



Exploring Medical Peace Education and a Call for PEACE MEDICINE

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Abstract

Medical peace work and peace education are requested and practiced. Experiences in practice and teaching are, however, unstructured and fragmentary, and there is a need for a sound and comprehensive theoretical concept. Applying Galtung's distinction between direct, structural and cultural violence, and between negative and positive peace, the framework of 'peace medicine' is presented as a possible new discipline in peace and health science. 'Peace medicine' would be a specialization on the health sector's contribution to all forms of violence prevention and sustainable peace building, both on a macro and micro level of society.

In order to explore the range of medical peace education, interviews were conducted with 25 representatives from Norwegian organizations and institutions that either involve health personnel in peace work or deal with peace education and research.

Information on content and strategies were then prioritized by 97 self-selected medical peace practitioners answering to an online questionnaire. The results revealed a preference for international work, addressing human rights violation and torture, poverty and development needs, refugee problems and racism, and other global peace and health challenges. Communication and cultural sensitivity, bio-psycho-social understanding of health and local/global context, and compassion and respect for others were identified as the most relevant skills, knowledge and values/attitudes for medical peace work. The most recommended teaching methods for these qualities were predominantly of a practical nature, such as student exchange and fieldwork, or experience-based lectures. Institutional co-operation with poor or conflict-prone countries was seen as the best way to improve medical peace education in Norway.

A systematic literature search in the medical database MEDLINE revealed that little has been published on global peace education. Well-established micro-level frameworks like 'violence prevention' and 'medical ethics' seem to be suitable for teaching most of the requested peace qualities, but emerging macro-level frameworks (e.g. 'global health' and 'peace through health') fit better. Yet, global education could benefit from the rich teaching and incorporation experiences of the former.

'Peace medicine', if used in Norway, would most probably be understood as a global health discipline. There is the need for teaching a more holistic peace perspective, if violence prevention, peace building and conflict handling should become a natural part of medical practice.

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“The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all.”

(World Health Assembly, Resolution 34.38, 1981)

“Violence is often predictable and preventable. Like other health problems, it is not distributed evenly across population groups or settings. Many of the factors that increase the risk of violence are shared across the different types of violence and are modifiable.”

(Gro Harlem Brundtland, Director-General, World Health Organization,
World Report on Violence and Health, 2002)

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1 Introduction

Peace education is seen as an important tool for the prevention of violence and war, and the building of sustainable peace. The United Nations General Assembly urged in 1978 “governments and governmental and non-governmental international organizations ... to take steps to develop programmes of education for disarmament and peace studies at all levels.”¹ This commitment was confirmed in year 2000 in *A Declaration on a Culture of Peace*, which encouraged the revision of educational curricula and textbooks, and called for further initiatives from institutes of higher education.²

The University of Tromsø took this call seriously and gathered the same year about 500 scholars, researchers and students in a conference on *Higher Education for Peace*³. As a result Tromsø became the first Norwegian university with a *Master program on Peace and Conflict Transformation*, and established the *Norwegian Centre for Peace Studies (CPS)*.

The relevance of peace education for particularly the health sector is expressed in different UN documents. In the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1984) the state parties are requested to “ensure that education and information regarding the prohibition against torture are fully included in the training of ... medical personnel.”⁴ An obligation for “education on health and human rights” is given under *The International Covenant on Economic, Social and Cultural Rights*.⁵ The *Study of Disarmament and Non-proliferation Education* (United Nations General Assembly 2002), the *World Report on Violence and Health* (Krug, Dahlberg et al. 2002) and key documents for WHO’s ‘Health as a Bridge to Peace’ concept (Large 1997) call for different aspects of medical peace education. These demands from UN bodies are strongly supported by professional associations, such as the *World Medical Association*⁶ and the *International Federation of Medical Students Associations - IFMSA*. The latter was organizer for several training workshops for medical students on issues of war and conflict prevention, human rights and peace building. It adopted the *Health through Peace Declaration* asking all Medical Schools to include peace education into the curricula (IFMSA and IPPNW 1999, p. 47).

¹ <http://disarmament2.un.org/gaspecialsession/10thsesmain.htm> (accessed 2004-11-13)

² <http://www.unesco.org/cpp/uk/declarations/2000.htm> (accessed 2004-11-13)

³ <http://www.peace2.uit.no/hefp/index.html> (accessed 2004-11-13)

⁴ http://www.unhchr.ch/html/menu3/b/h_cat39.htm (accessed 2004-11-13)

⁵ <http://www.unhchr.ch/tbs/doc.nsf/MasteFrameView/40d009901358b0e2c1256915005090be?Opendocument> (accessed 2004-11-13)

⁶ <http://www.wma.net/e/policy/e8.htm> (accessed 2004-11-13)

The importance and urgency of curricular reform is especially emphasized by professional organizations in violence-torn regions: The *Public Health Collaboration Network in South Eastern Europe* is determined to develop new curricula, which include issues of peace and human rights (PH-SEE 2002). The *Association of American Medical Colleges* has assumed a leadership role in bringing the issue of interpersonal violence into medical education. (Kassebaum and Anderson 1995)

In spite of all these claims and efforts there is no systematic international movement towards curricular reform. The sporadic initiatives depend mainly on individual commitment. It is striking that peace-issues are nearly absent in research on medical education, and that health professionals also are marginally involved in peace research.

This paper is therefore intended as a contribution to the exploration of the field. It was originally designed to investigate content and strategies of medical peace education in Norway, yet in the course of this project the need emerged to explore deeper the nature of medical peace work, and in particular of medical peace education. The challenge was to combine the gained knowledge in peace and conflict theory with the author's background in medical science. Galtung's comprehensive understanding of peace studies was the main source of inspiration for putting the different pieces of medical peace work together into one concept, here called 'peace medicine'. Also crucial for this approach was WHO's *World Report on Violence and Health*, which makes a clear appeal for health action, and which embraces interpersonal and self-induced, as well as collective violence.

The first part of this thesis focuses on the theoretical conceptualization of peace medicine. The approach is normative and constructive, with a peace science perspective as point of departure. The second part is written from a rather medical perspective. Qualitative and quantitative methods are used to examine the medical peace qualities requested by practitioners, and to relate them to the objectives and methods of existing frameworks of medical peace education. Finally, strategies are discussed on how to improve the peace capacity of medical doctors and how to integrate it into existing curricula.

The work intends to stimulate further discussion and research, and is rather seen as the starting point of a process, than as the final result of a research work.

This paper will focus on physicians and students of medicine. It is not intended to disregard other health professions. The author believes that the findings and discussions are transferable to health personnel in general, and has the whole spectrum of health professions in mind when using the adjective “medical”.

1.1 Working definitions

The terminology of ‘peace’, ‘conflict’, ‘violence’ or ‘peace work’ is not uniform; there exist many different definitions even within the peace community. This might be similar to the health sector having difficulties in defining ‘health’ or ‘disease’. For a common understanding it is necessary to clarify the terminology and the concepts used in this paper. As ‘peace medicine’ is central for this paper and the term and its framework are new, a thorough discussion on this concept will be undertaken in a separate chapter (see 2.2).

1.1.1 Peace – a minimal variant

Among practitioners, a widely accepted concept for **peace** includes at least two aspects, the absence of violence and destructive conflicts, and the presence of political, economic and social contentment. (Anderson and Olson 2003, p. 12)

Close to this is a simple definition of **peace work** which was used during the data collection: “Peace work can include a wide variety of activities contributing to prevention or reduction of physical and psychological violence, of oppressive and exploitative structures. Peace work can also be activities promoting dialogue, human rights, solidarity, and sustainable development.”

1.1.2 Peace – a holistic concept

For an exploration of the wide range of medical peace work and peace education it might be necessary to search for a more holistic and inclusive peace concept. Galtung offers a suggestion. In addition to laying down the foundation of peace science as an academic discipline, he also elaborated a comprehensive peace and conflict theory. The theoretical approach in this thesis is strongly influenced by *Peace by peaceful means* (Galtung 1996) and *What is Peace Studies?* (Galtung 2002).

In order to outline a holistic concept of peace, three aspects of peace will be discussed: Peace as absence of violence, as state of complete harmony, and as capacity to peaceful conflict handling.

1.1.2.1 Negation of violence

The term 'peace' is traditionally associated with the term 'war'. Most of us would probably think of a historical or current example of war, when asked to define peace. Which war, and which peace would we describe? What about alternative forms of war, like the Cold War based on the nuclear threat of 'mutual assured destruction', or the twelve years of low-intensity war on Iraq based on economic sanctions and air-bombing of infrastructure which contributed to the death of approximately half a million children under five years old? (Garfield and Yamada 2002. In: Salvage 2002, p. 4)

Or, what about the 'war against women' as a form of unorganized personal violence on a large-scale level? (Brock-Utne 1997, p. 151) The last example implies that peace cannot be obtained without addressing inter-personal violence. Feminist critique in peace research has so contributed to draw attention to daily day's violence at the micro level. Even intra-personal violence is a concern ('inner peace work') of holistic peace science. The fact that most deaths of intentional violence are caused by suicide⁷ might be a strong argument for such a comprehensive approach.

In the field of peace research the term 'violence' is therefore understood as opposite to 'peace', while 'war' is just an extreme form of collective violence. Analogue to disease and health, violence and peace can be seen as relative terms. The perception is subjective: What one would call 'peace' is still 'violence' for another. Common in most definitions is that peace grows, when violence diminishes.

In order to come closer to peace it is after all necessary to define violence:

WHO describes violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation." (In: Krug, Dahlberg et al. 2002, p. 5)

This definition is already unconventionally wide and includes even the threat of violence and acts of omission. Yet, in peace science this can be seen as 'just' one type of violence, called personal or **direct violence**. Besides direct violence (often conscious and intended) an indirect form of violence is specified as **structural violence**: The perpetrator is not a person but a social, economic or political system (often unconscious and unintended). Galtung defines so violence as "unnecessary insult of basic needs". All basic needs - survival, well-being, identity, and freedom needs - can be violated by both direct and structural violence. (Galtung 1996, p. 197)

⁷ <http://www.who.int/whr/en/> (accessed: 2004-11-14)

In addition to the direct and structural violence, a third one has been defined which lies beyond the other two - **cultural violence**. It includes all aspects of religion, ideology, art, science, language and cosmology, which justify and legitimize direct and structural violence (Galtung 1996, p. 31).

This theory assigns a special position to deep culture and gets empirical support by peace-psychological research: Ross, for instance, showed the significance of psycho-cultural factors influencing the willingness of a society to resort to violence. (In: Fuchs 2004, p. 391)

The dimensions of violence can for instance be categorized into macro, meso and micro level (Galtung 1996, preface), or into collective, inter-personal and self-induced (Krug, Dahlberg et al. 2002, p. 6). As simplification, in this paper is only distinguished between **macro-level violence**, thinking on the (inter-) national dimension and/or collective violence, and **micro-level violence**, embracing the inter- and intra-personal level.

The absence or reduction of the three types of violence at macro and/or micro level represents a certain state of peace, referred to as **negative peace**. Examples would be the ceasefire in a war, the divorce of a collapsed relationship, or the abolition of slavery. Yet, peace is more. It can also be a positive term. Similar to medicine, in which the absence of illness and disease is not identical with complete health, peace is more than the absence of violence. A second model can describe this aspect.

1.1.2.2 A state of complete harmony

In order to grasp positive peace, the WHO definition of health could serve: **HEALTH** is not merely the absence of disease or infirmity, but “a state of complete physical, mental and social well-being.”⁸ By including the word “complete” this holistic⁹ health concept represents a vision, a universal aspiration for mankind. **HEALTH** cannot be achieved for all people at all times, but the best possible state of health for all is the common goal. It determines the way forward. Analogous to Anderson and Olson’s “Peace Writ Large – meaning the big peace” (Anderson and Olson 2003, p. 12) **HEALTH** is therefore in this paragraph written in capital letter, meaning the big health.

