



## The Diplomat/Physician In the Emerging International System

Louis M. Marmon, MD, PhD, Christopher M. Seniw, BA, and Allan E. Goodman, MPA, PhD

The contribution of physicians to the making of national foreign policy and the practice of diplomacy itself promises to be substantially different in the post-Cold War era than the limited technical and advisory role played during such events as the famine in the Sahel during the 1970s or in the aftermath of the disaster at Chernobyl in 1986. The purpose of this article is to call attention to the need for a new breed of physician as well as diplomat, and for greater interdisciplinary innovation in the training each gets. Already, diplomats of every nation are practicing their craft in an age of intellectual, technological, geographic, and political upheaval. The emerging international system defies labels and its power structure remains fluid, often leading to problems that do not have states or national policies as their sources. For example, forces as diverse as fiercely separatist ethnic groups, multinational corporations, economic

actors in trade zones that may be sub-national but that are linked internationally, and public health issues such as AIDS and population growth, can have as great an impact on modern diplomacy and foreign policy as the decisions of any political or legislative body [1]. Consequently, physicians will be called on to do more than volunteer during disasters. Their expertise will be required to determine and design policy as the public health issues with which doctors as well as diplomats deal increasingly command the attention of the foreign policy establishment of many countries.

### AIDS as a Paradigm Example of the New Requirements

The movement of contagious illnesses across international borders and between continents has been greatly facilitated by the end of the Cold War and advances in communications and transportation. Fueled by trade, regional integration, and the substantial increase in refugees and migrant populations fleeing ethnic conflicts and civil wars, disease travels almost as easily as the international business executive. The evolution of low-cost, mass transportation -- improved roads and canals, railroad networks traversing Europe, Eastern Asia and North America along with maritime and air services linking all continents -- coupled to the political tendency to make leaving and entering most countries less restricted than ever before have allowed many deadly diseases to spread

*At the time of publication LMM was Director of Pediatric Surgery, The Pediatric Health care Center, Shady Grove Adventist Hospital, Rockville, MD USA; \*\* CMS was a graduate student in the Georgetown University School of Foreign Service and at the Georgetown University School of Medicine, working for Project Hope in Moscow; \*\*\* AEG was Associate Dean and Director of the Graduate Division, School of Foreign Service, Georgetown University, Washington, DC USA.*

© Copyright 1994 Medicine and Global Survival

rapidly. The virtually global diffusion of drug resistant strains of malaria and other parasites from the Asian and African tropics, of influenza viruses originating in China, of lethal staphylococcus bacteria, and of the several HIV types provide a graphic illustration of how such interconnections can result in major threats to public health in many different countries, regardless of the level of wealth or the availability of advanced technology and medicines for particular populations. [2] Like the Black Death of the 14th century, AIDS has surmounted all political and geographic boundaries. Yet, the search for methods to control AIDS and to discover its source has exacerbated already strained relations among certain countries. Efforts by Western researchers to ascribe the origin of the human immunodeficiency virus (HIV) to Africa have been denounced, for example, as some political leaders argue that research findings perpetuate racially motivated stereotypes. Regional and ethnic group relations have suffered due to the finding that some populations may be especially vulnerable to the HIV. [3]

While AIDS is still a smaller cause of death in terms of actual numbers when compared to other diseases such as cancer or heart disease, the specter of a global and perhaps incurable epidemic may soon require governments to rethink immigration and other national policies affecting the freedom to travel, the right to privacy, and the need to protect society from exposure to a deadly disease. For centuries, the reflex response to plague and pestilence has been to bar strangers from the city gates. Although today blood tests for antibodies to HIV could replace the obstacles of the past, the HIV-infected traveler can still travel freely to many areas. One of the authors, for example, has recently travelled throughout East and South East Asia where even communist and socialist governments with highly restrictive and cumbersome immigration policies and procedures manifest little interest in determining who might be entering the country HIV-positive. Although still not an issue of security in the classic sense in which this term is used in international relations, moreover, AIDS will soon force many countries to consider HIV as an agent which can cause regional economic and political destabilization. Especially in newly formed and rapidly developing countries, some economic and political elites may be decimated by AIDS-related illnesses and in other states maintaining national defense will become impossible due to the devastating impact of disease on military manpower and troops readiness. [4] Determining the right policies to deal with the social and regional impact of AIDS in

such circumstances will demand a blend of medical and political judgments that, given their present training, neither doctors nor diplomats can effectively make.

