

DOCTORS TAKE RESPONSIBILITY FOR OVERPOPULATION, AGAIN.

An NPG Forum Paper
by Edwin S. Rubenstein

Doctors and Overpopulation was established in 1972 in the United Kingdom. The organization's mission statement, published simultaneously in the *British Medical Journal* and *The Lancet*, declared: **"It is right that we as doctors should be especially concerned about the world population crisis. In the first place we bear some responsibility for its genesis, because it was due to our efforts that 'the captains of the men of death' [tuberculosis, smallpox, and other once widespread deadly diseases] were slain, and this was a major factor in producing the imbalance between birth rates and death rates. Secondly, sheer overcrowding in cities with its attendant pollution is a direct threat to the mental and physical wellbeing of our patients. Finally, doctors, as an informed and highly educated section of the community, are in a particularly strong position to influence society on this all-important topic."**¹

For its time, the statement was courageous. Population growth was a taboo topic for the medical profession back then. To the extent that physicians discussed it at all, it was in the context of increasing life expectancy, reducing infant, child, and maternal mortality, and increasing access to family planning. Limiting global population was not on the agenda.²

Indeed, use of the word "overpopulation" to mean a situation where the Earth's ecosystem cannot regenerate the resources depleted by global population each year, was difficult for most educated people – doctors and non-doctors alike – to fathom in 1972.³ Only population activists took the environmental issue seriously. (*One of them, Don Mann, founded NPG that year.*)

And if overpopulation was deemed a problem, it was widely regarded as a self-correcting one. As high child mortality rates fell, birth rates were expected to follow suit, as couples realize large families are no longer needed to replicate themselves. That is the premise behind the much-ballyhooed **Demographic Transition Theory (DTT)**.

DTT is a narrative, concocted by professional demographers, to explain how countries facing sharp drops in infant mortality manage to avoid catastrophic population increases. There are several variants, but the classic theory invokes the notion of couples opting for smaller families, young women putting education and jobs before motherhood, modern contraceptives becoming increasingly available, and poverty rates declining in developing countries.

Say it out loud: **Demographic Transition Theory**. It sounds so erudite, so intelligent, so comprehensive. The "theory" has been taught to generations of demography and economics students, along with the notion that **"Once fertility declines are underway they tend to continue."**⁴

Ordinary folks with an intellectual bent are often aware of the theory, as are medical doctors, many of whom may have encountered it as undergraduates.

To its proponents **"... [DTT]... ranks as one of the most important changes affecting human society in the past half millennium, on a par with the spread of democratic government, the industrial revolution, the increase in urbanization, and the progressive increases in educational levels of human populations."**⁵

Wow! That sounds like a keeper.

Reality check: Infant mortality rates *did* fall, with 4.1 million infant deaths in 2017 compared to 8.8 million in 1990. So did birth rates: the global Total Fertility Rate (TFR – the average number of children per woman) fell from 5 in 1950 to 2.4 children per woman today, according to the UN Population Division.⁶

What did *not* fall: Population itself, and the medical profession's lackadaisical attitude towards it.

In 1972 world population was 3.8 billion. In 2020, a mere 48 years later, the Earth was home to 7.8 billion

people. By 2100 global population is on track to hit 10.8 billion, according to the United Nations, and that's assuming steady fertility declines in many countries.⁷

Last October, Dr. John Guillebaud, a signatory to the 1972 overpopulation notice, co-authored a "second notice" to the 2020 cohort of medical professionals. Guillebaud, a retired professor of reproductive medicine in London, celebrates the drop in mortality. A fall in death rates is always desirable, he writes, "... **and any bias in the opposite direction to curb population growth would be unacceptable.**"⁸

But reducing population? That's a tough nut to crack. Population growth, Guillebaud explains, has an insidious momentum of its own:

"...This momentum results from a '**population bulge**' – of young people born while birth-rates were high – now entering into reproductive age.... In other words: **the population is not growing because people are reproducing more, but because more people are present to reproduce.** The population will keep growing until the number of people leaving the reproductive pool is bigger than the number of people entering it. In developing countries, the populations are young, so even when fertility rates drop and the current generation of parents adopt a *small family norm*, [population] will continue to grow."⁹

Population momentum enables declining fertility to co-exist with rapid population growth. The transition to population stability can last for "...**up to 70 years after the replacement level fertility is reached,**" Leon Kolankiewicz and Roy Beck wrote in 2001.¹⁰ A more recent paper, by a climate change expert, notes that: "**Depending on the time lag between mortality and population falling, the post transition population can be from four and ten times higher than pre-transition, and in rare cases even more.**"¹¹

But DTT proponents are unfazed. Be patient, they say: The final stages of the transition will see increased access to birth control, women's higher education, and wealth. At some point fertility rates – and global population itself – will decline.