How would then a positive peace vision look like? A suggestion could be: **PEACE** – a state of complete physical, mental, spiritual and social harmony. Applying Galtung’s

⁸ http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&record={9D1}&softpage=Document42 (accessed: 2004-11-13)

⁹ The broadening of the WHO definition is suggested “by including spiritual well-being (absence of hatred) in it”. Lang, S. (1998). "Challenge of goodness: twelve humanitarian proposals based on the experience of 1991-1995 wars in Croatia and Bosnia and Herzegovina." *Croatian Medical Journal* **39**(1): 72-6.

trilogy of direct, structural and cultural, this new model of peace could be: PEACE - a state of complete direct, structural and cultural peace. Table 1 is the attempt of a positive formulation¹⁰ of the three types of peace (adapted from Galtung 1996, p. 32):

direct peace	loving, harmonious acts to elicit the good in each other
structural peace	equitable, horizontal relations
cultural peace	religion, ideology, science, art, language and cosmology promoting direct and structural peace

Table 1: A Typology of Peace

Two aspects of peace, as well as of health, are now mentioned: the absence of anything negative and the presence of anything positive. Despite that the concept is far away from being holistic. It can also be criticized as too static, too visionary and too fixed on the endpoint. As known, wars are fought to prevent violence (e.g. “pre-emptive strike”) and to bring about peace (e.g. “violent revolution”).

To Gandhi is attributed the words: “There is no way to peace, peace is the way!”¹¹ The means determine the ends. Use of violence does not lead to a just and sustainable peace. For Galtung it is clear that “violence of any kind breeds violence of any kind.” (Galtung 1996, p. 32)

A further aspect is necessary to make the concept of peace more holistic. It has to do with notions of resilience and sustainability.

1.1.2.3 The capacity of conflict handling

We are daily exposed to pathogens and other health risks. A person with ‘good health’ will not easily get infected due to a strong immune system. In case of disease he or she will recover quickly supported by a good physical, mental, spiritual and social condition. **Health** is therefore also a “capacity of the spirit, the mind, the body and the society to handle pathogens of any kind with insight, creativity, and by healthy means”. (Galtung 2002, p. 7)

What in the concept of peace corresponds to the daily health challenges? Conflict theory may shed light on this question. The term ‘conflict’ when used in the media is often a synonym for violence, war and destruction. Yet, ‘conflict’ in peace science is neutral and even has a potential for positive change. The crucial question is, if conflicts are solved in a non-violent and constructive way or not. Conflicts exist always and everywhere, from micro (intra-/inter- personal) to macro level (intra-/international). The term ‘conflict

¹⁰ Personal communication with Joanna Santa Barbara, 2003-10-14

¹¹ Seen on a Gandhi-poster in Germany. (“Es gibt keinen Weg zum Frieden, Frieden ist der Weg!“)

prevention' is therefore rather misleading. More correct is the aim of 'prevention of destructive conflict handling', or simple 'violence prevention'. The following working definitions are therefore applied:

War is not identical with conflict, but rather an extreme form of collective violence, or in medical thinking an epidemic, endemic or pandemic of violence, dependent on its extension.

Conflict is the clash of incompatible goals in a goal-seeking system, challenging the status quo. It is determined not only by the content itself, but also by the attitude and behaviour of one or several parties in a conflict. This relationship is illustrated in the ABC-Conflict Triangle (Galtung, 1996, p.71), or similar in the Basic Conflict Structure Triangle (Mitchell 1981 In: Large 1997, p. 15). If goals are not reached, emotions are triggered. The attitude can turn into aggressiveness, the behaviour into aggression and the content gets polarized into 'win or lose'. Violence is used as the apparently easy way out. The conflict escalates and becomes destructive.

A **comprehensive concept of violence** would therefore include that violence is an event (direct), a process (structural) or an invariant (cultural) which unnecessarily violate basic needs. It is applied as a means to solve conflicts, when incapable or unwilling to find more constructive ways.

If, on the contrary, a conflict is seen positively as a challenge of the status quo with prospects of improvement, the attitude is characterized by empathy, the behaviour by non-violence, and the contradiction disappears through creative solutions which respect the needs of both sides (win-win). Peace is also a capacity of constructive conflict handling. A **comprehensive concept of peace** would therefore be: Peace is not merely the absence of direct, structural and cultural violence, or the presence of beneficial events, processes and invariants, but also the capacity to handle conflicts with empathy, creativity and by non-violent means. (Adapted from: Galtung 1996; Galtung 2002)

1.2 Background for the study

1.2.1 Linking health and peace

“In modern Western culture, these concepts [health and peace] have been defined as separate and the separation has been powerfully institutionalized. Hospitals have little to do with social healing or peacemaking, while peace initiatives, seen as the business of governments, are usually kept quite apart from health concerns.” (MacQueen, McCutcheon et al. 1997, p. 177)

Health and peace have many similarities, e.g. both, the health and the peace science, have a normative approach, and both depend on interdisciplinary cooperation for maximum success. That they can mutually serve as source for metaphors has been thoroughly explored. “Health is for the person what inter-state/nation peace is for the world, and intra-state peace for society.” (Galtung 1991, p. 1)

Nevertheless, there are clear intersections between health and peace, as professionals of both disciplines deal with ‘harm prevention’, ‘human security’ and ‘well-being’.

In real life the two concepts are strongly interconnected, and in a way that let us assume interdependency: Physical, mental or social ill-health can cause violence, and the highest attainable standard of peace cannot be reached when living with unnecessary health deficits, which are either inflicted or could easily be removed by mankind. Similarly, violence of all kinds is a threat to health, and the highest attainable standard of health cannot be reached when living under direct, structural or cultural violence. In short: Health deficit can cause peace deficit, and peace deficit can cause health deficit.

One example for the first statement might be the appearance of the HIV-endemic with enormous impacts on the social fabric, especially of African countries. It leads to high mortality rates, leaves millions of children without parents, and severely affects human development and social well-being.¹² As this disease could be prevented (through adequate information and protection) or be reasonably controlled (through adequate treatment), it represents and causes an “unnecessary insult of basic needs”. No doubt, malign epidemics are also an international security concern (See chapter 2: How do adverse health conditions affect conflict and security? In: Guha-Sapir and van Panhuis 2002). A further argument to be considered is the responsibility of sick individuals for violence and wars. It is for instance suggested that Idi Amin had been driven by syphilis (In: Lewer 1992, p. 99). War leaders like Hitler or Stalin are usually described as ‘psychopathic’. That sick military personnel is a severe peace and security risk was elaborated by IPPNW-doctors in ‘Accidental nuclear war: a post-cold war assessment’ (Forrow, Blair et al. 1998). Health professionals are more familiar, however, with the causal chain from diseases (terminal or mental) to acts of violence on micro level (e.g. suicide and homicide). All these examples make clear that the state of health, as well as the quality of health care can affect the level of violence and peace. Health deficit is therefore a risk factor for peace deficit.

With regard to the second part of the statement above ‘peace deficit can cause health deficit’, health personnel are even directly involved in the promotion of peace and

¹² <http://www.unaids.org> (accessed: 2004-11-29)

prevention of violence, or the opposite. Three aspects will be addressed below: Violence as a major health problem, the involvement of health professionals in peace building, and the health sector at risk of contributing to violence.

1.2.1.1 Violence as a major health problem

The World Health Assembly (WHA) stated in 1996 that violence is a major and growing world-wide public health problem, which has serious consequences for individuals, families, communities and countries, and a damaging effect on health care services. The Assembly therefore asked the World Health Organisation (WHO) to set up public health activities to deal with the problem. (Resolution WHA49.25 *Preventing violence: a public health priority*. In Krug & al., 2002, p. 22).

Finally, in October 2002 WHO published the *World report on violence and health*, which gives a systematic overview of the burden of direct violence. It summarizes that violence killed 1.6 million people in the year 2000 and that it is one of the major causes of death in the age group 15-44 years. Violence causes a socio-economic disaster through increased expenditures for the health system, loss of productivity and manpower, destruction of infrastructure, national treasure, properties and environment. Even more dramatic are the human costs with enormous pain and suffering. Like other health problems, violence can be prevented by identifying risk factors and by timely intervention. WHO asks health personnel to get involved in peace work: "... there is a strong role to be played by public health practitioners, academic institutions, NGOs and international organizations, to help governments increase their knowledge of and confidence in workable interventions. Part of this role is advocacy, using education and science-based information. The other part is as a partner or consultant, helping to develop policies and design or implement intervention." (Krug, Dahlberg et al. 2002, p. 19)

The extraordinary significance of this report is not only in the detailed statistics of mortality and morbidity, but in naming the suffering and facing the challenge. According to Jonathan Mann this is an important aspect of the ethos of medicine, because "until a health problem is named and adequately described, the problem itself does not exist -- at least in a professional or public sense." (Mann 1997, p. 3)

The concept of 'violence as a social disease' was explored at a conference on public health and peace in Skopje in 2001¹³ (Marusic 2002). Handling violence and war like a

¹³ Already in 1994 was youth violence called a "social disease" by professor Jewelle Taylor Gibbs of U.C.Berkeley's School of Social Welfare. In: The Sun Reporter, 05-04-1994, at <http://www.websters-online-dictionary.org/definition/disease> (accessed: 2004-11-29)

disease opens a window for systematic medical practice, teaching and research: the categorization of different types of violence (maybe also of weapons) by using medical concepts like aetiology, epidemiology, patho-physiology, diagnosis, prognosis, therapy and prevention. This could make it easier for the medical science to take responsibility for issues of violence and peace.

Even if the WHO-report can be seen as historical, both in defining violence (direct) on macro and micro level as a public health problem, and in asking the health sector for action, there is a long tradition for medical peace work.

Well-known examples for peace doctors are Rudolf Virchow (1821-1902), the founder of social medicine, who fought against famine, epidemics and war, or Charles Richet (1850-1935), who was awarded the Nobel Prize in Medicine in 1913, president of the French Society of International Arbitration and a champion of internationalism and the peace movement. Józef Polak (1857-1928) founded and headed the Polish Peace Society and requested a commitment of science for peace and sustainable development. Peace education and a healthy development of children was the passion of Maria Montessori (1870-1952), who was the first female MD in Italy. The Nobel Peace Prize was in 1953 awarded to Albert Schweitzer (1875-1965) for his humanitarian medical work in Africa. Later, he became active in the protest against war and nuclear testing. (In: Ruprecht and Jenssen 1991; Lewer 1992)

More recently, Jonathan Mann (1947-1998) set an example for medical peace work. He led the battle against AIDS and social injustice, linked public health to human rights and was a visionary for the international physicians' movement. (Mann, Gostin et al. 1994; Mann 1995; Mann 1997)

There are, however, not just individual doctor-activists: During the last century medical peace organizations have been (and some still are) an important part of the peace movement, like the *Association médicale internationale contre la guerre* (1905), *Internationale Gesellschaft der Ärzte gegen den Krieg* (1932), *Physicians for Social Responsibility - PSR* (1961)¹⁴, *International Physicians for the Prevention of Nuclear War - IPPNW* (1980)¹⁵ or *Physicians for Human Rights - PHR* (1986)¹⁶.

Although the *International Committee of the Red Cross – ICRC* (1863)¹⁷ and *Médecins Sans Frontières – MSF* (1971)¹⁸ are more known for their humanitarian work in war zones, they both play (-ed) a crucial role in prevention and reduction of violence; ICRC

¹⁴ <http://www.psr.org/> (accessed 2004-11-19)

¹⁵ <http://www.ippnw.org> (accessed: 2004-11-15)

¹⁶ <http://www.phrusa.org> (accessed: 2004-11-19)

¹⁷ <http://www.icrc.org> (accessed: 2004-11-19)

¹⁸ <http://www.msf.org> (accessed: 2004-11-19)

particularly through initiating and monitoring the Geneva Conventions, MSF through solidarity with war victims and the dissemination of information on behalf of those suffering from direct or structural violence (e.g. lobbying for free access to essential drugs). Both organizations, as well as IPPNW, have been awarded the Nobel Peace Prize. Common for all medical peace engagement is the conviction that violence and war are serious health problems, and that peace work is therefore health work.

