions of the Bamako Initiative, large groups remain without cover. Not Machiavellianism but commercialism is taking over.

In addition to the problems of the population explosion and destruction of the environment, Africa has very high crude mortality rates and low life expectancies and is in the latency period of the demographic effects of the AIDS epidemic. Sustainable development seems a distant dream as people spend almost all their energy on survival from day to day. They need hope.

The developed nations have brought about neocolonial dependency through indebtedness and the imposition of export-orientated economies, while local elites, by their desire for high technology and luxury goods, have exacerbated the situation. For Africa to feed its own people it would be necessary to restructure the economy, in particular with respect to agriculture and agricultural marketing. Food distribution would have to become more equitable and food production would have to rise faster than the population. Fertility rates would have to decline more rapidly than mortality rates in the medium to long term. In order to raise food production in most rural areas it would be necessary to reverse the tendency for young adults to depart, and there would have to be improved investment and incentives for farmers. The problem of demographic imbalance could well be heightened in the coming years by the impact of AIDS.

Health and survival in Africa depend more than ever on the whole health system rather than the health services system. Social dynamics favouring health and survival could well also favour a decline in fertility. Measures tending to increase mortality might also lead to increased fertility.

The enemies are heartless commercialism chasing short-term profits and the arbitrariness of national and international bureaucracies.

Planning has no meaning when people perceive they are powerless to influence their survival. Family planning and nationwide population policies are indices of hope and power. How can such hope and power be fostered? More decentralization,
better distributive justice and access to means of production are vital. In health services, community participation and primary health care are important factors. Decent referral systems focusing on highly effective secondary care at affordable cost are needed. There is an urgent requirement for safety nets or networks of solidarity which can easily be mobilized so that everyone can obtain the essentials at the time they are necessary. Dr Martin is right to say that such progress demands wide social debate. Arbitrary budget decisions hidden from the public eye are unacceptable.

Decisions to tax essential drugs or restrict their distribution have a direct impact on poor people's access to health care. Decisions to sell food at prices below or at local production cost rob the peasant and cause agricultural decline, the emergence of slums, pauperization of villages and the appearance of numerous unemployed people: all the ills of imbalance between production and population.

Humanitarianism in the face of individual suffering is an insufficient guide for health policy but is not wrong. The enemies are heartless commercialism chasing short-term profits and the arbitrariness of national and international bureaucracies.

We need global compassion that can reach out to future generations. A new vision has to encompass both individual and collective rights and the oneness of humanity and the environment. This calls for debate that will make people actors in history. There are no instantaneous remedies. The only hope lies in patient analysis and faith in the collective creativity of humanity.

Forget Machiavelli, open the debate and rely on true pragmatic humanism involving and respecting everyone.

Daniel Callahan

— Ends and means are one in the quest for survival with dignity

The trouble with looking to pragmatism to put the common interest above benevolence or individualism is that it is hard to know which values, ideals and people would be dispensable in the name of survival. Perhaps Dr Martin would lead us into a world where survival was indeed promoted but where no decent person would want to live. Many people, like a legendary American patriot, would undoubtedly say “Give me liberty or give me death” in the face of a pragmatic Machiavelli who is ready to set some important moral values aside that we might survive.

Dr Martin compellingly presents the situation in which the human community finds itself. However, it is necessary to take care that the process of seeking survival does not negate the reason for doing so: the welfare of human beings in particular, not simply of the species in general. I am not certain that I would much care if the species failed to survive if it had to brutalize itself in order to do so.

The crisis Dr Martin outlines seems to have been brought about by something in human nature. People want to live rather than die. They want happiness rather than pain and suffering. They also have desires that transcend what life can give them. Whether it be the poor trying to obtain the basic necessities of life or the affluent trying to avoid death from cancer or heart disease,

The author is Director of the Hastings Center, 255 Elm Road, Briarcliff Manor, NY 10510, USA.
everybody has to cope with the fact that we are finite beings, never fully happy, always striving for more. We are all subject to aging, illness and death, to thwarted desires and to unhappiness. Most of the harm and danger noted by Dr Martin can be traced to the effort to make matters better.

Seen thus, the problem becomes one that demands, above all, a better understanding of the human condition. If pragmatists are to deal with the problem, they have to perceive that human nature has created it and have to be aware of its inner dimensions, not merely its outer shell. This means understanding what people need in order to flourish, trying to achieve a global consensus on a hierarchy of human needs, and coming to a new appreciation of what technology and affluence should give people.

A failure to develop good health care systems can have two deleterious consequences. In poor countries a defective system is a threat to survival; in rich countries a defective system tries to prolong life beyond the point of sense and decency.

Global agreement on this matter should be sought. A good health care system should address the need of human beings to avoid premature death but should draw the line at trying to meet individual demands for life to be expensively extended far into old age. In endeavouring to meet health care needs, surely we should begin with public health measures and primary care, including the provision of effective means of family planning. And surely it can be agreed that a quest for affluence and self-fulfilment which ignored environmental costs would ultimately create conditions that people would not want their children to experience. Perhaps nothing is harder than trying to persuade people that happiness does not depend on the endless accumulation of the products of advanced technology, so coveted by rich and poor alike, but that is precisely the task before us.

