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Can medicine prevent war?

Imaginative thinking shows that it might

War is one of the world's most serious threats to health. The recent global burden of disease report has indicated that war will be one of the top 10 causes of disability adjusted life years lost by the year 2020.[1] For every combatant killed in war, one non-combatant is also killed directly, 14-15 civilians lose their lives from loss of shelter, food, and water or epidemics—and several times these numbers are physically or psychologically wounded. What can healthcare workers do about this threat?

In a provocative article Dudley Herschbach, a Nobel laureate in chemistry, reflects on what it might be like if human beings could speak to dolphins.[2] He imagines a fruitful interaction between humans and dolphins that would derive its force from the fact that the two species come from different habitats, face different problems, and have evolved different ways of communicating among themselves. He fantasises that a genuinely creative relationship would lead to the solution of many problems humans had thought intractable. He applies the parable to our human situation: "Each academic species has evolved its own language, so interdisciplinary communication is rare and fitful." He concludes with a plea for interdisciplinary communication, suggesting that we shall not make progress in tackling urgent problems without it.

In this spirit, we suggest that healthcare workers may indeed have something to offer to the understanding and eradication of war and that we should develop conceptual models about war which overlap with those for chronic diseases. Our suggestions are an attempt to apply Virchow's words: "Medicine is a social science, and politics nothing but medicine on a grand scale."

Try thinking of war as a complex disease process that attacks the global "group organism" humankind. Think of this disease as having risk factors that can be prevented from developing (primordial prevention) or modified (primary prevention) and whose effects we must treat (secondary prevention); and think of war as a condition which, once it has done its damage, leaves us with the tasks of healing and rehabilitation (tertiary prevention). And think of healthcare workers as having important roles at every stage of this process.

Let us start with the fourth stage and work backwards. Tertiary prevention seeks to promote rehabilitation after disease has been established. This refers to a situation where war has occurred. The need for rehabilitation in the normal sense—the physical and emotional rehabilitation of individuals— is obvious. But if our model is to offer anything innovative it must refer as well to the rehabilitation of society. Societal rehabilitation (especially after civil conflicts) can be greatly aided by the building of an equitable, accessible healthcare system in a war torn society.[3] As it is shown that all groups, whatever their ethnic or political status, have equal access to health care—and as a culture of care begins to replace a culture of hatred and vengeance—a societal rehabilitation begins to take place.[3]

Secondary prevention refers to a situation where war has broken out and we are searching for methods of making peace. An example of such peacemaking would be the humanitarian ceasefire, where hostilities are temporarily suspended to allow immunisation or other health interventions. The humanitarian ceasefire in El Salvador in the mid-1980s brokered by Unicef and the church provides a fine example of this, because it contributed not only to preventing disease in children but also to the construction of a framework for negotiation that ultimately stopped the war.[3]

Primary prevention is to do with preventing a war from breaking out when a situation of conflict, as well as the weapons with which the conflict can be waged, are already in existence. An example is the work of International Physicians for the Prevention of Nuclear War, which drew public attention to the health effects of nuclear war, to educate world leaders about the unwinnability of nuclear war, and to dispel, in the best tradition of scientific medicine, superstitions about war—such as the superstition that the accumulation of armaments makes a group more secure.

Primordial prevention could aim at preventing the "risk factors" for conflicts from developing in the first place, or from escalating to dangerous levels; or it could aim at removing other factors, such as armaments, that are necessary for the existence of war. It is at this level that we should direct our energies if we wish to be truly effective.

