The Future of the Global Physicians Movement

Jonathan M. Mann, MD, MPH

Paradoxically during the past decade, at the same time that the public image of physicians has been suffering in many countries, doctors have become important symbols of new global thinking. International Physicians for the Prevention of Nuclear War (IPPNW) and Médecins sans Frontières (known, along with Doctors for the World, as the "French doctors" movement) have actively pioneered and articulated a new global ethic for physicians and other health workers. IPPNW has demonstrated the tremendous power and influence that physicians united across borders can potentially command. The "French doctors" have placed action -- the relief of suffering -- above national borders and political considerations, thereby helping to revitalize the meaning of humanism in medicine. Both movements have required considerable courage, for they have challenged the status quo that embedded the physician so firmly within a national or administrative or organizational context. And both movements have required action -- action that liberated physicians by plunging them into unfamiliar situations and considerable controversy.

Now, in turning from the past towards the future, we should first paraphrase Sir Issac Newton, who stated that we can all see as far as we can today because we stand on the shoulders of the giants who preceded us. So with the international physicians movement: the Lowns and Kouchners -- to use one from each movement to represent many -- have brought us to this place and time, to be able to reflect now on a future so influenced by a collective history, shaped by their inspiration.

Each of these leaders -- true to their own ideals and with courage and considerable charisma -- would urge us now to challenge and then to break with the status quo of the very movements they helped to create. Not for the sake of change, but to ensure that organizations and institutions, with their weight and momentum, do not inadvertently crush or muffle the creative aspirations that have emerged precisely because the movement created the space within which such energies could emerge and flourish.

Change Through Self-Evaluation

Yet how, and in what directions, might the international physicians movement now change? How could a course into the future be charted? These questions might best be approached -- not by listing important global health issues and selecting from among them -- but rather by considering the central ethos and values which may distinguish the special and even unique nature of an international movement of physicians.

This process of self-definition and self-

Before his tragic death in 1998, JMM was François-Xavier Bagnoud Professor of Health and Human Rights, Professor of Epidemiology and International Health, Harvard School of Public Health, Boston, MA, USA. *This article was based on the author's keynote address to the 12th World Congress of International Physicians for the Prevention of Nuclear War on 25 July 1996.*

awareness is critical, since how an issue is defined -- how a situation is perceived or an identity articulated -- determines what will be done. Indeed, definitions predetermine the scope and shape of the possible, and the description of a movement contains within it, explicitly and unspoken, a belief about what should and can be done.

Four central elements may be proposed in working towards a definition of an international physicians movement.

* First, it is a movement of physicians, which itself raises several key issues.
* Second, the movement acts at the societal level, rather than at the traditional medical level of individual patients.
* Third, it seeks to promote and protect health in its broadest meaning.
* And finally, it proposes to operate and be relevant in a global context.

Thus, it involves physicians acting at a societal level to promote and protect health in a global context.

Each of these constituent elements merits reflection.

The Ethos of Medicine

First then, what aspects of the ethos of medicine are most relevant to the evolving self-definition of a global physicians movement? Five elements could be provisionally elaborated upon.

Intervention to Affirm Life

A first, central issue is the physician's attitude towards current reality. It is often assumed that medicine has been, is, and will always be an inherently conservative profession, drawing to it people who want very much to preserve the social status quo for the rich benefits it brings to them.

Yet most people who decide to become doctors respond to a deep intuition about life and their own lives. To become a doctor implicitly places us on the side of those who believe that the world can change -- that the chains of pain and suffering in the world can be broken. For every medical act challenges the apparent inevitability of the world as it is, and the natural history of illness, disability, and death. Every antibiotic, every surgical intervention, every consultation and diagnosis becomes part of an effort to interfere with the "natural" course of events. Thus, at a profound, even instinctual level -- because it precedes rational analysis -- people become physicians to find a way to say "no" to disease and pain, and to hopelessness and despair -- in short, to place themselves squarely on the side of those who intervene in the present to change the future.

Physician Commitment; Patient Trust

A second central tenet involves the uniquely trusting and intimate relationship physicians establish with patients. For beyond accurate diagnosis, beyond efforts to cure, and even beyond the ever present responsibility for relief of pain, the physician offers something else. The physician agrees to accompany the patient, to stand by the patient regardless of what happens -- through their suffering, and even to the edge of life itself. The physician steadfastly remains with the patient even when the only thing the physician can offer is the fact of his or her presence. This is as relevant to public health as for individual patient care. Public health must engage in difficult issues even when no cure or effective instruments are yet available and public health physicians also must remain with, and not abandon, vulnerable populations. This quality is the foundation for a trust that makes the relationship with physicians so unique and so precious. For in a world dominated -- perhaps necessarily -- by casual, superficial, or self-interested relationships, the physician stands, through his and her avowal and commitment, to never abandon the patient or the community.

