[The following editorials were published in Medicine & Global Survival, Volume 1, 1994]

Vol. 1, No. 1—March 1994

Lest Things Fall Apart

In this inaugural issue of *Medicine and Global Survival*, we speak of secrecy and radiation, human health and toxic agents, environment and its decline, and the ever present specter of war. Disparate issues, linked by the common thread of concern and inquiry that characterizes the perspective of our audience and those who write for us. As physicians, health professionals, or analysts of public policy and society, we care deeply about reduction of suffering, preservation of life, and protection of global ecosystems. We seek to describe and understand the ways in which human activity affects the health of human beings and the biosphere we inhabit. Sadly, in this century, a very wide range of topics and questions becomes grist for our mill.

The technological enterprise of our species and its relatively unchecked growth in numbers have accelerated and rendered more complex all the familiar pervasive threats to human and biological survival: war, famine, pestilence, disaster. This ebb and flow of human existence has taken place in a context that for too long, at our current peril, we have ignored or assessed as impervious to our rapacities. For two millennia, with increasing agricultural and imperial zeal, we have been trampling our nest, crushing and polluting the world that sustains us. In this century, as our human population has exploded from 1 billion in 1900 to the 6 billion projected for the year 2000, we must face the fact that aside from a few far cold reaches, the land masses of our world are now undergoing rapid, perhaps irreversible species extinction and contamination. The oceans and seas are not far behind in this descent into loss.

There is much to learn and much to do, if the world community is to find the ideas, leadership, and motivation to head in more positive directions. Physicians and others in the health care fields are accustomed to uphill actions, and we can turn to ancient precepts and newer disciplines to guide our analysis and assessment. First, do no harm; second, attend to the environment, the source of much health and disease; and third, prevent what you cannot cure. These admonitions, the first two dating from Hippocrates, persist as fundamental tenets of the individual doctor-patient relationship, and undergird the approach that public health takes towards society. We also have recourse to other, adjacent areas of human thought and experience, developing under the recent pressure of events and the necessity of making sense of them: epidemiology, ecology, risk assessment, human rights, medical ethics, international law.

In the pages of this journal, as we struggle to understand and moderate the tumultuous and too often dark influence we exert upon the world, we hope to trace the yet unexplored terrain of our past, stay vigilant to current trends, and discern suggestions of what lies ahead. We seek evidence of the expected and unanticipated, in order to educate, warn, and if need be, intervene. Those of us steeled in the fight against nuclear war know there is no second chance, no second coming. Yet we also are aware of the dangers that lie in efforts that do not account for complexity and contradiction. To conviction and intensity, we must bring knowledge and reason, and recognize in that combination the tools of our professional trade. As advocates from different lands and cultures, we may have different views and different attitudes. But we affirm our commitment to an intellectual discipline and we must aspire to that in our discussions together. Medicine in the face of global assaults, medicine on behalf of global survival -- this work can be undertaken only with an informed heart.

Jennifer Leaning, M.D.
Editor-in-Chief

Medicine and Social Responsibility: Tradition and Task

Just over 100 years ago, in August 1892, the Hanseatic town of Hamburg experienced a severe cholera epidemic. This was the last time that Germany was afflicted with this plague.

Cholera, the disease that today terrorizes the inhabitants of shanty towns and slums of the southern hemisphere, is a modern global scourge. For centuries indigenous to the rivers of the Indian subcontinent, cholera was spread to the rest of the world at the beginning of the 19th century through colonialism and foreign trade. In Cairo, for example, 13% of the population died in the first outbreak in 1831. In the same year, cholera reached Moscow (4,500 deaths) and Vienna (2,188 deaths), and a year later it invaded England and France (18,000 deaths in Paris in 1832).

There were subsequent numerous onslaughts of the epidemic. However, people's abilities to recognize the cause of the malady and to take remedial measures against it were hindered not only by lack of knowledge and limited technical possibilities, but also, then as now, by superficiality, palliation, and self-interest. On October 7, 1836, the Augsburger Allgemeine Zeitung (Augsburg General Newspaper) wrote:

According to letters from many corners of Germany, people are, much to our surprise, under the delusion that cholera is in Munich. As a result, many visitors are being prevented from coming to Munich, accommodation for the October Festival has been cancelled, and the number of visitors at this year's festival is strikingly low. One cannot repeat often enough, therefore, that there is no trace of cholera in

Munich or in the surrounding areas and there is not the slightest reason to believe that this dreaded sickness will occur here [1].

In that same winter of 1836-1837, however, the dreaded sickness did break out in Munich and took hundreds of lives.

The last great cholera outbreak in Germany, the epidemic in Hamburg in 1892, clearly shows that then, just as it is now, this disease was a plague of the poor, and that it is political irresponsibility and economic egotism that are partly responsible for its occurrence and spread.