The economic implications of AIDS also take the diplomat/physician into uncharted territory. In the "developed" world AIDS patients are a major source of health care expenditures and these costs are only projected to get worse. In many developing countries, the economics of AIDS usually means that HIV-positive patients get no treatment at all. In Africa the very existence of the extended family, which tradition ally has been the safety net for sick or unemployed family members, is now threatened as many of the members who support the extended family, i.e. the 15 to 64-year-old age group, are now becoming afflicted with AIDS. Who will support all of the orphaned children (many of whom are HIV positive themselves) when their mothers die from AIDS? The extended family? The government? International public health programs? Combined with these problems is the impact of loss of tourism that may occur as xenophobia and fear of HIV infection rise. This can only exacerbate economic difficulties -- and prevent an effective response to the vectors of the disease -- in those nations that depend largely on tourism dollars to keep the country afloat. In Thailand, where AIDS is rampant, recent social science surveys indicate that three-quarters of the urban male population visit a prostitute each week and tourist literature features "Sex Holidays" as well as tips for foreigners on how to arrange for "sexual services." Government health officials have supported only mild warnings for visitors to "take appropriate precautions." Thai prostitutes are urged, moreover, only to insist on the use of condoms when having intercourse with foreigners, since the belief is widespread that AIDS is a disease not transmitted among Thai people. [5]

The problems of how best to contain world population growth and deal with expanding energy consumption are further instances of the intersection of medicine and public policy in the international forum. The development of programs for birth control, women's health, and family planning are often at odds with local governmental policy and cultural bias. Economic pressures, environmental policies, and development efforts are often in conflict, within one state, within a region, or between the first and the third world.

The economic implications of world health issues directly affect the ability of the medical community to treat as well as prevent major health problems, the roots of which are in social or environmental stress.

As the health problems of the future and their myriad ramifications become every country's domestic priority, any approach to these concerns must be coordinated and executed at an international level in order to be effective. The political and medical difficulties involved in responding to the multiple threats AIDS poses to society can be seen as examples of common issues that arise in responding to other pressing international health concerns, such as revamping the health care system in the countries of the former Soviet Union or creating such a system in countries where the international community has taken on nation-building responsibilities such as in Somalia. It is evident, from this perspective, that physicians will be necessary to an adequate decision-making process in the development of foreign policy and that to be truly useful they will need to be as well educated as diplomats about the business, cultural, economic, political, and bureaucratic implications of the situations they are addressing. An appreciation of non-medical issues would also significantly improve the ability of medical personnel to coordinate and supervise international health and relief efforts.

### **The Role and Training of the Physician-Diplomat**

A physician does not have to be a diplomat per se in order to care for sick children in a United Nations refugee camp. But if he or she seeks to develop a plan to deal with refugees in camps in neighboring countries and to make such a project viable in the midst of possible ethnic, governmental, and international pressures, having had training in international relations will confer a distinct advantage. Likewise, a diplomat or medical aid coordinator does not have to be a physician in order to negotiate and administer an aid project, but to be able to determine the soundness of proposed medical aid projects or to evaluate conflicting research findings, medical training will be of significant benefit to any modern foreign ministry.