Affirmation of Dignity

A third principle: physicians respect, promote and sustain human dignity. The concept of dignity is -- at the same time -- conceptually elusive and highly concrete: it is a commonly used term for which there is no simple definition. For example, the Universal Declaration of Human Rights -- the core document of the modern human rights movement -- starts by declaring that all people are equal in dignity and rights -- yet while the rights are then listed in the document in some detail, there is no further elaboration of the specific meaning of dignity [1].

That physicians, particularly in modern health care institutions and systems, are frequent perpetrators of dignity violations does not alter the fact that medicine is dignity-affirming in its essence. Despite the impersonality of a large hospital, or the constraints of time, physicians have always had -- and have today -- a uniquely powerful capacity in their armamentarium: that of giving their close, in-the-moment, undivided attention to the patient. This affirms dignity and it has the power to uplift, to give courage, and even to heal. Affirming the dignity of others in their suffering is a physician's natural act.

Confidence and the Permission to Invade

A fourth relevant dimension of the medical ethos involves the physician's special privileges of confidence and invasion. Physicians face people who are literally and figuratively naked; the physician is the stranger who has a right to be present at some of the central moments of life -- birth, illness, death. Physicians are also allowed, even required, to break the societal rules that define the space around each person which should not normally be entered: from the surgeon who has societal permission and even encouragement to cut and penetrate the body of another, to the psychiatrist who probes secrets, hidden fears, and the unconscious. Abuse of this confidence or the privilege of entering personal space severely violates dignity: used properly, it is a source of legitimate and legitimized access to the intimate and sacred dimensions of the life of others.

Giving a Name to Suffering

Finally, medicine has the power to name the forms of human suffering and to seek their alievation. The history of medicine is composed of such efforts -- from the "love sickness" of the Middle Ages in Europe [2] to modern microbiology, which differentiated syphylis and gonorrhea, to the more recent identification of "accidents" as "injuries" [3], thereby transforming personal tragedies into injustices. The history of medicine also shows repeatedly that until a health problem is named and adequately described, the problem itself does not exist -- at least in a professional or public sense. Take the example of child abuse: until it was initially described a few decades ago in the medical literature as a "battered child syndrome" [4] involving severe cases -- strange broken bones, clusters of cigarette burns -- and until epidemiologic studies were carried out in a variety of settings that literally ripped away the veil of silence and secrecy which hid the universality, frequency, and longstanding nature of this severe threat to the health of children -- child abuse simply did not exist for medicine or for society. Another, more recent example is domestic violence -- violence in the household -- only recently recognized and acknowleged to be a major, pervasive, and severe global health problem [5].

It is clear that we do not yet know all about the universe of human suffering. Just as in the microbial world, in which new discoveries have become the norm -- Ebola virus, Hantavirus, Toxic Shock Syndrome, Legionnaires' Disease, AIDS -- physicians have become explorers in the larger world of human suffering and well being. And our current maps of this universe, like world maps from 16th Century Europe, have some very well defined, familiar coastlines and territories and also contain large blank spaces that beckon the explorer.

These five elements together suggest the special character and nature of physicians working in a global movement. Physicians bring to this challenge a belief that the world can change, a tenacious commitment to accompany others even when no cure or even immediate relief may be available, a consistent affirming of human dignity, societal authorization to deal with and participate in the most private circumstances of human life, and the capacity to identify, name, describe, and legitimize forms of human suffering, while also seeking their alleviation.

Attention to these unique and powerful elements can help ensure that the evolving global physicians movement remains true to its own central ethos -- the bedrock of authenticity that will allow the movement to evolve in changed circumstances with new creative energies and inspired by new leaders. Remaining true to the physician's identity is vital for public understanding and support. The public is appropriately sensitive and resistant to efforts by any group to use its credibility in one field -- such as medicine -- to speak authoritatively about another domain, in which both capacity and credibility may be seriously questioned. It also helps to go beyond an unfortunate history in which collective discourse by physicians has too frequently been tainted, if not dominated, by corporatist, professionally self-interested motives.