When Robert Koch, winner of the 1905 Nobel Prize for Medicine, toured the Hanseatic town as a government health inspector, he was appalled. "In no other city have I encountered such unhealthy living quarters, such dens of pestilence, such breeding grounds," he noted in a personal letter, dated August 25, 1892. To the senators who accompanied him as he walked through the city's slums, he said: "Gentlemen, I forget that I am in Europe." Although the financial aristocracy of Hamburg, whose wealth came from foreign trade, invested large sums of money in extending the harbour and in the newly built warehouse complex, they allowed the emergence of slums in the middle of the expanding city and they neglected the building of a hygienically sound water supply. Within a period of weeks, in the hot summer of 1892, this scandalous policy cost 8,500 people their lives.

Twenty years earlier, in 1872, at the initiative of a no less well known doctor, Rudolf Virchow, work had begun on the building of a large urban sewage system in Germany's second largest city, Berlin, work that was essentially finished by 1895. (In 1852, the British firm Fox & Crampton had been granted the rights, limited to a period of 25 years, to supply Berlin with fresh water from a central waterworks.) Because of these measures, Virchow could later state in Blatter des Darlkes fur meine Freunde (Leaflets of Thanksgiving to my Friends): "Thus Berlin has become not only one of the cleanest and most beautiful cities, but also one of the healthiest." Berlin was spared a cholera epidemic like the one in Hamburg in 1892.

Rudolf Virchow and Robert Koch were very different in their approaches to science and to politics. As is widely known, Virchow viewed Koch's research with great reserve (to put it politely) and politically they had little in common. On one point, however, their interests did meet: medicine and public health policy were always inseparable for both.

Today, when we are again living "in the time of cholera," the world sorely needs such commitment from those in leadership positions in medicine and politics. It was such commitment that led Rudolf Virchow to postulate that the doctor "should be the natural lawyer of the poor." In 1848, in a report entitled "Report on the Typhus Epidemic Prevailing in Upper Silesia," Virchow wrote:
There can no longer be any doubt that the epidemic spread of typhus is only possible under living conditions such as those caused by poverty and lack of culture

as witnessed in Upper Silesia. Remove the conditions and I am convinced that the typhus epidemic will not return [2].

"Removing the conditions," I very much hope that our new journal Medicine and Global Survival can continue this sociomedical commitment that today is often loosely denounced as utopian. Socially committed medicine, as it will be discussed in this journal, will always be pledged to the idea of preventive medicine. It can neither be indifferent to the proliferation of nuclear weapons, to the wars and civil wars by the dozen that are laying our planet to waste -- nor to the worldwide environmental destruction, which poses a danger to human health as well as to peaceful coexistence among all peoples.

It can also not ignore a world economic order with whose help a quarter of the world's population -- the rich industrial nations of the north -- seeks to protect its own prosperity and, in so doing, plunges the rest of humanity into deeper misery. It is our hope that systematic and critical reflection on the possibilities of medicine in the face of global threats to humanity and our biosphere will demonstrate to "those who believed and still believe, that medicine has nothing to do with politics, the extent of their error" [3].

Till Bastian, M.D.
Editor, German Edition

References

1. Concerning cholera. Augsberger Allgemeine Zeitung, October 7, 1836.
2. Virchow R. Notes on the typhoid epidemic prevailing in Upper Silesia [in German]. Archiv fur Pathologische Anatomic und Physiologic und fur Klinische Medizin 1849,2:143-322.
3. Virchow R. Die Offentliche Gesundheitspflege. Die Medicinische Reform, August 4,1848;1.

Vol. 1, No. 2—June 1994

Alarms Worth Heeding

In Rwanda, hundreds of thousands of people have been slaughtered in a swift frenzy that has stunned the world. The ugliness in former Yugoslavia grinds on, with scores dying daily in one part or another of that tortured terrain. Nothing is settled in Somalia and a vast swath of sub-Saharan Africa teeters on the brink of descent into bloody chaos. The religious and social schisms in North Africa, the Horn, and the Indian subcontinent are acquiring increasingly ferocious edges. In such smoldering situations, leaders make an enormous difference. Yet leaders seem very scarce these days, and even with leaders, as we know when we watch Mandela address vast crowds or Arafat head into Jericho, we may be only a heartbeat away from tumult.

We have witnessed, in the towns and cities of Bosnia, in Mogadishu, and, most recently, in Kigali, points along the spectrum of complex emergency, where human misery is laced with a pervasive and unpredictable violence that thwarts and baffles those who would render assistance from outside [1]. The debates in the United Nations, the North Atlantic Treaty Organization and the Western governments, reveal that no humanitarian interest is alone strong enough to warrant the inevitable loss of life that would attend armed intervention in a peace-making mode. Non-governmental relief organizations struggle to provide food and medicine at the margins, forced to halt efforts or to evacuate when the killing gets too close. In recent months relief workers have too often been used as hostages, raising the already high thresholds against the outside use of force. Negotiation is not working; humanitarian aid is feeding the beast; and no one wants to send in the military when both the rationale and the outcome are uncertain.