An important limitation of the WHO report, out of a peace science perspective, represents the omission of 'structural violence' (see 1.1.2.1.). Social, economical or political structures are merely identified as root causes of direct violence. In the report there is no acknowledgement of these factors as "unnecessary insults of basic needs", harming health and life of millions of human beings worldwide.

*The World Health Report 2004*¹⁹, however, estimates that communicable diseases, maternal and perinatal conditions and nutritional deficiency together are responsible for about 18.324.000 deaths in year 2002, which is more than ten times the deaths of intentional violence (1.618.000). Most of these lives could easily have been saved through access to proper antibiotics or/and sufficient nutrition. The main killer in our world is therefore poverty (WHO 1995, in: Medact 2002, p. 12). These deaths might be called as 'unnecessary'. When taking into account that at the same time US \$ 792.000.000.000 were spent on military activities²⁰, one could even argue that they indirectly represent 'victims of militarization'.

Health research and intervention on 'structural violence' is still rare. Important work on global structures as barriers to health is done by the British IPPNW-affiliate Medact.²¹

1.2.1.2 Health professionals in peace building

Because of wide access to war zones, existence of strong infrastructures and membership in a respected community committed to human well-being, health workers have special assets for peace building (Peters 1996, p. 7). This is the point of departure for WHO's concept of 'Health as a Bridge to Peace' (HBP)²². The fact that health professionals might have a special role and possibility in peace building became evident in Central America in the 1980s. 'Cease-fires for vaccination' not only enabled the inoculation of hundreds of thousands of children in El Salvador and neighbouring countries, but it probably laid also the foundation for peace talks in this region. The shared concern for

¹⁹ <http://www.who.int/whr/en/> (accessed: 2004-11-14)

²⁰ http://www.sipri.org/contents/milap/milex/mex_wnr_table.html (accessed: 2004-11-18)

²¹ <http://www.medact.org> (accessed: 2004-11-14)

²² <http://www.who.int/disasters/bridge.cfm> (accessed: 2004-11-14)

fundamental health issues can transcend political, economic, social, and ethnic divisions and provide the entry point to dialogue and negotiation (Guerra de Macedo 1994 in: Rodriguez-Garcia, Macinko et al. 2001, p. 11). In an internal inventory at WHO's headquarters Manenti and Cassabalian emphasized that many different Departments were involved in peace building activities and that solely the "existence of some Departments/units of WHO such as Health and Human Rights, Ethics and Health, Civil Society Initiative, Violence and Injury Prevention shows a certain commitment towards disciplines that enlarge the public health focus involving peace-related aspects." (Manenti and Cassabalian 2003, p. 25)

Similar concepts of medical peace building were simultaneously developed at McMaster University as 'Peace through Health'²³, and as 'Health Bridges for Peace'²⁴ by the Institute for Resource and Security Studies. Both gathered experiences in combining psycho-social trauma work with reconciliation respectively in Croatia, Palestine, Sri Lanka, Afghanistan, and in former Yugoslavia and North-Caucasus. Health professionals can build extensively on expertise from individual and group therapeutic settings. The concepts of medical peace building are backed up by the theory of Multi-Track Diplomacy²⁵ which stresses that many sectors ("tracks") are important in a peace processes. To leave the crucial issues of violence and peace to the political or military top leadership ("track one") is a fundamental mistake. Yet, there are also voices of warning: "It has been suggested that members of health teams working in the field for aid and development agencies may be in a position to influence the conflict process, but it must be remembered that acts of political insensitivity by well-intentioned, but poorly prepared and informed persons may result in worsening the situation." (Lewer 1992, p. 101)

A systematic evaluation of different medical peace building experiences (immunization cease-fires, joint surveillance activities, joint medical supply procurement, dialogue and cooperation among health workers, health services provision, training courses, decentralized cooperation, joint implementation committees on health, development of health protocols, demobilization, mediation, etc.) conclude that the universal value of good health "makes the international health community a potentially powerful force in peace efforts throughout the world, and one that should be tapped further through expanded HBP initiatives and continued research, evaluation, and training activities." (Rodriguez-Garcia, Macinko et al. 2001, p. 82)

²³ <http://www.humanities.mcmaster.ca/peace-health/> (accessed: 2004-11-14)

²⁴ <http://www.irss-usa.org/pages/internpro.html> (accessed: 2004-11-14)

²⁵ <http://www.imtd.org/about-theory.htm> (accessed: 2004-11-14)

1.2.1.3 Health personnel at risk of contributing to violence

Health personnel do not always contribute to peace (and health). Physicians are more likely to be guilty of violence than other health professions, because of their high social and professional position in most societies. They enjoy confidence, credibility and power, which can be misused for harming others, used for strengthening health and peace, or not used at all. Some medical disciplines might also be more at risk than others, due to double loyalty or working in a violent environment.

One such particular group are health professionals embedded in the military system. Sigmund Freud called them “machine guns behind the front line”, which have “the role of repulsing the runaways” (In: Jenssen 2002, p. 16). They face the dilemma of serving the individual (to save health and life) versus serving military interests (to strengthen the physical and moral power of the army). The contradiction between medical values on one hand and enabling and prolonging the horror of war on the other, is often ignored, but sometimes strongly condoned. John A. Ryle claimed in 1938 that physicians should remind themselves of their principle, that prevention is more important than cure. He even saw the possibility to prevent and stop war, when physicians, analogous to Aristophanes’ women in *The Lysistrata*, completely refuse to cooperate: “... the doctors could so cripple the efficiency of the staff and aggravate the difficulties of campaign and so damage the morale of the troops that war would become almost unthinkable.” (In: Sidel 1997, p. 289)

Even the concept of ‘limiting inhumane warfare’ through the prohibition of brutal practice and weapons is controversial, semantically, because it may imply that there is such a thing as ‘humane warfare’ (Galtung 1997, p. 13), and fundamentally, because it diminishes the threshold for going to war: “To alleviate the consequences of war means to render war possible and to facilitate its outbreak” (Alfred Hermann Fried, 1897, in: Jenssen 2002, p. 12). On the other hand, it can be argued that the work to limit the destructiveness of war (see ICRC and the Geneva Conventions: 1.2.1.1.) can gradually encroach on the scope of war and the beginning of its abolition.

Humanitarian aid, as well as development assistance, can contribute to violence prevention and peace building. Nevertheless, if these activities operate in conflict areas, they automatically become party in the conflict. An example is the famine in Ethiopia in 1984, when the government misused both the catastrophe and the international aid. Agencies like MSF wanted to maintain ‘neutrality’ and observed therefore silently an enormous population transfer on ideological, not on humanitarian rationale. In this way they became partly guilty for the additional loss of 150.000 lives (Brauman 1998). A

systematic analysis of aid projects showed that introducing resources and implicit ethical messages might have tremendous consequences for the recipients, positive, negative, or both. (Anderson 1999)

This chapter cannot be written without touching upon the medical war crimes and serious human rights violations by the Nazi doctors. The Nuremberg Trial revealed that the German medical profession not only failed when fulfilling deadly orders, like the selection of disabled patients for the gas chambers or false death certification in the concentration camps. The most ambitious members even conducted brutal human experiments by inflicting pain, disease and death upon defenceless prisoners on behalf of 'progress and scientific interest'. Yet, the physicians were not merely part of the fascistic system, but they were also heavily involved in building its foundation. Hitler and the National Socialism would never have obtained the same power without the strong ideological support of the German medical profession. "Doctors in fact joined the Nazi Party earlier and in greater numbers than any other professional group. ... doctors assumed leading positions in German government and universities. ... medical scientists were the ones who invented racial hygiene in the first place" (Proctor 1992, p. 19). Eugenics and euthanasia were predecessors of the Holocaust. "... doctors were given much of the responsibility for the murderous ecology of Auschwitz – the choosing of victims, the carrying through of the physical and psychological mechanics of killing, and the balancing of killing and work functions in the camp. While doctors by no means ran Auschwitz, they did lend it a perverse medical aura." (Lifton 1986, p. 18)

Even at present health professionals in many countries are at risk of supporting violent practices like torture and capital punishment, or the development of new weapon technologies. Through research and by fulfilling official functions they take part in a violent system, or help to legitimise it. The recent revelation about serious human rights violations at Abu Ghraib and Guantanamo Bay that were committed, observed or concealed by medical personnel reminds us of the responsibility of, and potential for failures by the health profession. (Miles 2004)

Less obvious, but neither less common, nor less harmful for many victims, is the medical cooperation with violent socio-economical and political structures, like the privatisation of health care, the protection of patents and profits of drug companies, or the high-tech priorities in health research. It often ignores the human needs of those who can't afford the western medical standard, i.e. the poor in rich countries and the majority of the global population. There is a strong call for global public health responsibility. (Yach and Bettcher 1998; The International Poverty and Health Network 2000; Lancet 2001)

Moving from macro to the micro level, different types of violence can probably be found at every health institution and medical working place. Examples for that could be patriarchal doctor-patient relations, neglect of symptoms, abuse, omission of evident treatment, over-medication, mechanisation, dehumanisation, commercialisation, corruption by the pharmaceutical industry, experimentation on vulnerable groups, research fraud, taboo making of mistakes, institutional hierarchy, harassment, women's discrimination, and much more.

In sum, there are medical disciplines or duties which might be particularly at risk of violence, as they either have to do with power positions, face the dilemma of double loyalty, or as they work in violent surroundings. Nevertheless, health professionals in general can easily contribute to violation of the needs, dignity and rights of people.

1.2.2 Personal experiences

Since the beginning of his medical career, the author has actively been involved in the medical peace work of IPPNW-Germany. One main goal of the student activities was to bring individual and collective aspects of medical ethics into German medical education, which still in the early 1990s, despite the Nazi doctors' legacy, was quite reluctant to deal with questions of ethical dilemmas, human rights and social responsibility.

Theoretical and practical experiences in medical peace education were gained as co-organizer of the IFMSA/IPPNW student workshop *Health through Peace* during *The Hague Appeal for Peace* conference (The Netherlands, 1999), of the seminar *Medicine and Human Rights* in Bergen (Norway, 2000), and of the international physicians' conference *Medicine and Conscience* in Erlangen (Germany, 2001). Since 2002 the author has been a board member of the Norwegian IPPNW-affiliate 'Norske Leger mot Atomvåpen' (NLA), which among other things works toward the inclusion of peace-related issues, like human rights, torture and conflicts, into the medical curriculum.

When starting the master program in Peace and Conflict Transformation in Tromsø, an elective course for peace students was being developed (*Peace and Health*, 2003), which focused on what peace workers could and should learn from medicine and other health sciences in order to perform better peace work. The term 'peace medicine' came up, and the question of what health workers could and should learn from peace science in order to perform better health work challenged further exploration.

1.3 Purpose of the study

The goal of this thesis is to improve medical peace education and to strengthen the medical peace capacity. As the final aim it wants to contribute to health through peace.

The objectives are:

The work should systematize the field of medical peace work and education. It will introduce ‘peace medicine’ as a possible discipline in health and peace science, and elaborate a coherent theoretical concept. Out of this perspective existing frameworks of medical peace education should be illuminated.

It will further explore the required skills, knowledge and values/attitudes for good medical peace work, and will identify if these qualities are covered by the existing frameworks. Finally, strategies for implementation of medical peace education will be considered.

1.4 Methodology

As the focus changed during the course of producing this thesis, so did the methodology. Instead of a solely empirical approach to existing medical peace education, the theoretical conceptualization of a possible new discipline became an important part. Galtung works out the difference between peace research and other social sciences, due to a normative approach of the former. Peace is not merely the object of peace science, but also its goal. The adjustment of theories to values and the production of visions of a new reality are described as ‘constructive peace science’. (Galtung 1996, p. 10-11)

The first part of this paper draws on this perspective and therefore comes up with **new terminology and a theoretical framework for ‘peace medicine’**. It reflects the fusion of peace and conflict theories with a medical and health perspective.