From an Individual to a Societal Model

The second major definitional element of a global physicians movement is the need for physicians to engage in societal-level analysis of threats to health, as well as societal-level responses to these issues. This is firmly grounded in what is known about the determinants of individual and population health. The evidence is abundant, universal, and clear: societal factors -- not medical care or technology -- are the major determinants of health status, accounting for probably two-thirds to three-fourths of the health differential among populations.

Analyzing health problems from a societal perspective, however, and developing societal-level responses is quite different from the individually focused medical model in which physicians are generally trained. To move from individual patients to societal analysis and response is a major personal and professional challenge.

To proceed, it will be essential to have a coherent framework for societal analysis in order to identify societal-level causes of preventable illness, disability, or premature death or, to put the problem somewhat differently, to identify the societal preconditions for resistance to, or vulnerability towards, these outcomes. In addition, a consistent and appropriate vocabulary is needed to describe the deeper societal issues that lie beneath superficially quite different cultural, social, and geographic contexts. Finally, a broad consensus is needed regarding the direction of necessary societal change -- the prescription, if you will -- regarding steps to relieve or prevent the damage to health associated with certain societal features.

In this regard medicine is stymied. For the scientific framework upon which biomedicine has been created was not designed for, not is it adequate for, the task of societal analysis and response. Indeed, even public health has relatively little to offer beyond a plethora of discipline-driven approaches by the economist, the anthropologist, the sociologist, or the behavioral scientist regarding how to identify and respond to the societal pre-conditions for health and the societal causes of vulnerability to preventable illness, disability, and premature death.

Constituent Elements of Well Being

The third defining element for a global physicians' movement is, of course, its focus on health. Yet here also, we recognize the scope of the challenge. Indeed, taking the World Health Organization (WHO) definition of health [6] as a state of not only physical, but also mental and social well being underscores how biomedicine has focused largely on physical maladies. There is relatively little understanding of the constituent elements of physical well being, let alone mental well being. Describing and defining societal well being has received little attention at all in medical circles.

Finally, the physicians movement -- initially defined as international -- must become global to work meaningfully and effectively in a global context. This necessarily engages the tension between respect for diversity and common identity. Diversity is best nurtured in the context of internal coherence regarding common goals, identity, and strategy; that is, "acting locally, yet thinking globally." This, in turn, raises the key question of whether sufficient coherence has thus far been articulated to provide the internal consistency needed for a wide -- and widening -- constellation of physicians movements -- local, national, and regional. The global physicians movement must become genuinely global -- a global network that is much more than a communications system, giving rise to true global thinking.

IPPNW, in its historic focus and work on the prevention of nuclear war, advanced powerfully the idea of an international movement of physicians. It focused on the physician's role; it worked on the sociopolitical dimensions and helped create societal-level responses to the challenge; it broadened the concept of a global health threat and made it profoundly relevant to individuals; and it started the difficult process of moving from a national or regional organization towards a global one.

In each of the definitional areas described above, new creativity and energy will be required. Most important, new leadership is needed to articulate and actualize the coherence that is the absolute sine qua non for a true movement -- that is, a movement greater than the sum of its parts.

This fundamental coherence must draw upon the ethos of medicine, must be capable of analysis and action at a societal level, must be based on a broad concept of health and well being, and must have sufficient conceptual, mobilizing, and moral character to be universal while at the same time encouraging and nurturing diversity.

Human Rights as a Global Framework

Fortunately, a powerful series of concepts and a useful framework has been developed, from entirely outside the domain of public health or biomedical science, that can help provide the critical conceptual "glue" for a global physicians movement. The modern movement of human rights -- arising in the aftermath of the Holocaust in Europe and born of the deep aspiration to prevent a recurrence of government-sponsored violence towards individuals -- provides:

* a coherent conceptual framework for identifying and analyzing the societal root causes of vulnerability to preventable disease, disability, and premature death;
* a consistent vocabulary for describing the commonalities that underlie the specific situations of vulnerable people around the world;
* clarity about the necessary direction of societal change that promotes health.

Modern human rights involves the world's first efforts -- necessarily incomplete and partial -- to define the societal preconditions for human well being. For this reason, promotion of human rights became one of the four principal purposes of the United

Nations, founded in 1945. The Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948, provides a list of those societal conditions considered essential for well being, peace, and health.

These documents describe what governments and societies should not do to people -- torture them, imprison them arbitrarily or under inhuman conditions, invade their privacy -- and what governments and societies should ensure for all people in the society -- shelter, food, medical care, and basic education, among other things. When and where human rights and dignity are respected, there will still be rich and poor -- Mozarts and people who cannot carry a tune -- but all are ensured a basic minimum condition of existence in which their individual potential can be developed.