The problems Dr Martin defines are mainly ones of success. Precisely because we have succeeded in transforming and manipulating nature the danger now exists that it may be destroyed. Reduced infant mortality and increased life expectancy are not failures. These things were wanted, and few people would now be willing to accept more dead babies and smaller numbers of people reaching old age.

However, we have failed to calculate the cost of success. The drive continues to improve life, to achieve more triumphs of medicine and technology. It would be more helpful to seek ways of curbing this appetite because, at some point, success could turn into disaster. In working out a solution, grass-roots discussion is essential. Even if we could find a consummate pragmatist, a modern Machiavelli, to be our guide, why should we trust him to act in our interests? Why should we believe he could create a morally and culturally tolerable world? We are left with only the imperfect alternative

Open democratic debate has a great advantage over the more efficient methods of Machiavelli: it recognizes the value of human dignity.

of open democratic debate, which has a great advantage over the more efficient methods of Machiavelli: it recognizes the value of human dignity. The search for that dignity is, after all, presumably why we want to survive.
P. Nymadawa

— Technology with humanity

Debate on individual versus collective interests, self-interest versus altruism, and curative versus preventive health care has been raging for a very long time, and ethical and philosophical values change from generation to generation.

The emerging technologies require health professionals to reassess some of their long-standing ethical attitudes.

There is nothing new about a gloomy prognosis on population growth. Malthus made dire predictions two centuries ago, perhaps failing to foresee the scope for regulating fertility and increasing food production. Today the world produces sufficient food for its entire population, yet famine continues for political and other reasons.

Given the technologies now available, pessimism is out of place. There are safe and effective methods for the regulation of reproduction, while genetic engineering and biotechnology hold out excellent prospects for food production and environmental protection. Over a large part of the world it is likely that infant and child mortality will decline sharply during the next quarter of a century and that birth rates will rapidly fall. However, a rise in the overall number of deaths can be expected as populations age (1).

Dr Martin is right to advocate more pragmatism on the part of health professionals. After half a century of discussion and experiment, most public health specialists now agree that a mix of public and private provision in national health systems offers the most effective approach, and an effort to achieve suitable combinations is being made in many countries.

Although efficient resource allocation is desirable in any sector, it has to be remembered that, in the health field, unnecessary death, disability and illness occur if resources are committed to a particular intervention when another would give greater health gains per unit of expenditure (1). Realistic and accurate assessments of the effects of interventions on cost-effectiveness are, therefore, vitally important.

The emerging technologies require health professionals to reassess some of their long-standing ethical attitudes, as, for instance, in regard to the ability to maintain life long after personality and consciousness have gone: patients and their close relatives should be consulted, before incapacity develops, about whether they want aggressive treatment in such situations. The most exciting breakthroughs in the twenty-first century are likely to come not because of technology but because of humanity.


Dr Nymadawa is Minister of Health, Ulaanbaatar, Mongolia.
Ren-Zong Qiu

New thinking on health care does not mean abandoning humanitarianism

Jean Martin covers a range of important problems. In order to tackle them, changes are undoubtedly needed in our thinking about health care. However, it has to be said that in many if not all developing countries, socioeconomic development would be severely hindered in the absence of demographic control. Furthermore, the developing countries are eager to modernize and promote socioeconomic development. It would be utterly futile to attempt to halt development in the name of environmental protection. Ways have to be found of achieving development without repeating the mistakes made in the West.

Of course, population control is not easy. In China the effort to slow down the rate of population increase has already had a clearly favourable impact on socioeconomic development and the improvement of living conditions. However, the long-term consequences are uncertain, as the aging of society can be expected to occur before development reaches the desired level. Both socioeconomic development and demographic control are indispensable in developing countries, and both have their positive and negative, direct and indirect, short-term and long-term, expected and unexpected consequences. The point is that there should be sound policies to promote positive and minimize negative outcomes.

As regards the delivery of health care, the rejection of humanitarianism and Hippocratic tradition cannot solve the dilemmas we face. Nevertheless, humanitarianism should be redefined and reinterpreted, as should the Hippocratic tradition. First and foremost it is necessary to change the way of thinking about health care. At present the dominant ideology in health care focuses on the rights of the individual but fails to consider whether communities have sufficient resources to meet the needs of all individuals when they exercise their rights. WHO’s definition of health as complete physical, mental and social well-being undoubtedly presents difficulties. “Well-being” is a broad heading under which much can be put, while “complete” suggests a bottomless pit of limitless needs, demands and desires.

It is necessary to think more about the collective health of society and less about the health of the individual. Health care systems should give priority to societal needs. The notion that health care should not be profligate with resources is no less humanitarian than the tradition that women and children should have first call on places in lifeboats when a ship is sinking.

It is necessary to think more about the collective health of society and less about the health of the individual.