What could healthcare workers do at this level? We could join others to establish international agreements that would prevent certain weapons from being used. In addition to nuclear weapons, obvious examples are blinding and biological weapons. The International Committee of the Red Cross's SIrUs Project (conceived by a surgeon, Dr Robin Coupland), which attempts to use objective, medically based definitions to ban weapons that cause "superfluous injury or unnecessary suffering," is an example of this approach.[4]

The globalisation of research networks could facilitate the development of a "group health mind" that prevents differences between groups or nations

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escalating to pre-war tensions. We could also promote international health, supporting medical (eg Médecins Sans Frontières), health (eg the World Health Organisation), and human rights (eg Amnesty International) agencies which try to transcend national boundaries to create a caring global society. The ending of privation and inequity will go a long way towards ending the disease of war.[5] We should use our skill in maintaining the well being of humans, as well as our legitimacy as healthcare workers, to seek medical, social, and political solutions that help eradicate or limit this disease that afflicts humanity.

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Reinventing doctors

Will move doctors from this winter of discontent to a position of leadership

This is not a happy Christmas for our profession or indeed for many doctors. Doctors work extremely long hours under difficult conditions and many are demoralised by lack of resources and constant criticism. We feel proud of the advances in medical science and find it difficult to understand when patients complain because our efforts are not always effective. Much of the recent poor publicity has originated from the reporting of cases before the General Medical Council. It is ironic that these demonstrations of self regulation should lead to criticism of the system of self regulation by both the public and politicians. Now the government is introducing legislation to ensure the quality of clinical services and to make the profession more accountable.

Last year Professor Roy Porter published a history of medicine entitled *The Greatest Benefit to Mankind*, which was Samuel Johnson's accolade to the medical profession.[1] Porter points out that we are healthier than ever before yet more distrustful of doctors and the "medical system." As he writes, such ambiguity is not new, but we need to attempt to understand it.

Much of medicine and medical practice has changed during the past generation. Modern medicine is complicated and often uncertain. For example, babies born at less than 28 weeks' gestation are now routinely ventilated and, though more survive, around a quarter of those who do have disabilities and 10% are severely handicapped.[2] Given that about 1% of pregnancies result in premature delivery are we sure that parents are fully informed of the risks and benefits of modern treatment and can we be surprised that faced with the problem of caring for a child with severe handicap they should seek to apportion blame? The advances in medical science and technology are set to continue, probably at an increasing pace.[3] The only thing that is certain is that the financial and personnel resources available to the National Health Service will not keep pace with these changes.

The cardinal principles of medical ethics are to protect life and health, to respect autonomy, and to strive for equity and justice. A new emphasis exists on autonomy and individual rights. This may be in part because totalitarian dictatorships have used mass movements in this century to gain power and have then terrorised individuals in the name of society. Emphasising the rights of individuals may be seen as a defence against such abuses of power.[4] Alternatively, it may be linked to increasing prosperity, leaving people with more marginal income with which to exercise choice.[5] In the NHS this rise in consumerism is represented by the various patient charters introduced over the past decade. Though these may well change, patients now wish and need to be informed and consulted about their medical care as never before.[6 7]

The circumstances of doctoring have changed, and we doctors need to change too. We need to be open and to work in partnership with our colleagues in health care and with our patients.[8] Like us, most patients wish to be in control of their own lives and often of their own deaths also. As Sikora points out, 70% of the cancer budget is spent in the last six months of life, and positive involvement in self help programmes will make it easier for patients and doctors to say no to last ditch medical interventions.[9] For doctors to work as advisers and partners rather than as controllers, however, they need good communication skills. Options need to be discussed with regard to the patient's own circumstances and wishes. Hospital doctors and general practitioners need to consult each other and other health workers, especially nurses, before framing their advice. Information needs to be shared and available when a crisis occurs. Too often patients are seen by doctors who do not know them when an acute event occurs against a background of chronic disability. Simple measures such as providing copies of all letters and summaries to patients would help.

Sharing responsibility with colleagues, not just doctors, is also necessary if the workload is to be managed satisfactorily. But good teamwork also requires special skills and training. We will need to learn how to audit processes of care and how managers, doctors, and nurses can best work together to provide good quality care which is appropriate rather than just being possible because of modern technology.

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