The human rights framework offers a more coherent, comprehensive, and practical framework for analysis and action on the societal root causes of vulnerability to disease, disability, and premature death than any framework inherited from traditional public health or biomedical science.

The aim of a global physicians movement may become, therefore, to promote and protect health by catalyzing, encouraging, and promoting societal change based on an analysis of how the lack of respect for human rights and dignity creates the preconditions for preventable disease, disability, and premature death. In the larger sense of the WHO definition, the realization of human rights and respect for dignity are required to promote and protect physical, mental, and social well being. This approach provides strategic coherence for work on a wide range of health issues and a large variety of tactical approaches. It is applicable to virtually all issues of relevance to health in different societies -- today and in the future.

The Example of Domestic Violence

Let us consider what this might mean, in concrete and pragmatic terms, by exploring a health and human rights approach to a particular problem, such as the issue of household, or domestic, violence.

Domestic violence -- to focus on the most common form among adults, which involves violence by a man against a woman -- is now recognized to be a major global health problem. In the U.S., male partners are the most frequent perpetrators of assault or rape against women [5]. An estimated one-fourth to one-third of emergency room visits by women are related to domestic violence [5]. In Papua New Guinea, 56% of urban women and 67% of rural women reported being abused and one of five wives have received hospital treatment for such injuries [5]. In Nicaragua, 44% of men admitted to beating their wives or girlfriends on a regular basis [5]. Yet the naming of this evil -- acknowledgement of domestic violence as a threat to health and well being -- physical, mental, and social -- is relatively recent.

The traditional medical approach to domestic violence starts with caring for the injured, focusing on the physical health -- and possibly on the mental health -- manifestations of this violence. At the public health level the traditional approach will start with epidemiological analysis. Epidemiology is a powerful tool, but it has important underlying assumptions and limits. Applying classical epidemiological methods to domestic violence will predetermine that "risk" will be defined with respect to individual determinants and individual behavior. Epidemiology has thus far been unable to develop models and methods suited to discovering the societal dimensions that strongly influence and constrain individual behavior.

Thus, the direct translation of epidemiological data on risk behavior -- defined exclusively in individual terms -- to the problem of domestic violence will lead inevitably to activities focusing on individuals in order to influence their risk-taking behavior -- through information, education, and services. This is the traditional public health approach: in essence, to consider diseases as dynamic events occuring within an essentially static societal context. Regarding domestic violence, the issue will be framed as a problem of "high risk" individuals, their behavior, and efforts to influence and modify behavioral patterns.

Medical attention to physical and mental injuries, and public health work to produce epidemiological information about distribution, occurrence, and identification of individual "risk factors" for domestic violence are both useful and important -- and will lead to programs of information, education in schools, and health and social services such as counseling, hotlines, and, perhaps, "early intervention" teams.

Unless the societal context is also addressed, however, the approaches mentioned above will be inherently quite limited in their effectiveness. To the extent that societal "factors" are major determinants of the phenomenon of domestic violence, societal-level interventions will also be required. Thus far, work to address societal factors -- governmental, sociocultural, and economic -- has been quite fragmented; the economist, political scientist, anthropologist, and social scientist all have naturally quite different disciplinary perspectives and recommendations.

The Universal Declaration as a Guide

A human rights perspective would start with the Universal Declaration of Human Rights as the principal text of reference. From the Universal Declaration, rights can be identified that seem most relevant to two issues: first, the response of society to the occurrence of domestic violence; and second, the deeper causes of domestic violence towards women.

The response to instances of domestic violence engages several important human rights, including:

* the right of non-discrimination, in this case involving how care for acts of violence towards women may differ from care for men;
* the right not to be subjected to torture or to cruel, inhuman, or degrading treatment;
* the right to recognition as a person before the law, involving specifically how the legal system responds to the occurence of violence towards women;
* the right to an effective remedy for acts violating fundamental rights.

These rights could be advanced concretely by ensuring legal protections for victims of domestic violence, guaranteeing rapid and fair response by police and judicial systems to situations of domestic violence, and other governmental efforts that demonstrate the government's commitment to providing care and enforcing measures to prevent and respond to the phenomenon of domestic violence. If the legal system does not grant women equal protection and recognition, this more fundamental issue of discrimination must also be addressed.