The second part uses rather a classical methodology and applies qualitative and quantitative research techniques. It is committed to the production of data, and confronts the findings with existing theories and values. In the above cited reference it would correspond respectively to ‘empirical’ and to ‘critical peace research’.

In order to get reliable data about **medical peace qualities required in the field**, the study utilizes the following sources of data:

1. Individual semi-structured interviews with key persons from
 - a. organizations which involve Norwegian physicians / medical students in peace work or
 - b. academic peace education or research organisations / institutions.
2. Online questionnaire targeted to Norwegian physicians and medical students who work with violence prevention and sustainable peace building on domestic or international level.

Information on **content, objectives and methods in existing medical peace education** is collected through a systematic literature search using respectively the MeSH database and MEDLINE. Key articles are supplemented with central publications of existing peace-health-frameworks. A more comprehensive description of the methodology of the three different types of data collections is given in the corresponding chapters.

The systematic review and comparative analysis of the gathered data should reveal the coverage of the requested peace qualities in the existing frameworks of medical peace education, and give rise for discussions about teaching methods and incorporation strategies.

Conclusions are drawn on what 'peace medicine' should prioritize in Norway, if used as concept for a new medical discipline.

2 The conceptualization of Peace Medicine

2.1 Evolution of a new concept

Medical involvement in the prevention of war and violence and in the amelioration of its health effects has many different faces (see 1.2.1.1). It has developed continuously since the foundation of the Red Cross and the articulation of the peace movement, and flowered in many different medical activities and organizations, like the IPPNW with about 250.000 members world-wide.

The deliberate integration of peace-issues into medical teaching and research developed, albeit slowly, since the 1980s, and is sporadic rather than systematic. A comprehensive discussion about the different types and levels of violence and the multiple roles of health professionals in peace work seems to be missing.

More advanced in this regard is the psychological profession with ‘peace psychology’ as a recognized discipline within ‘social psychology’. It resulted in the first teaching-handbook in ‘peace psychology’, published in February 2004 (Sommer and Fuchs 2004). In contrast to ‘peace psychology’, the term ‘peace medicine’ is new. It was apparently introduced in academia²⁶ by Peter J Safar, Distinguished Service Professor of Resuscitation Medicine at the University of Pittsburgh during his honours convocation *Thoughts About Academe and Humanism* on February 28, 2003 (Hart 2003). He addressed global health problems like unsafe water, malnutrition, poverty, illiteracy and infectious diseases, and asked for preventive health work.

Already in 2002 ‘peace medicine’ was discussed as a name for a specialization within the master course at the Centre for Peace Studies, University of Tromsø²⁷. ‘Social medicine’ was not seen as comprehensive enough, as it traditionally covers only the area of micro-level ‘structural violence’. The notion ‘peace medicine’ seemed to be more appropriate for encompassing all types of violence and peace. It was suggested that this specialization should provide deeper insights into the skills, knowledge and values, that peace students/workers could and should learn from medicine and other health sciences. During the development of this master thesis, ‘peace medicine’ became double-faceted: On one hand it is now understood as the health workers’ contribution to a multidisciplinary, holistic concept of peace studies. It would complement other

²⁶ Found through web-search with www.google.com, May 2003

²⁷ Personal communication with Vidar Vambheim

disciplines and specializations within peace studies like peace pedagogics, peace literature, or peace psychology.

On the other hand 'peace medicine' can be seen from a medical view point as one health specialization among others. Analogue to 'environmental medicine', which aims to prevent negative health effects of environmental imbalance, 'peace medicine' could be a health specialization on the prevention of negative health effects of peace deficits. Like 'psychiatry' is specialized on mental health and the treatment of psychiatric disorders, 'peace medicine' would be on peace and the transformation of violent conflicts. And, similar to 'physical medicine', which deals with physical rehabilitation, 'peace medicine' would deal with psycho-social rehabilitation and reconciliation of individuals and societies affected by violence.

It could therefore have a preventive, curative and rehabilitative aspect.

2.2 Defining peace medicine

Based on the holistic concept of peace and peace work (see 1.1.2.), the following definition is suggested:

Peace medicine could be a new discipline in peace and health sciences that contributes to peace and health through the prevention or reduction of direct, structural or cultural violence, through the building of harmonious, mutually beneficial relations, and through strengthening the peace capacity of individuals and societies. It embraces all practice, research and education in medical peace work.

Two crucial questions derive from this definition, to be discussed in the next chapters: Under what conditions is peace work 'medical' and therefore the task and responsibility of health professionals? What is the difference between peace medicine and already existing disciplines like war-, emergency- and military medicine, or humanitarian aid and development assistance?

2.3 What makes peace work medical?

Peace work contributes to the prevention of disease and disabilities (see 1.2.1.1). Yet, not all types of peace work should automatically be labelled 'health work', and not all peace-related practice, research, and teaching is best done by health professionals. Nevertheless, there seem to be some peace-skills, -knowledge, -values (and in addition: -tools and -opportunities) which are more attributed to physicians, and health professionals in general, than to other professions. In certain circumstances health

workers might therefore be better peace workers than for instance diplomats or anthropologists.

“Physicians and other health workers can, through their collective dedication to the relief of suffering, prevention of disease and general welfare of their patients, cross transnational and intercommunal boundaries more easily than most groups of professional workers.” (Lewer 1992, p. 96)

Competition between professions would, of course, be wrong. The earlier mentioned concept of ‘Multi-Track Diplomacy’ (see 1.2.1.2.) opens for several different actors within peace building, into which the health sector fits easily. All forms of professional and non-professional peace work are important and complimentary for preventing violence and building sustainable peace. In peace work, as in other health-related areas (e.g. nutrition), collaboration between health professions and with outside actors (politicians, teachers, lawyers etc.) is crucial for optimal health outcome. And, it is also self-evident that peace medicine has a lot to learn from other peace-related disciplines. When medical peace-qualities, -tools and -opportunities are intentionally used for improving health through violence prevention and peace promotion, it might be appropriate to talk about **medical peace work**.

During their professional training, health workers should learn skills, knowledge and values that will enable them to help or accompany patients in need, and avoid preventable suffering from individuals and societies. Some of these qualities are equally required for certain kinds of peace work, or they provide directly or indirectly (via ‘tools’) opportunities for dialogue, understanding, conflict transformation etc.

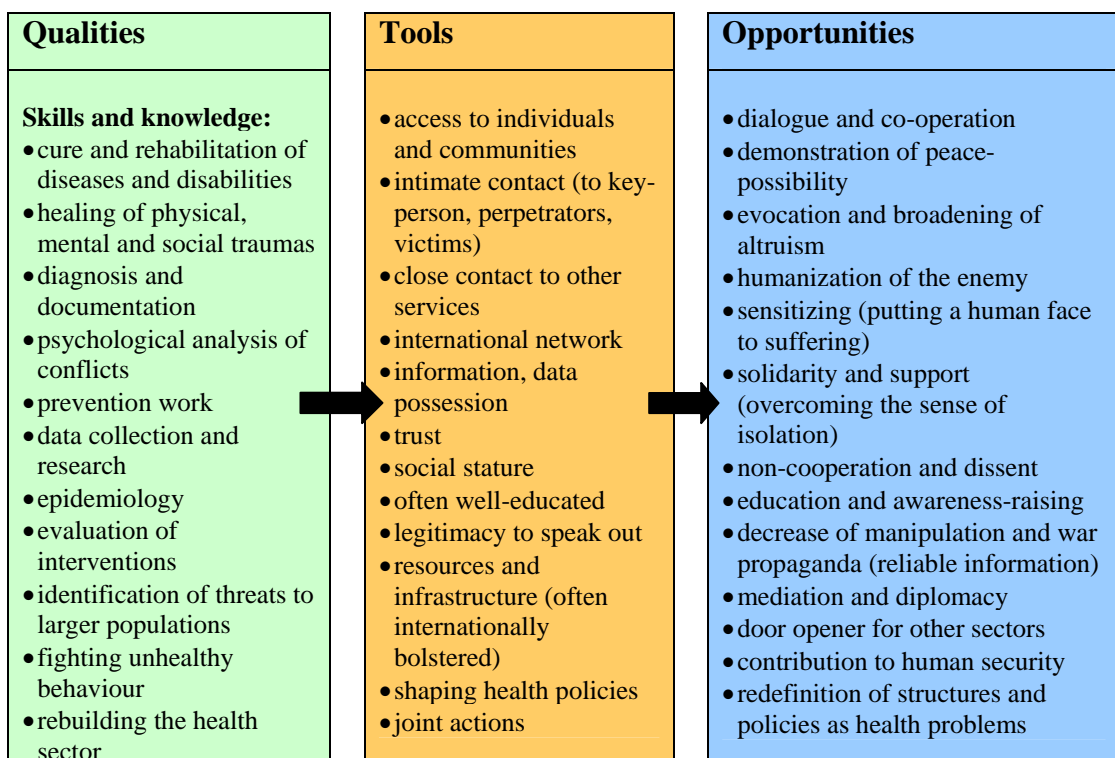
The following synopsis of medical assets for peace (Table 2: Medical peace assets) is based on the experiences in peace building through health initiatives published by the health-peace network at McMaster University (Peters 1996; MacQueen, McCutcheon et al. 1997; Arya 2003), and by WHO and associated institutes (WHO/EHA 1997; Gutlove 1998; Rodriguez-Garcia, Macinko et al. 2001; Guha-Sapir and van Panhuis 2002; Krug, Dahlberg et al. 2002; Manenti and Cassabalian 2003). Additional aspects are taken up from medical/public health associations and peace organizations:

The British Medical Association, for example, identified “Nine Basic Core Values” of modern medical practice (British Medical Association 2001, p. 10). *Commitment*, *integrity*, *confidentiality* and *advocacy* might be as important for peace work as they are for health work.

Reflecting on the global physicians' movement, like IPPNW and MSF, Mann elaborates on five elements of the medical ethos which constitute their special character and nature: "...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." (Mann 1997, p. 3)

From a public health perspective the peace-role of health workers is specified in "surveillance and documentation, education and awareness-raising programs, advocacy and participating directly in effective actions". (Levy and Sidel 1997, p. 388-93)

Examples at the grass root level, like from the Medico Friend Circle dealing with violent inter-communal conflicts in India, confirm that health workers as witnesses, advocates and healers have an extraordinary role in prevention of violence and in social rehabilitation: "Post-mortem records, medico-legal complaints and doctors' statements all provide vital support to victims seeking compensation and filing cases against the perpetrators of violence... Health professionals have an additional ethical and social responsibility, as close witnesses of the effects of violence. They must play a role in documenting what is happening and informing other sections of society, in analysing the causes of violence and suggesting both immediate responses and long-term preventive measures." (Medico Friend Circle 2002, p. 3)



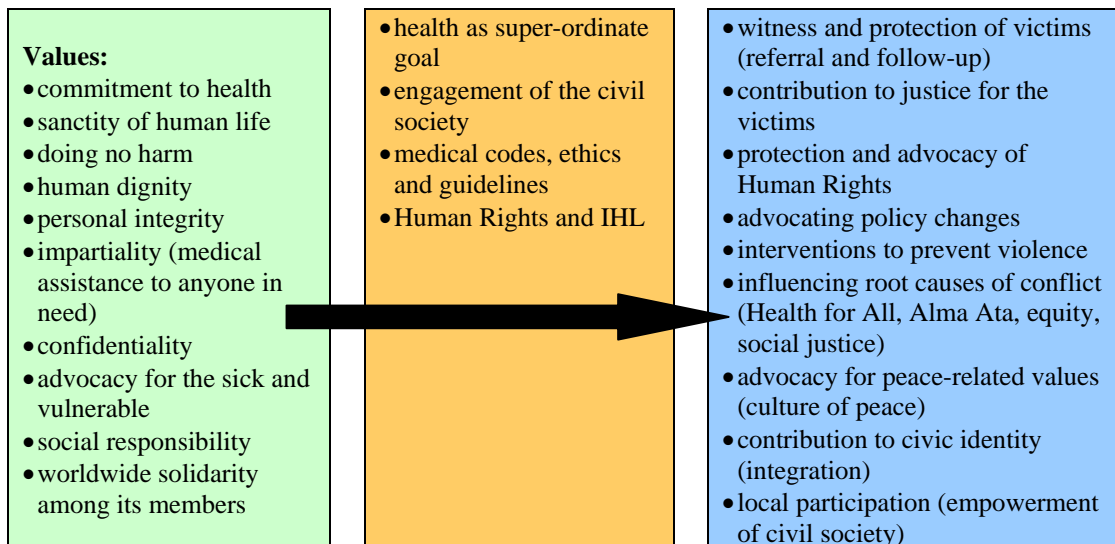


Table 2: Medical peace assets

2.4 What makes health work peace-relevant?

The second important question deals with the demarcation of peace medicine from other violence-related medical disciplines. Peace work, as defined earlier, is attempting to prevent violence and to promote sustainable peace. When health personnel face violence in their professional work, the distinction between medical peace work and conventional health work may not always be clear. The notion of prevention within public health could be a tool for clarification.