There are good arguments for and against continuing to pursue any or all of these three options. In fact, the world community is now inevitably entrained in precisely that mix of unsatisfactory discussion and action [2,3, 4]. In medicine and public health, we are familiar with the general features of this dilemma: options diminish and darken as events course down hill. It is at once too facile and inescapably important to point out, again, that intervention after the fact is less likely to prove effective than efforts in advance aimed at prevention. Too facile, because what constitutes, in the political and social arena, an adequate early warning sign? If the world won't intervene as thousands die, what would prompt it to help at the sight of lesser suffering? Inescapably important, because until we begin to address root

causes and proximal contributors we will continue to lose ground in late-pitched battles against hatreds spawned by generations of poverty, disease, deprivation, and oppression. Despite ample evidence, we continue to underestimate our species' capacity for carnage.

In the physicians movement against nuclear weapons, we knew well that the weapons were not the fundamental problem. It was because we recognized the full range of human fallibility, from error to evil, that we feared the arms we had acquired [5, 6]. As we recoil from the news of our world, we must recognize these facts as belonging to us. They belong to us because we are all human, because we have helped create the conditions for horror, and because we have wasted so much time in argument about whether and how to intervene.

The subjects discussed in this issue of the journal all connect to these deeply intractable problems of our modern existence: the grounds for social conflict; the manner in which conflict is acted out; the effects of conflict on those who must participate. Issues of scarcity and inequity have always fueled human antagonisms. Stott and O'Connell present the reasons for the fact that now, as we near the apogee of industrial expansion and population growth, control over and access to local, regional, and global ecosystems have become new motives for conflict [7]. The means, the weapons used, continue to exert an independently pivotal role in determining the extent of damage that violence can do. As Wesley and Sidel note, it is an important intermediate intervention to focus on the weapons at hand and reduce their influence. It is also crucial, if we can learn from anecdote, to present case studies of the human costs of conflict. Caught in the crossfire, and now coping with its aftermath, health workers in a Croatian hospital manage to treat war casualties in a range of ways captured by Chernack and Dressner, who, as participant observers, were allowed access over time to a drama now playing out in hospitals and war-ravaged towns all over the world.

We have not used the information abundantly available to craft sufficient warning. Nor have we prepared the audience. Warning is perceived only by those ready to deal with the consequences of knowing. It is for this reason that we have given the essay by Wing such a prominent position in this issue. We think every profession and occupation on earth must be challenged as he is challenging us: what are we doing, studying things as epiphenomena rather than searching for cause? What are we doing, fiddling while Rome burns?

Jennifer Leaning, M.D.
Editor-in-Chief

References

1. Jean F, ed. Populations in Danger. Medecins Sans Frontieres. John Libbey, London, 1992.
2. Urquhart B. Who can police the world? The New York Review of Books, May 12, 1994:29-33.

3. Renner M. Critical Juncture: The Future of Peacekeeping. Worldwatch Paper 114. Worldwatch Institute, Washington, D.C., May 1993.
4. Boutros-Ghali B. An Agenda for Peace: Preventive Diplomacy, Peacemaking and Peace-keeping. Report of the Secretary-General. United Nations, New York, January 31, 1992.
5. Abrams HL. Sources of human instability in the handling of nuclear weapons. Solomon, Frederic, and Marston, Robert Q., eds. The Medical Implications of Nuclear War. Institute of Medicine. National Academy of Sciences. National Academy Press, Washington, D.C., 1985:490-528.
6. Zuckerman S. Nuclear Illusion and Reality. Viking Press, New York, 1982.
7. Homer-Dixon TF. On the threshold: Environmental changes as causes of acute conflict. International Security 1991;16:76-116.

Epidemiology as a Subversive Activity

In this issue of *Medicine & Global Survival*, Steve Wing presents a passionate and anguished meditation on some of the deficiencies of his discipline, epidemiology. His discomfort is well founded, especially for the issue he studies, the effects of low-level radiation exposure among workers in the nuclear weapons industry on their health. He makes several points, and we were stimulated by his exposition to offer some further comments.

He faults epidemiologists for avoiding serious contention with interaction (effect modification, or seen another way, the way in which the context of effects modifies their causes): among whom, and under what conditions are causal effects stronger, or weaker, and most important, why? Wing's criticism is problematic. First, it may take uncommon insight (or luck) to predicate what interacts with what: unless we use some mindless procedure like automatic interaction detection (which more often than not produces something close to scientific garbage), the investigator has to have some idea of what to look for. In spite of this difficulty, there are many examples of just such elucidation of very important effect modifications. Some that come to mind are the multiplicative effects of radiation exposure and cigarette smoking on lung cancer among uranium miners, or the special vulnerability of emotionally fragile infants to weak maternal nurturing, or the effect of obesity on the expression of adult onset diabetes or essential hypertension. Insight and curiosity (and again, some luck) are needed to search for and to find such interactions, but examples abound.