Moreover, DTT true believers expect population to fall even without deliberate population policy interventions: "**Development is the best contraceptive, hence we can be contented and confident that population growth will cease,**" writes ecological economist Blake Alcott.¹²

Are you "contented" yet? Me neither.

Reality check #1: Only wealthy developed countries have seen fertility rates fall to replacement levels. An appropriate date to start this analysis for the U.S. is 1946 – the first year of the baby boom – when soldiers were coming home, getting married, and fathering children. In 1950 the Total Fertility Rate for American women was 3.5. As the post-war economy boomed, something astonishing took place. As described by William Ryerson: "[T]he **birth rate in the United States dropped dramatically ... By 1973, the fertility rate had fallen to replacement level.**" In 1975, the TFR was only 1.7, and the media proclaimed "**Population Problem Solved**" and "**U.S. Arrives at Zero Population Growth.**"¹³ Alas, reports of the death of U.S. population growth were exaggerated: U.S. population today is more than 50% above its 1975 level. But the *perception* of decline is unshaken, and may explain why so many U.S.-based scientists and medical doctors ignore the population issue.

Reality check #2: Replacement TFR is often given as 2.1 children per mother (one child to replace the mother, one to replace the father, and 0.1 to account for child mortality.) "**In reality**" writes University of Hawaii professor Camilo Mora, "**population stabilization is achieved when the natality rate is equal to the mortality rate, which by today's demographics would be equivalent to one child per woman.**" Achieving this through government policies is both "**unlikely and undesirable,**" he suggests.¹⁴

Recent data support Mora's pessimism. The CIA's 2020 Global Factbook puts world TFR at 2.42. Only two of the 228 countries surveyed by the intelligence agency – Macau and Singapore – had TFRs below one.¹⁵ Sub-Saharan Africa (TFR=4.6) is expected to account for more than half of world population growth to 2050.

Other reasons to doubt the DTT's universal validity include:

Fertility Rates May Be Inherited A 2018 paper titled *The heritability of fertility makes world population stabilization unlikely in the foreseeable future*, finds that people who grew up in large families tend to prefer similar sized family units for themselves. Over time, as children from larger families represent a larger share of a country's population, population will grow faster than estimates based on Demographic Transition Theory. The results "**...suggest world population will grow larger in the future than currently anticipated.**"¹⁶

DTT Ignores Immigration The last stage of transition, when mortality and fertility rates are low, and economic growth is high, should, according to the DTT, be a time of population stability. Data please? Sorry, there is none. While demographers have collected reams of data on fertility, mortality, female education, and contraception rates – they have yet to come up with data, or even a coherent theory, connecting these items to population growth. In most countries, population rises throughout the demographic transition, mainly because of the influx of immigrants seeking higher incomes, that usually accompanies economic growth. Adding an immigration component to the standard DTT model would rectify this oversight. In the meanwhile: **“The curious feature of the Demographic Transition Theory is that *there is not a single convincing confirmation of this theory in data.*”**¹⁷ (Italics in original.)

UNWANTED PREGNANCIES

The World Health Organization (WHO) estimates that 44% of worldwide pregnancies between 2010 and 2014 were unintended. A disproportionate number occur in developing countries, where hundreds of millions of women who want to avoid pregnancy still avoid modern contraceptives. There are many reasons for this, including prevailing religious beliefs, misconceptions about adverse side-effects, and anti-feminist ideology in male-dominated societies.

For whatever reason, the problem is getting worse, not better: After declining substantially in the 1990s, the number of unintended pregnancies increased slightly in the first decade of this century. Moreover, efforts to extend family planning services have stalled in recent years, and there is even some evidence that existing programs are not as effective as previously thought.¹⁸

Needless to say, these findings do not sit well with DTT enthusiasts. They increasingly realize that a hybrid strategy, involving free family planning services as well as government contraception mandates, may be needed to tame global population growth.

