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Medicine in the age of global interdependence

We must do the hardest thing of all—change ourselves

"The great question of this new century is whether the age of interdependence is going to be good or bad for humanity. The answer depends upon whether we in the wealthy nations spread the benefits and reduce the burdens of the modern world, on whether the poor nations enact the changes necessary to make progress possible, and on whether we all can develop a level of consciousness high enough to understand our obligations and responsibilities to each other."

Bill Clinton, 26 January 2002[1]

"A century of destruction unlike any other befalls and blights the human race—scores of millions of ordinary people condemned to suffer deprivation upon deprivation, atrocity upon atrocity, evil upon evil, half the world or more subjected to pathological sadism as social policy, whole societies organised and fettered by the fear of violent persecution, the degradation of individual life engineered on a scale unknown throughout history, nations broken and enslaved by ideological criminals who rob them of everything, entire populations so demoralised as to be unable to get out of bed in the morning with the minutest desire to face the day … all the terrible touchstones presented by the century, and here they are up in arms about … Monica Lewinsky! … This, in 1998, is the wickedness they have to put up with. This, in 1998, is their torture, their torment, and their spiritual death."

Philip Roth, *The Human Stain*[2]

Can we make sense of what is happening in the world since the attacks of September 11? Why did they happen? Is the world changed fundamentally? If so, how? What will be the consequences? How should we respond? The message of the two quotes is that we need to look up from our often petty concerns and begin to recognise what global interdependence means for each of us. The quote from Roth, arguably America's finest contemporary novelist, should not be read as anti-American. It applies to us all. Tony Blair, Britain's prime minister, made a speech soon after September 11 in which he argued the case for global reform. This week he is being criticised for travelling to Africa when he should be home sorting out the railways. Certainly we don't want to neglect our own children while concerning ourselves with children overseas, but how can we achieve a proper balance? This question is as acute for medicine as for any human activity.

As this theme issue shows, medicine has much to offer a confused world. It can help with understanding the conditions that breed violent conflict and predispose to terrorism.[3,4] It has always been the job of medicine to treat those injured by conflict, and military medicine is a long established specialty. Increasingly, however, it is civilians not soldiers who are damaged by war—and, as usual, it is the young, the old, the poor, the dispossessed who suffer most.[5–7] The manufacture of biological and chemical weapons means that medical knowledge may be used to kill as well as to treat.[8,9] Doctors can help rebuild healthcare systems in countries, like Afghanistan, shattered by war, and, as Jennifer Leaning describes in the box, medicine has developed since the second world war a much more sophisticated and evidence based understanding of how to manage what are now called complex humanitarian disasters.

The principles and practices of public health are much more likely than military activity in the long term to reduce terrorist activity, argues the *Lancet* accurately.[10] Colin Powell, US Secretary of State agreed when he said last week: "Terrorism really flourishes in areas of poverty, despair and hopelessness, where people see no future."[11] And the World Health Organization's macroeconomic commission on health has underlined that investment in health is among the best means of promoting development.[12,13]

But all this is not enough and not the end of medicine's duty. Responding to September 11 is not simply a technical exercise undertaken by people other than ourselves. "We are all going to have to change," argues Clinton.[1] We have to recognise and accept our interdependence. "We live in a world where we have torn down walls, collapsed distances and spread information." Medicine knows something about the tension

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Physicians and war

Those who wish to see health professionals stick to the pressing concerns of clinical practice and not comment on major world events like the war in central Asia should have stopped the clock on the eve of the second world war. Until then few outside the military saw war as their concern and thoughts about its causation had not got much further than Rudolf Virchov's 1848 conclusion that, "War, plague and famine condition each other."

But the carnage of the war galvanised the medical profession and in the past 50 years doctors have made significant contributions to international norms of armed conflict. They have also helped spur a quantum leap forward in assessing and quantifying the root causes and health consequences of war, disaster, and civil conflict. The challenge for the profession now is to help ensure that the next 100 years are less extreme than the last.

Jennifer Leaning

The full version of this paper appears on bmj.com

of having commitments at home and abroad. It is akin to the tension of doing your utmost for the patient in front of you but at the same time recognising commitments to other patients and the broader world. The group that devised the Tavistock principles for everybody in health care recognised the tension in its second principle: care of individual patients is central, but the health of populations is also our concern.[14]

Many doctors like to think that there is no tension between caring for individuals and populations, but there is—particularly in allocating resources. We once heard a doctor who had introduced renal dialysis into India regret what he had done—because it cost some $100 000 a year to dialyse a single patient when the health expenditure per head was a few dollars. The saving of one may have been the death of many. Yet there is an understandable anxiety about putting the interests of populations ahead of those of individuals, not least because it can culminate in inhuman acts. The tension is inescapable.

Many doctors—for example, British general practitioners—have learnt to live with the tension of caring simultaneously for individuals and populations. But usually the population means a practice list of 1500. Can we find a way to think meaningfully about our responsibility to six billion people, the population of the world? How should we practise medicine in a world where half of the world's people live on less than $2 a day, one billion people go to bed hungry every night, a quarter of the world's population never gets a glass of cold water, and a woman dies in childbirth every minute? All medical schools teach public health, but how many teach global health? Ten years ago the BMJ Publishing Group started a journal called *Medicine and Global Survival*, but we pulled out because we couldn't make it pay. Few doctors were willing to pay to subscribe to it, and we were unwilling to continue to support a journal that lost money. We were wrong. September 11 taught us all about global interdependence. But can medicine now rise to the challenge of thinking and practising globally?

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Complex political emergencies

We can learn from previous crises

Education and debate p 342

Acute disasters attract international media and political attention—and often funds to support a response. However, if hundreds of thousands of people, or even millions, die over several years because of prolonged conflict this may go almost unnoticed. A recent survey in eastern Congo revealed an excess mortality of 2.5 million people in only 32 months. Of these deaths 350 000 were because of direct violence; most died from malnutrition and disease.[1] The death toll in longstanding and continuing conflicts in Sudan, Angola, Burma, and Sierra Leone has been similarly massive. These too often forgotten crises are complex political emergencies, a term that underlines the political nature of these internal wars, with their complex origins and multiplicity of players.

Complex political emergencies are not isolated events but linked with globalisation, foreign policies,[2] and, as Stewart emphasises in this issue, economic interests (p 342).[3] Conflict in the Congo, for example, has been associated with struggles over access and control of coltan, a metallic ore which is an essential component of mobile phones.[4] But although prolonged war may be profitable for some people,[5] most suffer from widespread violence; forced migration; human rights violations; and administrative, economic, social, and political collapse.[6] Health services invariably deteriorate and are less and less capable of addressing increased health needs.

The full impact of these complex political emergencies rarely reaches the headlines, and world powers often fail to put their full weight behind efforts to resolve the conflict. The international community, however, does usually get involved in humanitarian relief, in which health activities play a substantial part. The bleak picture in the Congo questions the effectiveness of these activities. Was a concerted effort in place, with sufficiently targeted health action, backed up by sufficient funds from donor agencies? Or was the situation so insecure that relief never reached the population who needed it? It is difficult to be sure. Evaluations under these circumstances are rare and fraught with methodological difficulties.[7] The sectorwide evaluation of the humanitarian response to the 1994 crisis in Rwanda is still exceptional.[8]

One spin off of this evaluation has been the establishment of the Sphere project, which sets out

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