When Wing then goes on to describe the hesitancy of epidemiologists to search for prior causes for our stock risk factors, he opens up a truly important debate. These prior causes are often the social or political or economic determinants of how and why the exposure to the biological risk factors took place. Why were those uranium miners down there in the mines being exposed? Why are some parents unable to

attend to the needs of their infants? What is it about our lives that leads us to deny or reject our needs as creatures, so that we eat too much and exercise too little? The list is, sadly, endless. Why do so many people seek solace, or numbness in cigarettes, or alcohol, or drugs? What are the root causes of the violence we perpetrate on others (see the important exposition by Wesley and Sidel on p. 67) or on our selves (smoking, or torpor, or unhealthy diet)?

However, his argument can be taken further. This avoidance is not in any way specific to epidemiology. It may be more obvious, since epidemiology, if it is to speak truth, has to do some aggressive positive avoidance not to consider the social and political context in which disease occurs. The problems of avoiding context, of not seeking prior causes, and of not challenging near mythic prior assumptions are not confined to epidemiology; rather they are endemic to the whole scientific enterprise. Uncomfortable truths are avoided.

Uncomfortable to whom? Surely, we scientists reflect the culture in which we are embedded, including the subset who call themselves epidemiologists, and it will take perseverance, and courage to contend with the problems that follow our limitations. However, the problem is not just our personal failings. Most of us are strongly acculturated (very much parallel to being properly toilet trained) to avoid trouble. But trouble from whom? If we attempt to practice a richer and more searching epidemiology we may not find our efforts welcomed; quite the contrary, there are some very concrete agents of the status quo. And some of the strongest, and most immediate agents (there are always yet more proximate causes) are those who are paying for the research, most often in our society, industry, and government. We now know of Phillip Morris' suppression of its own scientists' work on the addictive properties of nicotine [1]. There are many examples of similar suppression or distortion in Wing's own field of radiation effects, where the government (or its contractors) has removed epidemiologists from their data, or fired them, or pressured them to fiddle their results and interpretations when they tried to transmit to the rest of us what they found their data to say [2].

Such illegitimate pressure is widespread, and not confined to any one issue or government agency. Wilshire [3] after his own sad experience of a government agency caring so much about getting the "right" results that truth was to be easily and readily sacrificed, began an illuminating collection of such episodes. His collection is neither exhaustive nor systematic, and is certainly incomplete, but is chilling nevertheless. Such pressures are probably pervasive, and are very likely a greater barrier to truth than the relatively uncommon examples of scientists cooking their data. We, and U.S. congressman Dingell, seem to have great fascination, and an easy time morally condemning those individual scientists who cheat, while not challenging a system that cheats us all.

There are no pat or easy solutions. Neither revolution nor semi-religious conversion experiences will bring about lasting, beneficial change. It helps to have multiple sources of funding: whatever their limitations, our society is better off having

foundations and citizens groups as alternative sources for funding scientific research. We should promote tax laws that favor such alternative funding sources. Peer review is flawed, but it is infinitely preferable to contract letting by a few executive branch scientific (and not so scientific) bureaucrats. One concrete help would be to develop communities of like minded scientists to support each other intellectually and spiritually, to foster individual insight and courage, to better challenge the agencies of stasis and limitation. One path is that we should be better as individuals. We could be, but we need to help each other to do so.

Are there other ideas lurking out there among our readership?

David Rush, M.D.
Associate Editor
Boston

References
1. Hilt P. New York Times. April 29, 1994:1.
2. Geiger HJ, Rush D. Dead reckoning. Washington DC, Physicians for Social Responsibility 1992.
3. Wilshire HG. Dissemination of scientific information obtained by government scientists. American Chemical Society. Research Ethics, Manuscript Review, and Journal Quality. Madison, WI, ACS 1992.

Bridging the North-South Divide: Are We Up to the Task?

I am an idealist at heart. Yet I feel I must caution my colleagues about the way forward within the reality of the world today. It is not as we wish to perceive it: that people mean well; that they wish to work out a common global solution; that they really desire to change their own lifestyles and consumption patterns; or that they wish to work in truly equitable partnership with people from the South to achieve global solutions to global problems.

From the United Nations, the World Health Organization, the International Monetary Fund, and the World Bank, to international non-governmental agencies such as CARE and Save the Children, and even in local governments in the developing world, "the system" pervades everything. The "system" is about power relationships -- power relationships grounded in economic imbalances. The world has been and will continue to be at war within nations and between nations, within one group and between groups, within individuals and between individuals, due to imbalances in power relationships. That war could last millennia.

The war has pitted man against woman in domestic violence, the Israelis against the Palestinians, the White South Africans against Black South Africans, the former

Soviet Union against the United States, expatriates against local human resources in international NGOs, and the "elite" against the working class in transnational corporations as well as in governments everywhere. As the groups involved become larger, economic imbalances among and between them play a significant role in causing violence to sprout.

Researchers, academicians, and policymakers from the so-called developing world lack unedited or uncensored information from -- or facilitated by -- the developed world. They then lack the ability to debate and communicate among themselves, in order to make their own conclusions and to present solutions to their problems in the first instance, and then to play a role in securing global survival.

