Editorials

Ethics and Public Health Policies

Anand et al. highlight the role of ethics in the planning and execution of public health policies using four disparate issues as examples. In each instance, the policy decision is examined using the cardinal principles of medical ethics. When, and only when, these principles are incorporated in the policy to be implemented, can it pass muster and be seriously considered. Common sense dictates that any policy on the health of the populace should aim at benefiting all and harming none. It should never benefit select groups at the expense of the rest, especially when the latter are underprivileged or handicapped. How often do we encounter such an approach in practice?

A prominent plank of several governments has been the reduction of our population and attainment of ‘zero-growth’. The policy laid down by the ‘extra-constitutional authority’, Sanjay Gandhi, if examined through the lens wielded by Anand et al., would immediately have been discarded on several grounds—discrimination and injustice, violation of the autonomy of the individual, insufficient measures at preventing harm to the person to be sterilized, placing the need to inflate statistics above the welfare of the populace ... Subsequent policies at ‘family welfare’ have fared little better on ethical scrutiny. (The ease with which our ‘leaders’ camouflage illogic by playing on words is, in itself, a travesty of ethics.)

We also need to rethink several existing policies, focusing on ethical principles in each instance. I place some examples before you. Did we act ethically in sanctioning the creation of private medical colleges? Do the attributes necessary for admission to medical colleges and courses (undergraduate and postgraduate) need revision, especially with respect to the need for an unswerving emphasis on merit and the abolition of reservation on any other ground? Should we not match our medical education and healthcare facilities with the needs today and on the basis of a long term programme? Does the country need a plethora of departments, each with its own huge budget, to foster medical research? Should the research projects on which millions of rupees have been spent so far be subjected to a publicly transparent cost–benefit analysis? Should those working in medical colleges and hospitals ever be permitted to go on strike? Can we afford to permit the proliferation of very expensive investigative and care facilities without any logical short term and long term plan? Most important of all, can political expedience ever be permitted to rear its ugly head in healthcare planning and policymaking?

Producing an ethical policy on paper without ensuring its implementation in the fullness of intended spirit is, in itself, unethical for it raises hope that is doomed to frustration. Consider our policy on healthcare in the villages and small towns. We have a variety of plans, proposals and policies to ensure that the sick villager will be promptly attended to by the doctor at the primary health centre, necessary elementary tests performed at the attached laboratory and medicines supplied from the stocks at hand. How often are any of these expectations met? The doctor may not be available. If traceable, he may be poorly trained, surly, indifferent and unwilling to help unless bribed. Reagents and equipment at the centre, when available, are outdated or faulty. Drugs shown on the listed schedule are not to be found, having found their way into the market soon after their arrival.

Another example of an excellent policy on paper that has never been implemented...
is the one condemning and prohibiting determination of the sex of the unborn child solely for the purpose of killing the female foetus. This issue also highlights the total lack of concern for ethics not only on the part of the authorities whose duty it is to implement the law, but also of the medical councils and, of course, of the medical profession and its many august bodies—none of which raised even a whimper against the unethical and illegal practice. It was left to the judiciary to pass strictures and demand action.

There are several other issues crying for public debate and the formulation, implementation of ethical policies: criteria for availing of expensive tertiary care (including intensive care) in public hospitals, streamlining the transfer of seriously ill patients from a primary healthcare unit to an appropriate tertiary care facility, the right of a terminally ill person in unmitigated suffering to die, advance directives against resuscitation and heroic therapeutic measures, gene manipulation and therapy.... The medical profession has been rightly condemned for taking too much decision-making power into its own hands, to the detriment of the common people. The making of public health policy has been dominated jointly by the medical profession and politicians. If we are to ensure ethical consideration in the formulation and implementation of such policies, it is essential for the people to be involved in these processes. Since the public is an amorphous mass, the responsibility devolves on the intelligentsia, especially those with a social conscience and those acting as our watchdogs—the media. This responsibility cannot be discharged in a ‘one-time’ exercise but must form a continuing and enduring effort.

REFERENCE

ISSUES IN MEDICAL ETHICS carries, in its volumes, several essays, discussions and reports on relevant topics. The interested reader may wish to refer to them.

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Maternal Mortality in India: No room for complacence

It is fifteen years now since the launching of the International Safe Motherhood Initiative in 1987, and ten years since the Government of India’s Child Survival and Safe Motherhood Programme was initiated. Tragically, however, maternity continues to claim the lives of millions of Indian women year after year. According to the National Family Health Survey (NFHS)-II, the maternal mortality ratio in the country is 540 per 100,000 live-births (1998–99), showing no decline from the levels reported by NFHS-I in 1992–93. These ratios are among the highest in the world.

It is indeed baffling that in a country that boasts of medical expertise comparable to the best in the world, women in the prime of their lives are allowed to die during the course of bringing forth new lives. Unlike rare or newly emerging health problems and conditions about which little is known, and for which there are no known cures, we have the benefit of more than a century of accumulated knowledge about the causes of maternal death and what needs to be done to avert them. Why then does this state of affairs continue?

One of the major reasons is our failure to learn from the experiences and mistakes of the past fifteen years of implementing maternal health programmes. For example,