Prevention is differentiated into primary, secondary and tertiary. “Primary prevention aims at lowering the occurrence rate of the event, i.e. the incidence rate of the disease. Secondary prevention aims at lowering the occurrence of the later and more severe stages of the disease, often by identifying diseases at a curable stage, as in screening, thus reducing the prevalence of the disease through treatment. Tertiary prevention aims at reducing the social consequences of the disease.” (Olsen 2002, p. 1812)

By naming violence and war as serious health problems, the different types of prevention might be helpful to understand the scope of possible interventions. In recent years this public health approach has been applied not only to war and militarism (Levy and Sidel 1997, p. 389), but also to all levels of direct violence (Krug, Dahlberg et al. 2002, p. 15). Both sources define secondary and tertiary prevention from a temporary perspective as immediate versus long-term response to violence. This is not fully consistent with the definition of prevention cited above, but seems to be the most common interpretation. It might be confusing that ‘violence prevention’, besides the relevance for the victims (prevention of negative health effects), is also used with regard to the perpetrators

(prevention of violent acts). The Cochrane Protocol on secondary prevention of violence in schools is one example of such perpetrator-focused application. (Mytton, DiGiuseppi et al. 2003)

The question remains: What makes health work peace-relevant? It is here suggested that the distinction between peace medicine and conventional health response to violence could be based on the target-group (perpetrator versus victim) or on the focus of prevention (violent acts versus its negative health effects). ‘Violence prevention’ will therefore on the following pages only be used in relation to the violent act.

Primary prevention of violence and primary prevention of possible health effects

both work through the reduction of risk factors (vulnerability for violence vs. disease) or the promotion of protective factors (peace capacity vs. health capacity). While the first one represents ‘medical peace work’, the second one can be labelled ‘conventional health work’ due to its lack of an explicit peace-goal, e.g. vaccination of soldiers against possible biological agents.

Primary prevention of violence should be the core task of peace medicine, because the physical, mental, and social traumas caused by violence are often not completely treatable (‘restitutio ad integrum’), and they may leave a life-long, even lives-long (over several generations) scar. (Klain and Pavic 2002, p. 130-131)

Secondary and tertiary prevention of negative health effects are traditionally the task of war medicine / humanitarian aid and the national health system / development assistance respectively. The interventions are victim-oriented and focus on the treatment of the acute or chronic symptoms (physical and psychological) of a violent conflict.

Secondary and tertiary prevention of violence are different. Interventions are perpetrator and conflict oriented. The treatment approach in regard to the violent conflict is curative. Early warning and de-escalation systems aim to prevent the further escalation or prolongation of a violent process, while conflict transformation and reconciliation is used for social rehabilitation and peace building.

When illustrated in a ‘cycle of violence’ (Santa-Barbara 1997; Arya 2003), primary, secondary and tertiary prevention would correspond to before, under and after the violent act (e.g. war). Applying the differentiation presented above, the ‘prevention of violence’ would try to prevent violence from happening, from escalating, or from re-entering into a new round, while the ‘prevention of negative health effects’ would deal with the alleviation of its symptoms (see Figure 1: Direct Health Work and Medical Peace Work in the Cycle of Violence). Peace interventions aim to break out of the cycle of violence,

while traditional health work would be integrated in it, awaiting and observing the violation.

The suggestion is therefore that peace medicine has to go beyond the humanitarian duty of treating the negative health effects (direct health work), to a more comprehensive approach which includes the violent process and the perpetrator (indirect health work). Conventional health work in violent settings can have positive peace effects, but these would be accidentally rather than intended. Nevertheless, the traditional role of health professionals as neutral and impartial healers of the sick and wounded is absolutely necessary and can function as the entry point for medical peace work. (See qualities in Table 2: Medical peace assets)

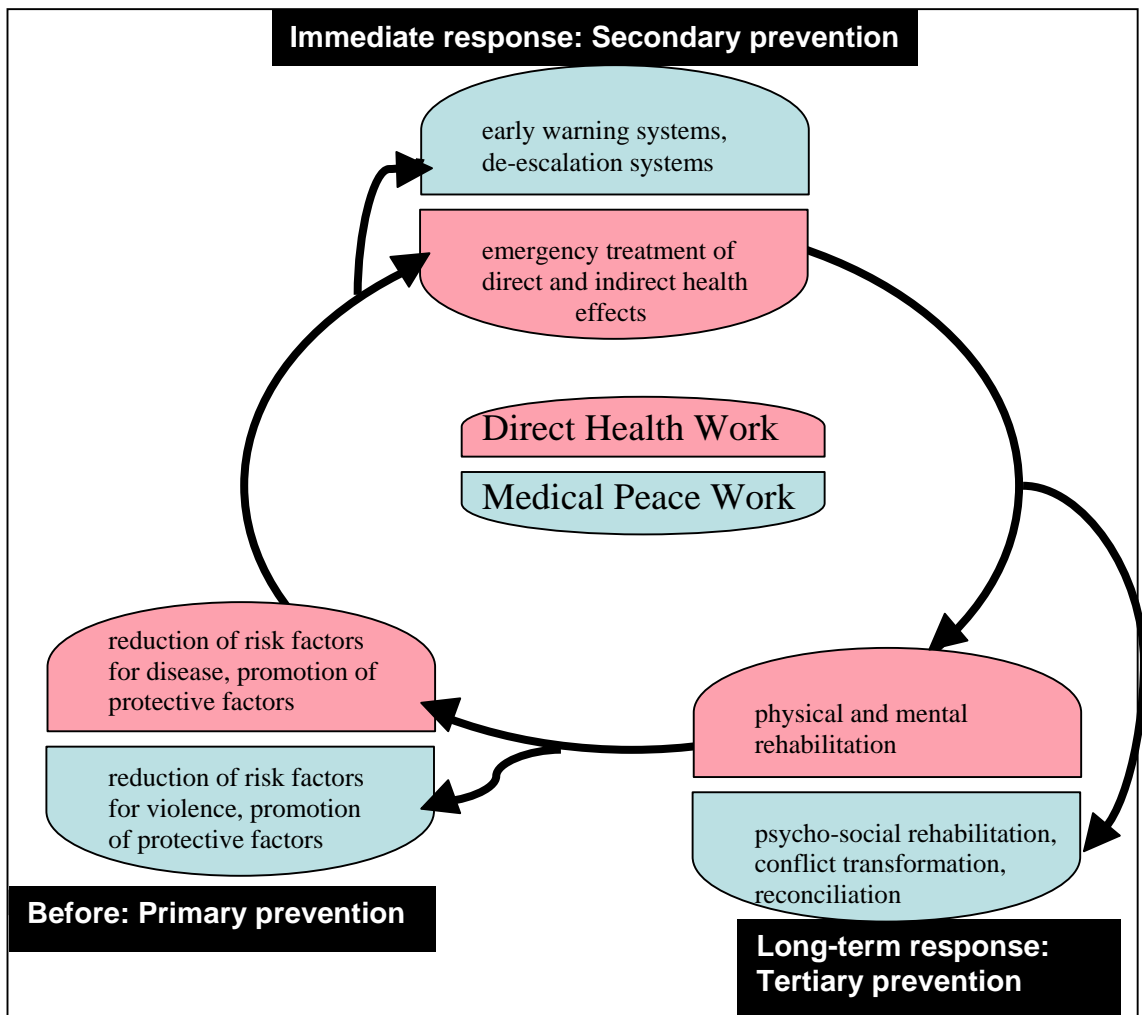


Figure 1: Direct Health Work and Medical Peace Work in the Cycle of Violence

What is elaborated above for violence on the macro level could also be applied for the micro level. “A comprehensive response to violence is one that not only protects and

supports victims of violence, but also promotes non-violence, reduces the perpetration of violence, and changes the circumstances and conditions that give rise to violence in the first place.” (Krug, Dahlberg et al. 2002, pp. 15-16)

Often, the distinction between primary, secondary and tertiary prevention of violence is blurry, as it contains overlapping elements and is often conducted by the same actors. In addition, according to Keltner’s ‘Struggle Spectrum’, every stage in a conflict can move into two directions, either towards de-escalation or escalation (Keltner 1997, p. 5). A post-war period might be a pre-war period, or “after the war is before the war.”²⁸ The different types of violence prevention must not be limited to just one conflict stage; all three types of prevention are equally necessary and might have synergistic effects.

2.5 The scope of peace medicine

It is important to have in mind that the model for medical peace work elaborated above (Figure 1: Direct Health Work and Medical Peace Work in the Cycle of Violence) does circulate around ‘direct violence’. The model can be applied for both macro- and micro-level direct violence, but is useless for ‘structural’ or ‘cultural violence’. Even if the latter two forms are important at all stages of the ‘cycle of violence’, they are also significant ‘unnecessary insults of basic needs’ without connection to ‘direct violence’. For instance, innumerable human beings die or have to live with the burden of disabilities and diseases due to socio-economical and political factors (see: 1.2.1.). Like direct violence, also violent structures and cultures are human-made health barriers. They should not only be addressed in anticipation, during or after violent conflict, but also as a peace deficit in itself. Peace medicine should therefore treat all three types of violence, and put them in relation to the macro and micro level. It would cover all six categories in figure 2, and not only deal with violence, but also with positive peace.

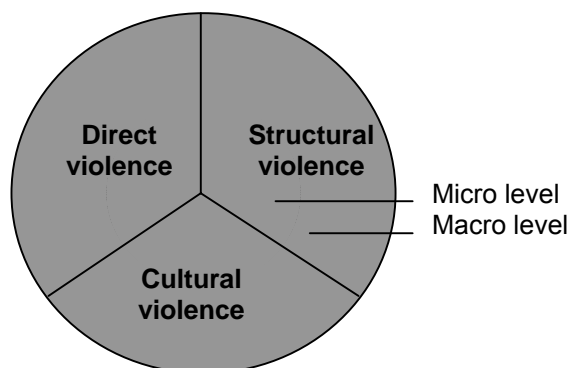


Figure 2: The scope of peace medicine

²⁸ A German book title (*Nach dem Krieg ist vor dem Krieg*, VSA-Verlag, Hamburg, 1999).

2.6 Limitations of the peace medical concept

The developed concept of ‘peace medicine’ relates strongly to Galtung’s peace and conflict theory. With an unconventional and quite wide understanding of ‘peace’ and ‘peace work’, it challenges the mainstream use of the terms ‘peace’, ‘violence’ and ‘conflict’. Those who are not familiar with peace science might interpret the term ‘peace medicine’ quite differently.

Defining peace as capacity of non-violent conflict handling or calling violence a ‘serious health problem’ dismisses military and revolutionary means. Instead it calls for empathy, creativity, and healthy solutions. Non-violence, and thus peace medicine, may have limitations, particularly in extreme situations such as genocide or oppressive dictatorships. Early diagnosis, exact prognosis and evidence-based intervention require experience and good preparation. Interdisciplinary co-operation and the knowledge of own limitations are fundamental.