Instead, in frustration, we rumble like thunder before a storm at the "North" or at each other. People of the West patronize or push aside issues that they should try to understand, outside of their own self interest (e.g., to be the first reporter to document atrocities in Somalia, to be the first to speak about the debt burden, to live a life of expatriate luxury among the squalid tenements of third world cities without blinking an eye, or else to live safely and securely in the developed world). We stand at that point in time in global history where three very significant illnesses pervade our societies:

* Violence, both domestic and international, where the dominant underlying factor is socioeconomic and pertains to the maldistribution of resources;
* Development, as it incorporates the international economic crisis with its spectrum of manifestations such as the growing recession and worldwide unemployment, interwoven with the debt crisis in much of the developing world that labors under the stringent conditions of structural adjustment;
* And last, but not in any way least, the environmental crisis that exhibits itself in the heaving earth that struggles to accommodate the bulging, inequitably resourced populations in both the wasteful industrialized countries and the predominantly rural developing countries.

To address these crises, there must be collective action from all corners of the globe in an unprecedented analytical effort -- an effort I believe is at the heart of *Medicine & Global Survival's* mission. There has to be qualitative and quantitative support and constructive criticism of research and views presented by writers from the North as well as from the South. An international perspective has to be maintained and constructive criticism sustained without sweeping generalizations in order for our material to be applicable and palatable to our new international audience. This journal should seek, in the history and tradition of the British Medical Journal, to be distributed and sought after in faraway lands. The task will not be easy, but my pessimism about past global endeavors is buried in my optimism for the future role our journal can play.

Let all health professionals across the North-South divide that exists within and between our communities in the developed and developing world not delude

ourselves. This change in outlook, which is just as inevitable as the dawn of the civil rights movement in the United States, the fall of communism in eastern Europe, and the dismantling of apartheid in South Africa, is one in which we must participate. Or are we too comfortable in our consumptive lifestyles, or too caught up treating the spiral of disease and poverty that threatens to swallow us as it churns out ever increasing numbers of patients?

Our research and debate needs to get out to the people in the developed and the developing world who need information in order to demand change, and in order to argue collectively and coherently along with us to influence policy makers. Dissemination requires not only the use of the popular media, but also participation in seminars, workshops, and small group discussions throughout communities, most especially in the developing world. *Medicine & Global Survival* is just one very important vehicle that will bring about change. The challenges are enormous. But all of us, together, are up to the task.

Angela Wakhweya, M.B.Ch.B., MSc.Econ.(HPF)
Associate Editor
Kampala

Vol. 1, No. 3—September 1994

The Bell Tolls

In this issue and the next we take up the multi-faceted topic of humanitarian intervention in the setting of regional or international conflict. Here the discourses of public health, humanitarian relief, human rights, international politics, and military strategy must mingle. Some definitions and distinctions are needed, if only to highlight what is still unclear.

Complex Humanitarian Emergency

The term "complex humanitarian emergency" has come into recent use to mean a crisis in life support and security that threatens a large civilian population with suffering and death and imposes severe constraints upon those who would seek to offer help. At its core is a synergistic mixture of human disaster and undisciplined conflict -- a mix that hamstrings and stifles attempts to restore order and safety and then provide, in that order and safety, some semblance of solace to noncombatant men, women, and children.

The term has been applied to the Kurdistan exodus after the Gulf War, to the ongoing strife in the former Yugoslavia, to the unresolved turmoil in Somalia, and now to the evolving catastrophe within and abutting Rwanda. When the press presents the case, the term clearly applies as well to the bitter civil war in the Sudan, and to the simmering cauldron in Haiti.

One could easily ask why such a term has only recently appeared, since the generic concept would appear to apply to countless situations stretching back over the centuries. There is both a normative and a practical explanation.

A general public recognition that there is something wrong about widespread civilian suffering during war and conflict is a relative latecomer to the list of international norms. Only after the cumulative experience of World War II did the international community draft and put into force the Fourth Geneva Convention (1949), which proscribes most of the terrible actions against civilians we see at work in war (1).The day-to-day efficacy of this Convention is (as with all legal documents) dependent upon the extent to which it is deemed applicable in a given situation and the extent to which it is enforced.

The practical response is that in all major wars of this century there has been civilian suffering of vast magnitude, but it was always eclipsed, in terms of international attention, by the overriding objectives of the military campaigns. Wars have been about victory, not suffering, and the world has grown used to that fact. The term "complex humanitarian emergency" can really only be usefully employed in settings that are not wholescale outright war, and in settings where the alignment of the great powers does not obstruct press access or make the thought of intervention preposterous. (Stalin's gulag, for example.)

These conditions have evolved only since 1990, with the waning of the Cold War, and it is only in this period that the term "complex humanitarian emergency" has begun to acquire currency. The weakening of the rigid and artificial allegiances imposed by superpower rivalries has permitted the rekindling of long-festering and unresolved conflicts -- regional and intranational, communal and ethnic -- in virtually all parts of the world. Also, the end to the division of the world into enemy and friend has allowed nations, as well as international relief agencies, a new freedom to bear witness and offer humanitarian assistance on behalf of suffering peoples anywhere, according to criteria that suddenly have little or nothing to do with superpower politics.