There is no sense in placing high technology on a pedestal. In the final analysis it cannot prevent aging and death. Its application consumes valuable resources, sometimes for the only purpose of allowing the dying to linger in their beds. It is therefore important to distinguish between healthy life and mere
existence as exemplified by persons who are irreversibly comatose or in a persistent vegetative state. It is also desirable to recognize that, for some terminally ill people in great pain, putting an end to their suffering by withdrawing treatment is an act of kindness.

New thinking on health care does not mean rejecting humanitarianism, the Hippocratic tradition and the well-being of the individual. It means that health workers should be concerned not only with the individual but also with the patient’s family, society at large and even future generations. This is actually an extended version of humanitarianism, not a rejection of it or of the principle of benevolence. Moreover, from the societal or community perspective, individual interests and rights are protected by a network of social cooperation in which rights and duties are balanced. Individuality is like a drop of water in the sea which would easily evaporate on its own; conversely, without innumerable drops of water there would be no sea.

Only international solidarity can make it possible to solve the problems under consideration. It is to be hoped that the peoples of the world, recognizing this, will one day take the actions required.

Jean Martin replies

—if all leaders concerned were to show the same commitment, one could be more optimistic

I believe we are fortunate in having such a distinguished group of participants and I should like to thank them for their frankness and the serious attention given to my article which, despite its imperfections, led to an exchange of high quality. If only our present problems could be faced with the same concern as shown by these commentators — concern for the common good as well as for the good of each human being — one could then be less pessimistic!

I should underline that I feel very much like a citizen of the world and try to behave as such. Before becoming medical adviser to the Health Minister of a Swiss canton, I worked for eight years and learned much in Latin America, South Asia and Africa. I was therefore saddened that my presentation could be seen to contain Western prejudices; I now feel that I must have expressed myself very inadequately if the reader could believe that I would want the developing countries to limit their aspirations to well-being and health so that those in the North might continue to enjoy the privileges they already have.

In a strong manner, Professor Banerji has asserted that my thinking is patently ethnocentric and follows a Malthusian approach which experience has shown to be futile. I do not believe that my proposals can be caricatured as very timid for the North while I roar like a lion at the actions by countries of the South. May I say categorically that that was certainly not my position; in my view, the North bears a heavy share of responsibility for the present situation and for the measures needed so that our common boat can be prevented from being wrecked on a very rough sea.

Dr Ratanakul has raised some relevant points with which I am in large agreement, especially in distinguishing between the role of governments and short-term commercial interests all over the world, on the one hand, and the role of the multitude of our fellow human-beings, on the other, many of whom are still without means to change
significantly the course of their own lives (not to speak of changing the political evolution of their country). I too am pained by the daily reality that, although we are indeed in the same boat, some passengers are extremely favoured as compared with others. I sincerely call for a genuine South-North coalition for a more equitable world. In this respect I appreciate Prema Pandurang’s reminder of the statement by Mahatma Gandhi (and others) that everyone may have according to his needs, but not to satisfy his greed, and that we should eradicate the exploitation of man by man. All our spiritual traditions include, in one way or another, such a message: let us hope that our children will know better than their fathers how to implement this.

Like Dr Hathout and Dr Ratanakul, I have for a long time been affirming, against certain Western pressures, that development is the best way to master the global demographic growth and, in my own field, that the improvement of the health of mothers and children is the best “pill”. Now, twenty years later, I am not at all sure that, by these measures, we will reach lasting solutions soon enough. In any case, it is essential to repeat over and over again that vast resources could be made available for health, social and development work if those in power would slow down (and ideally stop) their mad arms race.

The remarks by Povl Riis and Daniel Callahan are both judicious and enlightening. And I should very much like to be convinced as they are that the democratic process will be able to respond adequately and, most important, in time to today’s challenges. However, the way in which so often, in practice, our democracies appear inevitably to favour short-term myopic options and decisions does not allow me to be very optimistic. Yet, like Callahan, I realize there is a risk that a pragmatic approach may permit our survival in such conditions that one would really not want to survive... Yes, one should be careful of the danger that our well-meaning actions could destroy the very values they aim to preserve. As regards the comments by Nymadawa and Ren-Zong Qiu, I appreciate their balanced, constructive views and their search for harmony between the interests of the individual and those of the community.

Finally, I should like to pay tribute to Vangie Bergum and Cécile De Sweemer-Ba for the relevance and substance of their contributions. Lack of space does not allow a detailed discussion, but may I say that I fully agree with them. The values and actions of women should have a stronger impact on our daily lives and long-term prospects and plans, all over the world. Their views make a fitting conclusion to this Round Table: Bergum thinks that we should go beyond Hippocrates and Machiavelli, towards new models of cooperation and collaboration worldwide; De Sweemer-Ba recommends that we forget Machiavelli and strive for true pragmatic humanism, involving each one and respecting everyone. I believe that all the participants will agree that, in the future, we should try harder to go in this direction.

Acknowledgement

The Editor is grateful to his predecessor, Dr Elif Liisberg, for putting together this Round Table discussion.