A rights analysis, however, also opens issues of root causes at a societal level. The question could be framed as follows: "What do governments in particular, and societies in general, do or not do, that creates vulnerability to domestic violence?" Women's equal rights to marriage, during marriage, and at its dissolution, and definitions of partnership and cohabitation will be important in ensuring that women are granted equal status in unions not officially considered to be marriages.

The vulnerability of women to suffering domestic violence and to being unable to leave an abusive home environment is also created or enhanced by a lack of realization of the following rights:

* the right to work and to just and favorable conditions of work, including equal pay for equal work; for women who work outside the home have a demonstrably improved capacity to make and effectuate free decisions about their lives;
* the right to education and to non-discrimination in education; receiving even an elementary education would give women broadly enhanced societal opportunities;
* the right to take part in the government of his/her country and the right to universal and equal sufferage; this would allow women to influence social norms through the political process;
* the right of peaceful assembly and association; for it has been demonstrated that organizations of women can powerfully influence public opinion and policy much more effectively than individual women acting in isolation.

Actions to promote and protect these rights -- to equality in marriage, to work, to education, to political participation and to association -- would work to improve women's capacity not to become victims of domestic violence, or to respond with a greater and freerer range of choices in the event such violence occurred.

Therefore, applying a human rights framework to the problem of domestic violence can lead to a series of concrete actions by physicians, in concert with those in each society already striving to improve the respect for human rights. Actions by the physicians organization could include:

* collecting physical and mental health information and using it to help legitimize the problem of "domestic violence" as a serious health and social issue;
* working with human rights groups and other social organizations to identify priority targets for political action, expressed most often in efforts to change laws and official policies;
* insisting on proper, dignity-affirming health care for victims of domestic violence;
* contributing energy and expertise at a policy level, including advocating increased educational access for women, ensuring non-discrimination in employment, or removing barriers to creation of grassroots women's non-governmental organizations.

Thus, a human rights analysis deconstructs or separates the problem of "domestic violence" into a series of health and human

rights issues, relevant to the care of victims as well as to the identification of and response to societal root causes of domestic violence.

Ending the Cycle of Violence

A health and human rights approach to domestic violence -- like preventing environmental contamination, or seeking to end the tobacco plague, or finding new means of conflict resolution -- clearly engages the central values of physicians. For the struggle to end domestic violence requires confidence that the world can change, that the eruptions of violence within a household, extending also from generation to generation, can be ended. It also requires affirmation of human dignity, expressed concretely as universal human rights. It will not be an easy struggle, and accompanying those who suffer domestic violence -- even in the absence of any readily available source of relief -- will be necessary. To understand the deep roots of domestic violence, physicians will have to enter the private precincts of families, couples, and intimate relationships. Finally, the forms of human suffering that cause -- and that result from -- domestic violence remain to be named and described. This also is the special domain of medicine.

The tasks of a global physicians movement -- envisioning global healing and global health -- reflect a clear understanding that societal-level forces are the major determinants of health. Moreover, they demonstrate an awareness of how human well being and human rights protection and promotion are inextricably linked. This vision, with its implicit justification for physician involvement, provides strategic coherence for actions -- local, national, or regional -- toward relevant health threats.

Yet projecting this leadership for global health, linked to promoting and protecting human rights and dignity, will be difficult. There will be the inevitable accusation that physicians are "meddling" in societal issues that “go far beyond” their scope or competence. Moreover, physicians are generally unfamiliar with human rights concepts and language; human rights are not taught in schools and few health professionals -- even in the most governmental domain of public health -- have received any formal education or training about human rights. Education about human rights is only beginning to become available for health professionals.

In addition, physicians may seek to "own" the problem; in other words, so long as the discourse around a health problem remains focused on medicine, the preeminent role of physicians is assured. To work within a human rights perspective requires active collaboration with others -- as equals -- as well as great attention to the involvement of people and communities in health.

Issues of human rights inherently and inevitably represent a challenge to power and health professionals are often part of -- or direct beneficiaries of -- the societal or institutional status quo that is challenged by the claims of human rights and dignity.

The global physicians movement is changing and must change. Leadership will require a focus on what the global physicians movement is "for." Only to be "against" is not enough -- is never enough. This "for" must be broad and clear.

The new global physicians movement calls upon physicians, as citizens of the modern world, to promote and protect health at a societal level. It embraces diversity within a movement that recognizes and defines itself through its expression of fundamental physician values. It views human rights and dignity as the key to coherence in its determination to act directly on the societal root causes of illness, disability, and death. And it accepts that to accomplish its mission, it will have to work for societal transformation, towards the realization of human rights and respect for human dignity that defines the societal essence of well being. ❧

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