From this perspective, the fact that we can now speak of complex humanitarian emergencies represents a remarkable breakthrough in international consciousness and international opportunity. However, wherever we find this term to apply, we see that policy has not caught up with impulse. In this new world, there is little coherence and no leadership in the present structures and alliances, there is no consensus on strategic parameters to guide decisions on thresholds for intervention, and the logistics to support such intervention have not been developed.

Military Support of Humanitarian Intervention

The customary definition of military intervention is the use of the military to wage war. Such intervention has ancient traditions and is well under stood. One can argue for or against such intervention, but that is not what is under discussion here. When we speak of military intervention in the context of humanitarian assistance, we refer to one of two distinctly different activities: intervention to provide logistic support; or intervention to create secure conditions, such as safe corridors, through which humanitarian aid may flow. Both of these interventions bring the international community into new territory, and require the UN and relief agencies to develop with military forces an expanded set of definitions regarding mission and rules of engagement. Until such work is done we will continue to swing in cycles of expensive futility and recrimination, as we are now doing with Somalia, former Yugoslavia, and Rwanda.

We know how to use the military to kill people and win battles. We do not yet fully know how to put the military's formidable logistic capacities to best use in the face of overwhelming population distress, but we are learning (the 1991 relief of the Iraqi Kurds; the 1991 response to the Bangladesh cyclone; the current deployment in the Rwandan refugee camps in Zaire). We have made little progress at all in defining the military's role in creating secure conditions: peace-keeping where violence is not restrained becomes a farce, yet what does peace making actually entail? How does the military use force to save lives, rather than take them?

Sanctions and Trials

Two stalwart methods employed in the old world of international diplomacy (prior to 1990) may need substantial re-examination and re-definition. Sanctions have been used repeatedly, with arguable effect, as the method short of war to compel certain behaviors from a renegade state. Seen through the lens of complex humanitarian emergencies, however, sanctions are unquestionably very blunt instruments that may disproportionately burden the civilian populace, rather than their putative targets, the ruling political or military elites. We need to draw some further distinctions. How can sanctions be designed so as to affect most harshly those who are in power? How can the provision of essential life support systems be assured? At what point of general privation should sanctions be lifted and an alternative method employed?

In terms of trials, it is clear that complex humanitarian emergencies do not just happen. Warring factions create the conflict and, to a large extent, determine the level of carnage or suffering that results. It is not only understandable but essential that the international community hold responsible those who in the process of inflicting grave injury on society have acted in violation of international law. Without accountability there can be no justice, and without justice, peace is very unstable.

There is no accessible tradition to turn to, however, when we move to design the structure that will deter mine accountability in settings like the former Yugoslavia or Rwanda. The War Crimes Trials at Nuremberg and Tokyo were conducted by the victors against the vanquished, a feature that assured their completion, but since then has hampered their standing as precedent in the eyes of many people and cultures [1,2]. Proceedings of some kind are certainly warranted against those who have now committed war crimes in Central Europe and in Central Africa, but it is at the moment unclear what format they should take, who will underwrite the expense, and who has the authority on the ground to ensure that evidence is gathered and suspects rounded up. The difficulties are enormous but the moral stakes are very high.

Next Steps

The international community must give substance and definition to its obligation to act in response to complex humanitarian emergencies; must resolve the existing ambiguities that attend current military support of humanitarian intervention; and must refine its capacity to restrain despots and assign accountability. Absent these advances in definition and policy, we are destined to a future where at best we spend increasingly vast sums mopping up the blood spilled by murderous regimes.

Jennifer Leaning, M.D.
Editor-in-Chief

Footnote
1. The First and Second Protocols to the Geneva Conventions, published in 1977, expand upon these protections.

References
1. De Lupis ID. The law of war. LSE Monographs on International Studies. Cambridge: Cambridge University Press. 1987:352-353
2. Hosoya C, Ando N, Onuma Y, Minear R, eds. The Tokyo war crimes trials: an international symposium. Tokyo: Kodansha, Ltd. 1986.

The Fatal Urge to Intervene

The Catholic writer Lactantius (actually Lucius Caecilius Firminianus, 250-317) was sent to teach rhetoric in Nicomedia by the Roman emperor Diocletian. Because of his conversion to Christianity, however, Lactantius was forced to leave and to live in oppressive poverty. In his work Institutiones Divinae, written in this situation, he argues that one who makes a glass does not do so in order to give the impression that something has been done ("ut tantum fecisse videatur"), but so that the glass can be filled. Since then, this saying -- "so that at least something is done" -- has become familiar around the world.

In my lectures I often cite this sentence (Uut aliquid fieri videatur" or, in short, "ut aliquid fiat") as an example of the urge to intervene, born of impotence and helplessness. This urge causes us to resort to questionable and often desperate means, rather than remain inactive. The psychoanalyst Leon Wurmser spoke of the "change over from the passive to the active" [1]. When among doctors, I usually mention by way of illustration that about half the infusions given in clinics, as far as I can tell, are administered according to this law -- i.e., not because they are therapeutically necessary, but in order to give the patient the feeling that something important is happening and to keep the patient in bed. In discussion, the other doctors often correct me, saying "Why only 50%? Is it not at least two-thirds?"