Categorizing violence as a social disease confronts the biomedical concept of ‘disease’, as this is limited to an abnormal condition of body or mind.²⁹ It also contains the risk of ‘medicalizing’ a problem.

The modification of the ‘cycle of violence’ in figure 1 is based on a critique of currently used models of violence prevention. Yet, the strict differentiation between ‘direct health work’ and ‘medical peace work’ is artificial and not always possible, as it is contradictory to the overlapping aspects (harm prevention, human security, and social well-being) of a holistic peace and health concept. When applied on the micro-level, it is even more difficult to define a boundary between peace and health work (such as psychotherapy).

Figure 2 might give the impression of equity between direct, structural and cultural violence, as well as macro and micro level. The scope-model ignores that even within peace studies it is the direct violence on macro-level (in particular war) that gets most of the attention.

²⁹ “A **disease** is any abnormal condition of the [body](#) or [mind](#) that causes [discomfort](#), [dysfunction](#), or distress to the person affected or those in contact with the person.” Wikipedia encyclopedia <http://en.wikipedia.org/wiki/Disease> (accessed: 2004-11-27)

3 Exploring medical peace education

‘Peace’, ‘peace work’, and in consequence also ‘peace medicine’, as outlined in the first part of this paper, can have many different aspects. This makes it understandable that also existing or future ‘medical peace education’ will vary a lot in content and strategy, dependent on the local context, the understanding of the notion ‘peace’ and the national priorities in medical studies and vocational training.

Yet, which conflict issues are seen as most relevant for medical education, which peace qualities are requested, and which strategies are recommended? The following discussion of existing frameworks and of collected data from interviews, an online questionnaire and a literature search will suggest answers to these questions.

3.1 Different teaching frameworks

The arising of different peace-related teaching frameworks will be discussed in relation to three levels: Micro-level violence prevention, global public health and peace building, and medical ethics and human rights. The chapter is concluded with a brief description of the status of medical peace education in Norway.

3.1.1 Micro-level violence prevention

The need for education on **inter-personal violence prevention** was already expressed 20 years ago (Hydle and Stang 1984). This voice was loudest in the U.S., the country that faces the highest rate of firearm-related mortality in the industrialized world (Krug, Dahlberg et al. 2002, p. 323). As early as 1994, most U.S. medical schools reported offering curricular components that deal with adult domestic violence. However, these components are not taught in a systematic manner, as a review article in 1997 admits: “... with the exception of efforts in the field of child abuse, the profession of medicine has not yet adopted an effective, comprehensive strategy to educate medical students and practicing physicians about how to screen for, diagnose, treat, and prevent violence.” (Alpert, Sege et al. 1997, p. S42) As an explanation for the lack of concerted teaching efforts the same article identified insufficient expertise among the faculty and low socioeconomic status of the majority of the victims.

The prevention of self-induced violence was recognized as an important teaching issue already in 1974 (Cohen 1974), albeit mainly within the psychiatric field. As a public health concern, **suicide prevention** still needs much further development.

A global turning point for involving the health sector in different forms of (direct) **violence prevention** and its education might be the above mentioned *World Report on Violence and Health*, which expresses a clear mandate for medical commitment. (see: 1.2.1.1.)

3.1.2 Global public health and peace building

Violence on macro level was introduced into medical schools already in the 1980s, with the support of IPPNW and its model curriculum **Medicine and Nuclear War** (IPPNW 1988). A global survey in 1985 showed that 54 % of 140 responding medical schools had curricular content on this issue (McCally et al. 1985. In: McCally, Cassel et al. 1988). The UN Commission on Disarmament Education, in co-operation with IPPNW and PSR, released in 1993 the curriculum **Medicine and Peace** (UN Commission on Disarmament Education, IPPNW et al. 1993). It found international dissemination powered by committed IPPNW affiliates. The modular character of the concept was seen as an advantage. Schools were asked “to adapt the material to their own needs, and to use one or more modules in any way they think best for their own regions and culture” (Miles 1997, p. 331). This curriculum focused heavily on the health effects of nuclear war, but included modules on other weapons, on medical ethics, conflict resolution, and on underdevelopment as cause and consequences of warfare.

Global structural violence was deliberately addressed for the first time by the UK organization Medact, with the framework of **Global Health**. The Global Health curriculum deals with health effects of globalization, debt, poverty, environmental degradation, and of armed conflicts (Medact 2002). Similar to this is the Canadian **Ecosystem Health** framework applied at the University of Western Ontario³⁰. Both concepts differ substantially from the **International Health** framework³¹, popular in the U.S., with a rather ‘traditional tropical medicine’ approach.

McMaster University in Canada plays a key role in teaching medical peace building, with the **Peace through Health** framework. This framework emphasizes, by not excluding other global issues sketched above, the possible role of health professionals in peace processes and reconciliation (see: 1.2.1.2.). The “world’s first university course in Peace through Health (PtH)” was launched in January 2004. (Arya 2004)

³⁰ <http://www.med.uwo.ca/ecosystemhealth/education.htm> (accessed: 2004-11-16)

³¹ www.ihmec.org (accessed: 2004-11-16) There exist, however, terminological inconsistency by some institutions, which might contribute to confusion. E.g. IHMEC at the University College London (www.ihmec.ucl.ac.uk) uses the ‘Global Health’ approach.

Vocational training courses for health practitioners in peace building have been organized several times by WHO, under the concept **Health as a Bridge to Peace**. Since 1999, health professionals from different conflict sides have been brought together in Sri Lanka, Indonesia, former Yugoslavia and North-Caucasus, in order to learn the basics of Human Rights, International Humanitarian Law and conflict resolution. These joint training courses can themselves be seen as ‘tailor-made’ peace building projects.

3.1.3 Medical ethics and human rights

Medical ethics teaching might be as old as the Hippocratic Oath. Yet, it seems that the technological revolution and medical orientation toward natural sciences somehow pushed aside important humanistic values. Medical ethics awoke as a teaching discipline in the 1970s, with moral philosophers and theologians as early teachers. By the 1990s, it had conquered its place in the core curriculum of all U.S. medical schools. (Fox, Arnold et al. 1995, p. 762)

While medical ethics had for a long time confined itself to ‘microethical’ dilemmas in medical research and patient care, the last ten years have seen the emergence of a new trend that includes ‘macroethical’ issues. “Today’s medical professional cannot escape broader societal problems, as more and more patients are victims of gunshot wounds, child abuse, drug addiction, AIDS, and homelessness. Macroethical concerns about access to health services, allocation of scarce resources, and rights to medical care have come to the fore ...” (Fox, Arnold et al. 1995, p. 766).

The same concerns gave birth to the **Health and Human Rights** movement, which requests that the Universal Declaration of Human Rights should be a foundation for all medical practice and education (Leaning 1997; Gruskin, Mann et al. 1998). It is even suggested as the best solution for the Public Health’s struggle to find its core values: “... modern human rights, precisely because they were initially developed entirely outside the health domain and seek to articulate the societal preconditions for human well-being, seem a far more useful framework, vocabulary, and form of guidance for public health efforts to analyze and respond directly to the societal determinants of health than any inherited from the past biomedical or public health tradition.” (Mann 1997, p. 9)

Public Health Schools, especially in the U.S., have over the last years adapted this framework, while Medical Schools only sporadically have included human rights into their curricula, e.g. Mostar School of Medicine (Oreskovic and Lang 2001, p. 6).

Both ‘macroethics’ and ‘Health and Human Rights’ are underlying concepts for ‘Global health and medical peace building’ and would as such better be classified under ‘Global

public health and peace building (chapter 3.1.2). Differently from them stems the framework of **Medicine and Human Rights** which applies human rights primarily to the micro level and to direct violence. Its core focus is the violation of civil rights of individuals, as in torture and capital punishment. The development and dissemination of this concept is predominantly carried out by PHR and Amnesty International, with strong support from BMA (British Medical Association 2001).

3.1.4 The scope of different teaching frameworks

In order to compare the span of the teaching frameworks described above, a scope-model is applied. This model was originally designed for visualizing a holistic understanding of peace medicine (in chapter 2.5) to visualize how peace medicine should focus on all six categories of violence. An overview over the likely scope of the other frameworks is given in figure 3.

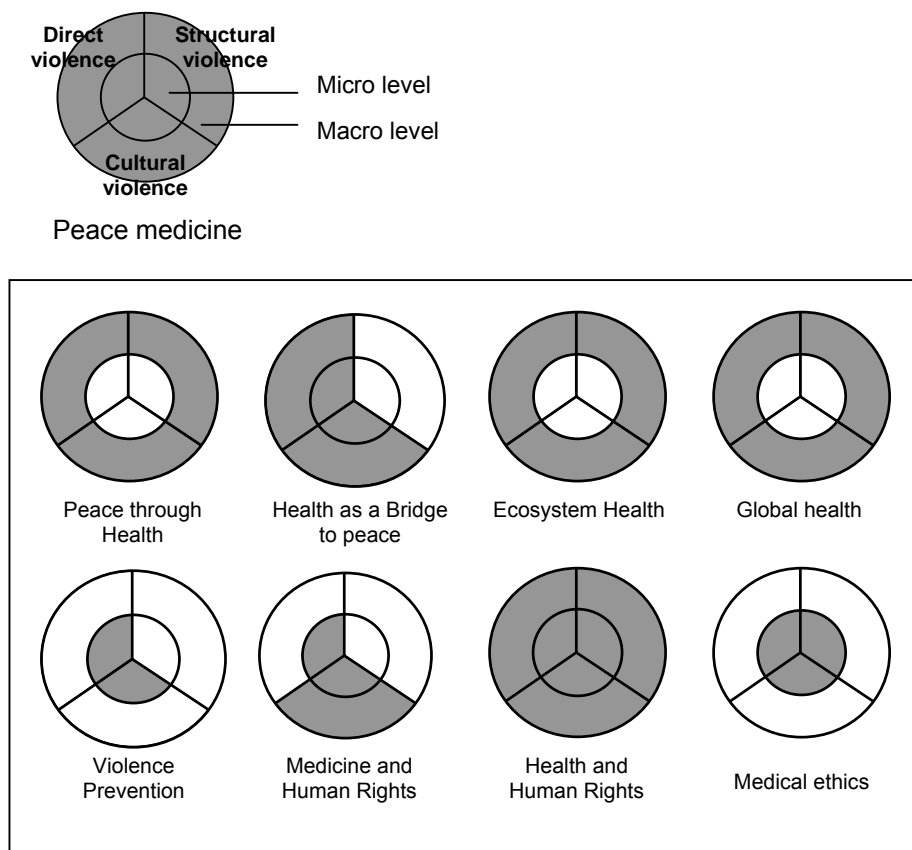


Figure 3: Assumed scope of different teaching frameworks

Like the comprehensive concept of 'Peace Medicine', the framework of 'Health and Human Rights' also seems to cover issues of violence and peace from all six fields in the scope-model. It is therefore believed that both could be used in similar ways to address

all unnecessary health barriers, calling them either ‘violence’ or ‘human rights violations’.

Other considered teaching frameworks seem to be less inclusive, as they tend to focus on only one type or one level of violence.

3.1.5 The Status in Norway

Applying a comprehensive understanding of medical peace education will surely reveal that many peace-related issues and objectives already are present in the current medical training. They are probably not associated with the term ‘peace’, in spite of their clear link to mutual respect, good relationships and communication, or conflict avoidance and -handling. Often they might not even be visible in the written curricula, but depend on the personal commitment of individual faculty members. The description in this chapter does therefore not claim to be comprehensive. The intention is just to provide a brief overview over identified medical peace education at the time of writing this thesis.

Suicide prevention has in the last years been covered in the core curriculum of all four Medical Schools in Norway (Bergen, Oslo, Tromsø, and Trondheim). The issue is also addressed in postgraduate courses attended by specialist candidates in psychiatry, general practice and occupational medicine.