A physician who is trained in international relations and who understands the complex nature of dealing with different organizations, cultures, and governments can more effectively communicate the medical issues and participate on a more equal level with the administrators of health programs. Thus, the diplomat/physician would not have to receive "on the job" training but would be able to participate from the outset in all aspects of a cooperative effort from planning to implementation. Such doctor/diplomats would have the knowledge of different cultures and ethnic groups

in order to better deal with problems that may arise when instituting an effort to address an international health problem. These specialists would be able to work for governments, international health efforts, or bodies such as the United Nations. They could fill any number of positions in the management structure or be on site participating with relief efforts. Having skills in both arenas makes the diplomat/physician a valuable asset for organizations actively involved in international health care issues.

How can the training of physicians to be diplomats who can move between both the medical and foreign affairs communities best be accomplished? The traditional route has been for physicians to acquire a graduate degree in public health. Many doctors already gain substantial experience, without any formal training, through their work as volunteers or on staff with private international health and relief organizations. We foresee a world whose problems, however, now call for more than this type of training or experience provides. To acquire a knowledge base in diplomacy, foreign language, international business and economics, and foreign policy decision making we think at least a small number of physicians should undertake joint degrees in medicine and international affairs. In the United States, this could be accomplished by entry into any of the Schools affiliated with the Association of Professional Schools of International Affairs (APSIA). Presently 15 graduate schools are part of APSIA [6] and all are part of university systems that contain medical schools or where links could be established with nearby medical institutions. The APSIA schools have been offering joint degrees in law, business, and social science disciplines for nearly twenty years. Only one (at Harvard University) has a joint MD-Public Policy degree program in which a handful of students participate. The scarcity of such programs in the international affairs field generally is due, in part, to the absence of cognate courses taken in one degree that could count for credit toward the other. One of the authors has designed his own "joint" degree by taking leave after completing the second year of medical school, enrolling in the graduate program of the Georgetown School of Foreign Service, and developing a schedule to enable all the courses required for both degrees to be taken over a five-and-a-half year period. We think, however, that such programs should be institutionalized and organized to provide greater integration. The way to solve the problem of the absence of cognate courses in international affairs for medical students is to develop a five year MD/International Affairs program

that allows joint degree candidates to spend an academic year doing course work in international affairs. Candidates would thereafter write a mini-thesis on some aspect of the nexus between health and international relations issues, under the close and joint supervision of a faculty advisor from each campus, in order to earn the remaining credits needed for the international affairs degree. This is not to suggest that a master's degree in international affairs should supplant a degree in public health, but rather that the problems already manifest in the emerging international system now also require doctors to work and, especially, think as diplomats.

While nothing can replace experience gained over time, an individual trained formally in both medicine and international affairs would acquire a core of knowledge, ideas, and skills that would provide a rigorous basis for further learning from actual experience in the field. As international health education specialists are increasingly finding for themselves, "any further elaboration of international health [as a field of study] may require a closer association with international relations." [7] By combining the knowledge of diplomacy and medicine the physician/diplomat can be a vital contributor to the solutions of international health problems.



7. Godue C. International health: A north-south debate. Washington, DC: Pan American Health Organization. 1992.

## References

1. For a survey of recent trends and a forecast of how they are changing the nature of international relations, see Goodman AE. A brief history of the future. Boulder: Westview Press. 1993.
2. Shannon GW, Pyle GF, Bashshur RL. The geography of AIDS: Origins and course of an epidemic. New York: The Guilford Press. 1991.
3. Sabatier R. Blaming others: Prejudice, race, and worldwide AIDS. Philadelphia: New Society Publishers. 1988.
4. Hamilton KA. HIV and AIDS in foreign policy. *The Washington Quarterly*. 1994;Z01-215.
5. Interviews by Professor Goodman with Thai Foreign Ministry officials and university specialists, February 1994. Quotations taken from Tourism Ministry information leaflets and guide books available at Don Muang International Airport, Bangkok.
6. The APSIA graduate schools are located at the following: The American University; University of California, San Diego; Columbia University; University of Denver; Georgetown University; The George Washington University; Harvard University; The Johns Hopkins University; University of Maryland, College Park; University of Pittsburgh; Princeton University; University of Southern California; Tufts University; University of Washington; Yale University.