So that something occurs... Doctors take up the fight against sickness and death in the interest of the patient (officially speaking). We know that in the end we can only lose (although we too often ignore that fact); death holds all the cards, death calls the shots, death has patience. We are impatient; we want quick success and we prefer action to passive suffering. Doctors tend toward activism -- medical sociology has pointed out that we avoid incurably ill people for whom "nothing more can be done." This may be because we suffer from an above-average fear of death and below average health (as we all know, doctors make the worst patients).

This activism often has bizarre consequences. At a symposium in April of this year, the philosopher Rainer Otte cited the case of a 77-year-old patient known to have only 100 days left to live at the time of admittance to the clinic, and who, in this timeframe, underwent 56 x-rays, three computer tomographies, and a number of gastroscopies. The upshot of this, Otte said, is that "Due to massive employment of technology, medical care has lost its human dimension."

As far as the evils of the world are concerned, activism -- coupled with an extraordinary day-to-day lethargy -- rules. A tendency toward military intervention takes the place of medical technology. Military strategists talked of "surgical operations" (i.e., air strikes) during the Gulf War. Everyone knows that the world has not become more peaceful since the end of the Cold War, which was so ceremoniously proclaimed at the Paris Conference on Security and Cooperation in Europe in November 1990. On the contrary, unrest, revolt, war, and civil war all demand their pound of flesh. This is hardly surprising in a world of poverty and exploitation, progressive environmental destruction, and an increasing cleft between North and South (which is the same as saying rich and poor).

But how is this to be remedied? Through the agenda proposed at the mammoth -- and almost forgotten -- Earth Summit in Rio de Janeiro in 1992? By the creation of a just world economic order? Wrong! Instead there is talk of military intervention "ut aliquid fiat"...so that something is done, or at least appears to be done. A disastrous UN military operation in Somalia has already cost $1.5 billion -- approximately twice the country's gross national product. UN Deputy General Secretary Eliasson, who has since resigned his post, announced in bitter undertones that the UN had put up a tenth of this amount -- $166 million -- for humanitarian aid, which was supposed to be the reason for this dubious enterprise in the first place. On top of this, 21 medical and humanitarian aid organisations working in Somalia warned in an open letter that the UNOSOM mission, which had turned into a military action, would only hinder effective long-term aid [2].

The spirit of intervention, achieving peace through military means, is misleading. Has it already been forgotten that neither the U.S. in Vietnam nor the Soviet Union in Afghanistan was able to "enforce" peace with violence? Military intervention in current violent conflicts, which are often at least partly due to accelerating environmental destruction from drought, desertification, and migration, is hopeless

for practical reasons. There are no longer clear enemy fronts, no separation between the war zone and behind the lines; there is more often only a chaotic "everyone against everyone else" environment. As is clear in the former Yugoslavia, this not only makes diplomatic peacemaking difficult, but also cuts the ground from under military intervention. The problems of the world are often imperceptibly linked and knotted. They do not, however, constitute a Gordian knot that can be untied with the blow of a sword.

Of course, no one wants to deny that there are some situations where some kind of intervention -- whether medical or political -- is valuable (e.g., in certain medical circumstances an intravenous infusion can be extremely helpful). But that is not the problem. The problem is that we have to confront an ideology of interventionism ("so that something should be seen to be done"), because if we don't, military intervention will more and more often take the place of political prevention. That happened in Somalia and will probably happen quite soon in Haiti, and with what result?

The ideology of interventionism has its psychological benefits: instead of changing our own attitudes and behaviour (overconsumption, abuse of resources, international trading in arms) we prefer to manipulate others, claiming it is for their own benefit. But that activist attitude of our present civilisation has always provided an easy way of denying urgent problems. For the most urgent of these problems there is no cure, only prevention.

Never were prevention and prophylaxis so essential and important as they are today and never have they been so undervalued. This paradox is founded in power politics and social psychology and is closely connected with the current world economic order. In the long term, this order will prove to be a weapon of mass destruction far more dangerous than any explosive device. There is still time to work against it -- time to avoid the worst. The best comment on this was written more than 2000 years ago by Laotse:

What is still small can be easily diffused,
One must work on what is not yet there,
Organize what is not yet confused.
(Laotse, Tao te ching, 64th poem)

Till Bastian, M.D
Editor, German edition

Reference

1. Wurmser L. The mask of shame. Baltimore: Johns Hopkins University Press. 1981.
Aid organizations condemn military action in Somalia. Suddeutsche Zeitung. July 15,1993.

Vol. 1, No. 4—December 1994

Complex Emergencies: Dilemmas and Challenges

The articles in this and the previous issue of *M&GS* are part of a critically important and long overdue inquiry into one of the most significant yet disturbing health phenomena of our contemporary world. They address the tragic human survival crises taking place around the world, in countries as diverse as Bosnia, Rwanda, and Cambodia. In the five years following the collapse of the East-West nuclear confrontation, millions of people in more than 30 countries have been subjected to organized violence resulting in callous destruction of human life, unparalleled human suffering, and human degradation in seemingly senseless medical crises around the world.