Issues of **global public health and peace building** do not seem to be particularly integrated in the present curricula. Exceptions might be the one-week course in international health at the Medical School in Bergen, which teaches important issues of global health determinants, and the course in disaster medicine in Tromsø including aspects of social justice and solidarity.

Among medical students there is considerable interest in global health issues, as a national survey in 2001 demonstrated: 840 Norwegian medical students responded to questions about global health issues and prioritised poverty, epidemics, wars, environmental pollution and refugees as the five issues with probably the greatest impact on global health over the next 10 years. 89% of the students thought that there should be some teaching on these topics in the medical training, and 70% would even attend an extracurricular course. Finally, 87% of the students announced their interest in working in developing countries.³²

³² Unpublished material. The survey was conducted by NLA-students in co-operation with IFMSA-Norway.

In Oslo, NLA (IPPNW-Norway) launched an extra-curricular course in *Radiobiology and Politics* in 1999, where, among other issues, the effect of ionizing radiation, risk analysis, the present nuclear threat and psychosocial aspects of nuclear war were discussed.

The University of Tromsø currently prepares an elective course for medical and other health students, called *Peace, health and medical work*. The course will be organized in February 2005 and aims to create awareness about the potential role of health professionals in global violence prevention and sustainable peace building.

While **medical ethics** is part of the core curriculum in all Norwegian Medical Schools, **human rights** seems to be systematically addressed only at The University of Tromsø. In 1994, this university integrated human rights violation and torture into the courses of medical history, community medicine, and paediatrics (Cohn 1996).

NLA- students in Bergen have recently succeeded in their efforts to ask for incorporation of some aspects of human rights, torture and conflicts in the teaching of general practice, paediatric, social medicine, international health, and forensic medicine (Sandoy and Melf 2003).

3.2 Interviews

The aim of the interviews was to systematically consult representatives from organizations or institutions that may require peace qualities from Norwegian physicians, as well as the individuals who might teach them these qualities. It was intention to explore the range of medical peace work and peace education, building the foundation for the development of the online-questionnaire. In addition, the interviews would serve for network building and for easier access to peace-involved physicians and medical students.

3.2.1 Methodology of the Interviews

3.2.1.1 Development of the interview questions

Following a literature study on qualitative research (Patton 1990) an interview guide was designed with twelve knowledge/experience questions (see: Appendix I). It included questions about the nature of the organization's peace work, the medical contribution, needed peace qualities, existing peace education and strategies for its improvement. All but two questions were open-ended.

3.2.1.2 Selection of the interview partners

Through brainstorming with the CPS management, web-searches and a peer-discussion, a database was established containing 94 Norwegian institutions and organisations that were involved in peace work or peace education. 60 of them were judged as possibly relevant for medical peace work and peace education and therefore contacted. In 23 cases the answer revealed that they did not fit into following two selection criteria:

- A. The organisation/institution deals with one or several types of violence and involves Norwegian physicians or medical students in its kind of peace work.
- B. The organisation/institution conducts peace research/education and works mainly on an academic level.

12 selected organizations/institutions did not respond to email, or the contact person was not available during the limited time of the two fieldtrips (October/November 2003), while in 25 cases it was possible to perform interviews (including one that was conducted in March 2004). The initial contact was most often established by an email where the project was outlined and with the interview guide attached. The intention was to reach experienced scholars in research and teaching institutions, and staff managers in organizations/institutions that employ health professionals.

3.2.1.3 Conducting the 25 interviews

With the exception of two telephone interviews, all dialogues were performed face to face. Six of these took place in Tromsø (four in connection with the “Peace Education Conference” in October 2003). The remaining 17 interviews were conducted during two fieldtrips to Southern-Norway (five in Bergen, eleven in Oslo, one in Trondheim). At the beginning of each session, a short definition of ‘peace work’ was provided stressing a wide concept which includes direct, structural and cultural violence (see simple definition of peace work, 1.1.1). The interviews were conducted in an semi-structured way, mostly following the interview guide, while giving room for additional questions and explanations. They lasted between 14 and 83 minutes, and were conducted in Norwegian. Minutes were taken simultaneously from the fifth interview onwards, and all sessions were recorded (but one failed).

3.2.1.4 Analysis of the interviews

The substance was extracted from the records, using the interview guide as protocol form. In a first analysis round (February/March 2004), the collected thoughts on medical peace qualities and teaching strategies were categorized, summarized and reprocessed into possible alternatives for the online questionnaire (see development of the

questionnaire: 3.3.1.1). The analysis was repeated more carefully in a second round (September 2004), revealing information that was not adequately represented in the questionnaire.

3.2.1.5 Weaknesses and limitations of the interview methodology

The database of possible interview objects was inclined to non-governmental organizations. It neglected classical working fields of the health sector (hospitals, surgeries), in which peace qualities might be relevant, too. In addition, interview partners were selected from a utilitarian point of view, having in mind the demands for medical peace qualifications from possible employers, i.e. aid and peace organizations. This ignores the fact that also aid recipients and users of health services, as well as donors, politicians, etc., might have legitimate demands on the peace qualifications of (future) physicians.

A further bias was the location of interview partners. Easily accessible organizations, e.g. those in Tromsø or in Oslo, received more attention. In spite of several attempts, some important organizations, like Amnesty International or the Norwegian International Health Association could not be covered within the chosen timeframe. Due to the expected huge number of involved physicians, it was assessed as desirable to include peace keeping forces. Particular efforts were undertaken to complement the list of interview partners (see Appendix II) with one representative of the Medical Service of the Norwegian Defence (telephone interview in March 2004).

The categorization of the open interview answers constitutes one analytical weakness: Synonym and related concepts were summarized, but it was not always clear to which category the answer belonged. Even the distinction between peace skills, knowledge and values/attitudes was sometimes difficult and became subject to the author's interpretation. The intention of designing a brief and easy questionnaire enforced strict limitations to answer alternatives.

3.2.2 Findings in the interviews

3.2.2.1 What kind of peace work do they do?

The organizations/institutions of 14 interview partners fit into the first selection criterion (block A) as they involve Norwegian physicians / medical students in different types of peace practice, while representatives of the remaining eleven deal with peace education and research (block B). (see Appendix II)

Within block A peace work ranges from ‘prevention of suicide and interpersonal violence’ (micro level), to ‘prevention of nuclear war’ (macro level), and from ‘non-cooperation in discrimination’ (fighting cultural violence) to ‘development of the civil society’ (building peace structures). In order to summarize the different types of medical peace work, Manenti and Cassabalian’s four categories of ‘Health as a Bridge to Peace’ (joint actions, advocacy for peace-related values, health policies influencing root causes of conflict, and development of the civil society) (Manenti and Cassabalian 2003) were applied and supplemented with nine additional categories. Table 3 shows that even the peace work conducted by the organizations in block A often had to do with ‘capacity building, peace education’. Similarly frequent were answers fitting to ‘influencing root causes of conflicts’ and ‘advocacy of peace-related values’.

The interview partners did not always easily identify themselves with the term ‘peace work’. This was even true for an organization once awarded the Nobel Peace Prize. Several persons stressed that “we are not a peace organization” or they made it clear that they were not “pacifists”. Yet, they agreed that their work contributed to the prevention of war and violence, or to the promotion of human rights, solidarity, sustainable development and dialogue. For that reason they were willing to participate in the interviews.

Peace work categories	No. of respondents from block A
Capacity building, peace education	8
Influencing root causes of conflict	8
Value advocacy	7
Sustainable development	5
Joint action	4
Violence/suicide prevention	4
Dialogue, conflict transformation	4
Civil society development	2
Disarmament, weapons control	2
Research	2
Violence documentation, monitoring	1
Non-cooperation	1
Peace-keeping mission	1

Table 3: Peace practice of interview partners in block A

3.2.2.2 Medical peace contribution and assets

Organizations in block A engaged or had engaged between one and 300 medical professionals in peace work during the last three years (median: 13.5; missing: 2). Even in two of the eleven institutions in block B, five and two physicians/medical students were involved in peace work respectively.

When asked about the special role of doctors in peace work, the most frequent answers were ‘dialogue promotion / bridge building’ and ‘teaching / advocacy (influencing people and policy)’.

Special role of doctors in peace work	block A	block B	total
Dialogue promotion / bridge building	6	4	10
Teaching / advocacy (influencing people and policy)	4	6	10
Harm prevention	5	1	6
Health service in conflict / post-conflict areas	2	3	5
Documentation of violence	2	2	4
Research	1	0	1

Table 4: Physicians' special role in peace work according to interview partners

Many interview partners stated that medical professionals have a special role in peace work due to their ‘medical ethos’, their ‘access to and close contact with conflicts’, their ‘social status and authority’, and their ‘knowledge’.

Doctors' asset for peace work	block A	block B	total
Medical ethos	4	8	12
Access to and close contact with conflicts	6	5	11
Social status and authority	5	6	11
Knowledge	6	4	10
Received confidence	3	1	4
Peace work belongs to health work	3	1	4
Perceived neutrality	1	2	3
Health is a super-ordinate goal	1	1	2
Global medical community	1	0	1
Key positions	1	0	1

Table 5: Physicians' asset for peace work according to interview partners

3.2.2.3 The range of important medical peace qualities

Important peace skills

When asked about the skills that are particularly important for good ‘medical peace work’, most respondents quoted with ‘communication skills’ or ‘culture and conflict sensitivity’ (see table 6). Other oft-mentioned skills were ‘stress and conflict handling’, ‘teaching of knowledge and involvement, ‘building of self-confidence, strengthening of self-healing capacities’, ‘creativity, improvisation’ and ‘team work’.

In a second round of data analysis, additional categories of skills were identified which had not been respected adequately in the questionnaire design: The issue of ‘inner peace’ was expressed by several interview partners, while skills in ‘lobbying’, ‘integration of

minorities / individuals’, and in ‘physical and mental healing’ were each mentioned by one person only.

Important skills	block A	block B	total
Communication	10	5	15
Culture and conflict sensitivity	9	5	14
Stress and conflict handling	9	3	12
Teaching of knowledge and involvement	7	4	11
Building of self-confidence, strengthening of self-healing capacities	6	4	10
Creativity, improvisation	7	2	9
Team work	8	1	9
Community mobilisation	3	4	7
Careful listening	4	2	6
Diagnosis and documentation of violence	1	4	5
Conflict analysis	2	3	5
Public work, use of media	2	3	5
Knowledge building, research	3	1	4
Broad networking	3	1	4
Group leadership and organizing	3	0	3
Evaluation of own involvement and its consequences	0	3	3
Process facilitation, mediation	2	0	2
Inner peace	2	3	5
Lobbying skills	1	0	1
Integration of individuals and minority groups	1	0	1
Physical and mental healing	0	1	1

Table 6: Important medical peace skills according to interview partners

Important peace knowledge

Asked about particularly important knowledge for good ‘medical peace work’, interview partners most frequently answered “health professionals’ role in bridge building” (see table 7). Knowledge about ‘conflict solving strategies for macro and micro level’, ‘local context’, ‘global health issues’, ‘international rules and human rights’, ‘health impacts of different types of violence and weapons’, and the ‘link between physical, psychological and social health’ were also quoted in more than one third of the interviews.

Not sufficiently covered in the questionnaire design, but mentioned in two interviews, were ‘tropical medicine, war surgery’ and the ‘link between local and global peace work’.