One of the most controversial of these proposals involves mandatory long-term contraception.

As described by University of Stockholm medical ethicist Greg Bognar, this may involve **“...a capsule which could be implanted under the skin and which would release hormones to prevent pregnancy in women and to cause sperm cells to be infertile in men. ...the capsules could be removed**

when one would like to become a parent. Otherwise, they would last for decades and provide a safe and reliable method of birth control without any side effects.”¹⁹

You think population control is a taboo topic? Mandatory contraception may be the taboo of all taboos. But the idea isn’t as far-fetched as it seems. A contraceptive implant, Norplant, has been marketed in the U.S. for decades. Some states and big cities tried (unsuccessfully) to pay women on welfare who agree to use Norplant. Baltimore gave Norplant to teenage women without parent approval. Teen birth rates plunged.²⁰

We already have vaccines and other public health programs that are mandatory. COVID masking mandates are but the latest. For decades school districts have required incoming kindergarteners to be vaccinated against childhood diseases. Most people do not consider them coercive, though they really are.

Are mandatory contraceptive implants any different? Consider this: they are completely reversible. No one would be prevented from becoming a parent. Getting pregnant would be a matter of choice rather than chance. Abortions – and the health risks associated with them – would all but be eliminated.

Bognar warns: **“There is no doubt many people still find these proposals repugnant... As [economist] Kenneth Boulding said... ‘The sheer unfamiliarity of a scheme of this kind makes it seem absurd at the moment. The fact that it seems absurd, however, is merely a reflection of the total unwillingness of mankind to face up to what is perhaps its most serious long-run problem.’”**²¹

DR. WALKER ON THE END OF LIFE

“It is my strong opinion that doctors should be prolonging everyone’s life, but no one’s death. But, I am a stronger believer in health span rather than life span. Any sensible doctor knows when a person’s life has finished and their death phase has begun. When a person has entered the death phase, I believe it is the responsibility of the medical profession to ensure that person’s death occurs as quickly, painlessly and with as much dignity as possible. Unfortunately, many relatives and members of the medical profession believe it is their responsibility to pull out all stops and do everything possible to maintain someone’s existence,

regardless of the quality of that existence.

“The death phase, in my view, is when a person has a terminal illness with absolutely no possibility of recovering...”

“Unless someone with a public profile is brave enough to make these comments...we will continue to see an exponential rise in the population, wars fought over food and water and a continually rising divide between the haves and the have nots.”²²

Dr. Ross Walker is an expert in the field of preventive cardiology.

SUMMARY

Overpopulation presents a dilemma for the medical profession. Doctors helped cause the problem by reducing infant mortality and increasing life expectancy. Those two goals are protected under the “Do No Harm” pledge embodied in the Hippocratic Oath. But non-medical barriers to population control can be addressed by doctors.

There are millions of women who want to control their fertility but do not have access to reliable contraception. Even more live in societies where men are the sole deciders of family size, and even gender. Women are forced to become mothers because that is the only role open to them.

Physicians have been slow to recognize the dangers of overpopulation, and the relationship between medical care, women’s education, and environmental degradation. The 2020 Doctors and Overpopulation notice could change that.

NOTES

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Edwin S. Rubenstein, president of ESR Research, is an experienced business researcher, financial analyst, and economics journalist. He has written extensively on federal tax policy, government waste, the Reagan legacy, and – most recently – on immigration. He is the author of two books: *The Right Data* (1994) and *From the Empire State to the Vampire State: New York in a Downward Transition* (with Herbert London, 1994). His essays on public policy have appeared in *The Wall Street Journal*, *The New York Times*, *Harvard Business Review*, *Investor’s Business Daily*, *Newsday*, and *National Review*. His TV appearances include *Firing Line*, *Bill Moyers*, *McNeil-Lehr*, *CNBC*, and *Debates-Debates*. Mr. Rubenstein has a B.A. from Johns Hopkins and a graduate degree in economics from Columbia University.

NOTE: The views expressed in this article are those of the author and do not necessarily represent the views of NPG, Inc.



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