

four important questions¹: Have I sought for or tried to develop methods that obviate the use of animals? Am I proposing to use an appropriate species of animal? Does my protocol project using the fewest possible number of animals? Is my proposed use of animals in accord with the principle of humane treatment?

Great controversy arose after various examples of inappropriate human experimentation were identified in the 1960s. Experiments were often done on human subjects without informed consent, and some of the experimental designs were blatantly unethical. This led to the development in 1974 of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Perhaps it is time for the federal government to appoint a commission to examine the use of animals in experiments and to analyze the different points of view concerning animal rights and morality. The appointment of a national commission for the protection of animal subjects in biomedical research would help all Americans understand the issues and establish reasonable guidelines for animal experimentation.

Animals should be used in experiments only when clearly necessary, and they should always be treated according to the principle of humane treatment. A dog is not a boy but still can be a loving companion and friend. Animals have feelings, and their lives have value. Extreme acts carried out by elements of the animal rights movement and inappropriate animal experimentation should stop. As Gelpi recommends, physicians should become more knowledgeable concerning animal experimentation and the animal rights movement so that they can assist in solving this problem. A moderate position can be identified, and the creation of a national commission for the protection of animal subjects in biomedical research might assist in the process.

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International Health

THE BIGGEST HEALTH CARE breakthrough of this century, affecting the lives of millions throughout the world, occurred in 1978 at a historical meeting, convened by the World Health Organization (WHO) at Alma-Ata in the USSR.¹ This revolution has embraced all the nations of the world at grassroots, community, and administrative levels, yet has bypassed North America and Europe. A set of unique health principles and an achievable goal of equity in health expressed as WHO's goal of health for all by the year 2000 became the priority of the 166 member nations. The target was the

“global human being” in need of health—physical, mental, social, and spiritual—to reach his or her true potential without hindrance.

What is international health? There is no clear-cut definition, but to the novice it conjures a picture of health teams traveling from North America and Europe to the Third World, loaded with medical supplies and cures with the application of the latest antimicrobics, vaccines, and other technology. The top-down approach still looms in the minds of many. But the goals and ideals of WHO and, indeed, of most Americans, are to target the health care of the global human being. Hence, international health can best be described as “health care that is *shared* between nations (international) and encompasses multiple disciplines and sciences including Primary Health Care, Public Health Care, Nutrition, Maternal-Child and Women's Health, Geographic and Tropical Medicine, Infectious Diseases, and so on. Unlike the component disciplines, it has a *moral* and *spiritual* component.”² This is in keeping with the idea of health as defined by the World Health Organization's charter. The principles and imperatives of “health for all”¹ include the following:

It is intended to reach everybody, particularly those in greatest need; it is intended to reach to the home and family level and not to be limited to health facilities; it is intended to involve a continuing relationship with persons and families. Primary health care is the key to health for all and should include the following concepts:

- Universal coverage of the population with care provided according to need—that is, equity, no matter how poor or remote.
- Services should be promotive, preventive, and rehabilitative.
- Communities should be involved in the development of services to promote self-reliance and reduce dependence.
- Approaches to health should relate to other sectors of development.

It is necessary to impress on the minds of our colleagues, especially those who are entering the field of international health, that sharing and moral and spiritual components are crucial elements in our bonding efforts abroad and at home and especially if we are going to usher in a “new world order.” This leads to my addressing another quiet revolution that has just taken place in the past few months—the formation of a consortium for international health programs in North American medical schools.² This idea germinated in the minds of Lynn Bickley, MD, (University of Rochester, New York) and me and was presented to the business and planning committee meetings of the National Council of International Health in June 1990. The idea got momentum with the involvement of Hakon Torjesen (Case Western Reserve University School of Medicine, Cleveland, Ohio), Ron Pust, MD, and Ms Susan Moher (University of Arizona, Tucson), leading to the first meeting. All told, 34 academicians from 24 US Medical Schools attended the meeting at Tucson, Arizona. The movement is historically significant. It will bring together under one organization all of the diverse international activities of all American medical schools. All the schools are, however, free to pursue the genius of their own individual programs. The organization will have leverage at national and international levels in policymaking and in devising curricula. It will also address long-felt predoc-

toral, doctoral, and postdoctoral needs in international health with regard to clinical sites, funding issues, curricular changes, academic credits, career tracks, resource sharing, providing a "clearinghouse." This has been a dream of the American Medical Students Association—800 of its members have an active interest in international health (L. Barthauer, oral communication, February 1991).

One of the ways we can achieve good global health is for the consortium to help expand the medical schools' horizons. Currently they function primarily as educators and researchers and entities isolated from societal concerns. It is hoped that they will eventually become active collaborators with the WHO, providing moral, spiritual, and social leadership in bringing health to that global human being abroad and at home. It is a way of delivering the promise of health for all³ in an equitable, caring, sensitive manner and training foreign and local health care workers to take on the incredible challenge that lies ahead. To quote from a recent elegant and succinct editorial, "The basic issue is not health or illness

care. The basic issue precedes the point at which this care must intervene We must now pull together, clarify our values, reassert that vulnerable people are a high priority [all over the world], and move ahead."⁴

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