A new term -- "complex humanitarian emergency" -- has been coined to capture the multidimensional nature of these crises. The paper by Bok describes both the apparent and more subtle meanings of this new term. Does new nomenclature suggest a fresh phenomenon, or are these crises the same as the multitude of man-made disasters associated with war and conflict that have characterized human history?

Certainly the human toll of war and conflict is not new; nor is genocide; nor is the targeting of civilian populations in warfare. In World War II, genocide against Jews by the Nazis and the indiscriminate bombing of cities such as Dresden and London were accompanied by the massive loss of human life. Some have argued that during the 45 years of the Cold War, the struggle between East and West led to superpower suppression of conflicts in client states; with these motivations gone, long-standing tensions such as ethnic antagonism, have been allowed to flare without control. There is, however, contrary evidence that even during the Cold War, the apparent calm was due more to the suppression of information than to the absence of human crisis. Only decades later did we learn that 20-40 million Chinese perished during the 1959-61 famine exacerbated by Mao's Great Leap Forward in China.

Despite these past horrors, contemporary "complex humanitarian emergencies" possess several fundamentally new attributes. As vividly demonstrated by the crises described in this issue and its predecessor, the term "complex" is useful because it reflects our very feeble understanding of causes characterized by interacting forces

-- political, ethnic and religious, economic, ethical, and humanitarian. The idea of complexity also captures well the agenda and institutional response systems of the international community. International interventions usually have multiple objectives -- humanitarian, human rights, nation building, and often geopolitical interests. And the many organizations -- United Nations, non governmental organizations, and diverse national governments -- established to address more traditional Cold War problems are faced with entirely new institutional challenges. Moreover, the international media now have unprecedented access to these crises and their reporting has reached a previously unheard of scale. Hardly any tragedy in even the most remote corner of the world escapes the possibility of appearing on newspaper headlines or being projected onto TV screens in millions of homes. (Whether the media actually pays attention to a particular humanitarian crisis, as pointed out by Russbach and Fink, and by Bok, can also play a determining role in the level and quality of international response.) Unlike the Chinese famine, contemporary tragedies have become public events, open to the conscience of the world community.

For the health field, complex emergencies not only call forth traditional scientific and professional roles, they also pose new dilemmas and present fresh challenges. The technical basis of emergency medical relief is well established. Refugees and civilians trapped in conflict require basic provisioning of food, water, sanitation, infectious disease control, and primary health care for human survival. These material requirements are compounded by the need for care and management of mental distress and psychosocial trauma of victims.

The application of technical requirements to real-world situations is far from simple, however. As described by Russbach and Fink, Toole, and Marks based upon the respective experiences of the International Committee of the Red Cross, the U.S. Centers for Disease Control and Prevention, and the UN -- the scale and nature of the affected populations are rapidly changing. In addition to an unprecedented number of refugees who cross international borders, many more are displaced and dislocated within national boundaries, because most recent conflicts have been intra-national rather than between nation states. Moreover, in many complex emergencies, such as Cambodia and Haiti, epidemiological studies are showing that those trapped in their own homes may represent an even greater proportion of the vulnerable, who correspondingly absorb a major share of humanitarian insults and human rights abuses. The health challenge, thus, is less what to do than how to do it, given real-world situations.

Finally, it is becoming increasingly obvious that no curative or emergency relief approach can fully meet the scale, rapidity, and complexity of contemporary emergencies. Surely, the way ahead is through prevention and preparedness -- how to prevent such tragedies and how to improve preparedness for future eventualities. Prevention requires an understanding of the basic causes of crisis and an effective system of early detection and amelioration of underlying causes before conflict is

ignited. Preparedness requires not simply the technical know-how, but the political commitment, the institutional capacity, and economic resources for effective action.

Unlike natural disasters, these crises are partly man-made, caused by political failings that result in a vicious spiral of organized violence. Therefore, all peaceful paths to mutual accommodation should be promoted before tensions escalate -- cultural pluralism, border revision, non-violent succession, federation or confederation, and regional autonomy. Negotiations will require governmental leadership and facilitation by the international community. Falk suggests that "bottom up" forces of international civil society should also be mobilized.

The health professions should not leave the playing field to politicians, statespersons, or political scientists and professors of international relations. Public health experiences in disaster and famine prevention are relevant, and should be adapted to complex emergencies. Through epidemiological and human rights assessments, the international community can be informed about the early signs of humanitarian and human rights deterioration. As the profession charged with protecting health, our expressions of solidarity with and advocacy for health-promoting actions can add weight to the promotion of human security during and before crises. Allies would be many in the general public who are more engaged than ever and plainly intolerant of preventable human tragedy. Health can operate as a unifying force for mobilizing the will of the public and their governments more effectively to prevent and respond to complex humanitarian emergencies in our new world.

Lincoln Chen, M.D.
Cambridge, MA