Important knowledge	block A	block B	Total
Health professionals’ role in bridge building	6	7	13
Conflict solving strategies for macro and micro level	6	5	11
Local context	7	4	11
Global health issues	8	3	11
International rules and human rights	6	5	11
Health impacts of different types of violence and weapons	5	5	10
Link between physical, psychological and social health	5	4	9

Risk factors and violence-preventive measures	4	4	8
Psychology, sociology of aggression, violence and identity	4	2	6
Root causes of conflicts	3	3	6
What is needed for a stable and peaceful society	1	4	5
Quick construction of a stabilizing health service	3	2	5
Medical ethics and national guidelines	2	2	4
Dynamics and complexity of conflicts	2	2	4
Tropical medicine, war surgery	2	0	2
Link between local and global peace work	1	1	2

Table 7: Important medical peace knowledge according to interview partners

Important peace values/attitudes

Most frequently considered as particularly important values/attitudes for medical peace work were ‘Responsibility for others’ health and life’, followed by ‘compassion, humanitarian attitude’, ‘respect for others’ culture and knowledge traditions’, and ‘equity, partnership’. Table 8 lists all considered values/attitudes.

In addition to the designed answer alternatives in the questionnaire, the second round of analysis also identified ‘sustainability, subsidiarity’ as a value/attitude requested by two interview partners.

Important values and attitudes	block A	block B	total
Responsibility for others’ health and lifes	7	5	12
Compassion, humanitarian attitude	8	3	11
Respect for others’ culture and knowledge traditions	5	5	10
Equity, partnership	8	2	10
Peace, non-violence	4	3	7
Patience	4	3	7
Commitment, involvement	5	2	7
Tolerance, respect for diversity	4	3	7
Modesty	2	4	6
Solidarity	4	2	6
Confidence in local capacities	3	2	5
Neutrality, impartiality	2	2	4
Being inquisitive	4	0	4
Optimism, belief in improvement	1	2	3
Truth, honesty	2	0	2
Sustainability, subsidiarity	1	1	2

Table 8: Important medical peace values and attitudes according to interview partners

3.2.2.4 Where medical peace qualities can be learned

Table 9 outlines that the interview partners mostly referred to their ‘open seminars, workshops’ or to their ‘internal preparation, briefing’ as existing options for physicians / medical students for learning the important peace qualities.

Existing learning possibilities	block A	block B	total
Open seminars, workshops	3	6	9
Internal preparation, briefing	7	1	8
Published teaching material, online resources	2	4	6
Peace-related higher education and research possibilities	0	6	6
Internship, voluntary work	3	2	5
Teaching of medical students	3	1	4
Medical specialization course, conferences	4	0	4
Use of external teaching possibilities	3	0	3
Research project for medical students / doctors	2	0	2
Exchange program for medical students / specialist candidates	1	0	1

Table 9: Existing learning possibilities according to interview partners

Peace-related teaching for medical students was only brought up in four interviews, pointing to curricular content on suicide prevention, the course in international health in Bergen, and the disaster medicine, as well as the peace-health course in Tromsø (see also status in Norway: 3.1.5). Student exchange was only brought up by one informant, referring to a scholarship program for students from the South, while research possibilities for Norwegian doctors or students were offered twice – one in war-torn societies and one in developing countries.

Four representatives mentioned specialist courses or medical conferences which address (-ed) prevention of suicide and interpersonal violence, and issues of human rights and global health. Five interview participants (all from NGOs) invited doctors and medical students to voluntary work within their organizations, embracing micro and macro level conflict issues primarily in Norway.

3.2.2.5 The range of teaching strategies

Best teaching methods

The interview partners were asked about the best form of teaching in order to improve the peace work capacities of Norwegian physicians / medical students. Table 10 indicates that the most frequent answers to this question were ‘supervised practice, field work’ and ‘practical exercises, role play’. Not processed into questionnaire answers exploring teaching methods, but combined with answers about implementation ways, were ‘interdisciplinary/international seminars’, ‘internships abroad’, and ‘research work abroad’. The second round of data analysis revealed that distinctive from the answers above but absent from the questionnaire were ‘inclusion of the participants' experiences’, ‘consciousness work’, and ‘linking the local with the global level’.

Best incorporation way

When faced with the question of how a more extended peace training could be

implemented in the medical education and specialisation (see table 11), the respondents most often suggested the idea of separate ‘specialist courses’, ‘integration in existing clinical modules’, a ‘dedicated module within the core curriculum’, and ‘supplementing and strengthening social medicine, public health’. Again mentioned here were ‘internships abroad’ and the idea of ‘research, PhD scholarships’.

Best teaching methods	block A	block B	total
Supervised practice, field work	3	4	7
Practical exercises, role play	2	4	6
Exchange programmes for students	3	1	4
Group work with case studies, problem-based learning	2	2	4
Processes that encourage involvement	2	2	4
Experience-based lectures	1	2	3
Recommended reading lists	0	1	1
Inter-disciplinary / international seminars	4	1	5
Internships abroad	0	3	3
Research work abroad	1	1	2
Inclusion of the participants' experiences	2	1	3
Consciousness work	2	0	2
Linking the local with the global level	0	1	1

Table 10: Best teaching methods according to interview partners

Best ways of implementation	block A	block B	total
Specialist course	4	3	7
Integration in existing clinical modules	5	1	6
Dedicated module within the core curriculum	4	2	6
Supplementing and strengthening social medicine, medical anthropology, global health, etc.	3	2	5
Internships abroad	0	2	2
Research, PhD scholarships	2	0	2
National competence centre	1	0	1
Articles in the journal of the Norwegian Medical Association	1	0	1
Institutional cooperation with poor, conflict prone countries	1	0	1

Table 11: Best way of implementation according to interview partners

Best evaluation form of teaching effectiveness

Personal transformation towards more ‘peace-related values and involvement’ was regarded as the best measure of the effectiveness of medical peace education, followed by the ‘satisfaction of the course participants’ in an internal evaluation, preferably after practical experiences. (See table 12)

Best evaluation of effectiveness	block A	block B	total
Increased level of peace-related values and involvement	7	4	11
Satisfaction of the course participants (also after practice)	3	4	7
Increased level of peace-related skills and knowledge	3	1	4
Satisfaction of other staff members, clients, partners	3	1	4
Increased number of successful intervention / treated	2	1	3

patients			
Reduction of violence / changing of attitude	1	2	3
Popularity of the course / number of trained students	0	2	2
External course evaluation (goals reached?)	1	0	1

Table 12: Best ways to evaluate the education's effectiveness according to interview partners

Best trainers

‘Health personnel with field experience in Norway or abroad’ were most frequently suggested as the best trainers for medical peace education, followed by ‘specialists from different disciplines (social anthropology, human rights, etc.)’ and ‘peace researchers or resource persons in communication, dialogue, process facilitation’.

Best trainers	block A	block B	total
Health personnel with field experience in Norway or abroad	7	6	13
Specialists from different disciplines (social anthropology, human rights, etc.)	6	3	9
Peace researchers or resource persons in communication, dialogue, process facilitation	3	5	8
Resource persons from different nations (incl. the south)	2	3	5
Engaged teachers	1	1	2
Trainers with critical / reflective mood	0	1	1
Patients/clients	0	1	1
Trainers able to systematization of own experience	0	1	1

Table 13: Best trainers according to interview partners

Important conflict issues

The last interview question focused on the conflict issues which ‘should absolutely be included’ in medical peace education. Table 14 presents the entire range of mentioned issues. ‘Human rights violation and torture’ was named by nearly half of the interview partners.

Absolutely important conflict issues	block A	block B	total
Human rights violations and torture	6	6	12
Refugee/migration problems	6	2	8
Distribution of resources and North/South research priorities	4	4	8
Dilemmas in humanitarian aid	2	6	8
Poverty and development needs	4	3	7
War and terror	4	2	6
Ethical dilemmas in clinical practice and research	3	2	5
Globalization	3	2	5
Privatization and patent rights	3	2	5
Ecological degradation	2	2	4
Double-loyalty in public health, military-, prison service, etc.	3	0	3
Bullying in schools	2	1	3
Cultural intolerance, racism	2	1	3
Weapons of mass destruction	2	1	3
Small arms and landmines	2	1	3

Workplace environment	1	1	2
Discrimination against women	1	1	2
Suicide	2	0	2
Domestic violence	1	0	1
Youth violence, gang fights	1	0	1
Religious fundamentalism	1	0	1
Myths about Norwegian peace engagement	0	1	1

Table 14: Absolutely important conflict issues according to interview partners

3.3 Online questionnaire

The intention of the online questionnaire was to ask those Norwegian physicians and medical students who had been involved in some form of medical peace work. They should prioritize the collected information from the interviews, using their own experience.

3.3.1 Methodology of the online-questionnaire

3.3.1.1 Developing the questionnaire

After the first round of interview analysis, twelve questions were designed (see: Appendix III). Four demographic questions addressed the interviewees' profession, gender and age group, as well as their medical specialization / specialization plans. The latter was an open and optional question while the former three had answer alternatives and were obligatory.

Question 5 and 6 explored personal experiences in peace work, question 7 to 9 required peace work qualities, and 10 to 12 strategies for improvement of medical peace education. All these questions had answer alternatives and an open space for additional thoughts. In order to improve the compliance of interested website visitors and to increase the response rate, a simple 'tick the favoured answer alternatives'-system was adopted.

The questionnaire was then transformed into the WebSim format and published on the website of the Centre for Peace Studies, University of Tromsø.³³

3.3.1.2 Conducting the online-survey

During March 2003 an email with short information about the survey and a web-link to the online-form was spread via the 25 interview partners and other networks to peace-involved Norwegian physicians/students, relying to some extent on the snowball

³³ <http://uit.no/cps> (accessible: March 9-31, 2004)

principle. The Norwegian Medical Association and the medical peace organization NLA (IPPNW-Norway) put the link on their homepage. The same information was also personally announced in two classes of medical students, and sent via the internal email lists to all medical students and scholars at the University of Tromsø. In addition, posters with the same text were put up at the Medical School and the University Hospital. The questionnaire had to be filled in online and was accessible from March 9th to March 31st 2004. More comprehensive information about the survey was provided on the web-site.

3.3.1.3 Analysing the questionnaire result

The collected data was converted into an Excel-file, and used for descriptive statistics. With the help of Excel and SPSS software the results were transformed and visualized in bar and pie charts. The prioritized answers were compared with and discussed in relation to the interview answers.

3.3.1.4 Methodological limitations

The design of the questionnaire was mainly based on the first round of analysis of the interviews with the limitation and weakness discussed above (see 3.2.1.5). For a common understanding of 'medical peace work', a short definition was given in the questionnaire with the risk of biasing the response. The definition was neither conventionally narrow, nor as holistic as elaborated for the concept of 'peace medicine' in chapter 2.

As the intention was to keep the questionnaire as short and simple as possible, a reduction to twelve questions was seen as necessary. Interesting aspects that came up during the interviews and the literature search, e.g. on existing peace education, were left out. The questionnaire design did not allow the respondent to grade their preferred priorities in their answers.

The chosen methodology of a freely available online questionnaire as well as the applied form of web-link distribution does not allow for any control mechanism. There is no way of knowing how many physicians and medical students in Norway who regard themselves as peace-involved, or indeed how many were reached by the different forms of announcement. As the survey was based on a process of self-selection, there is no guarantee that the respondents actually belonged to the targeted population of medical peace practitioners, or if the respondents were representative. It is, however, supposed that peace-committed doctors and medical students might have been particularly

attracted by the invitation. Finally, a clear local bias is expected as the main spreading efforts were undertaken in Tromsø.

3.3.2 Findings in the questionnaire

97 forms were completed in the fixed timeframe of three weeks.

3.3.2.1 Demographic information

47 respondents stated that they were 'medical students', while 50 identified themselves as 'physicians'. When asked about the medical specialty of their focus, only 14% (all students) left the given space blank. After sorting the multiple answers into clinical medicine, community medicine, and medical biology³⁴, 53% of the respondents fit into the clinical medicine category, 27 into the community medicine category, and three into the medical biology category. Another three percent belonged to both the clinical and the community category (see: Appendix IV, fig. 4a and 4b).

59% of the respondents were 'female' while 41 'male'. 57% of the participants were less than 35 years old, 21 % between the age of 35 and 50 years, and 22% were older than 50 years (see: Appendix IV, fig. 5a and 5b). Based on the information about profession and age, it may be assumed that the younger generation is more interested in medical peace work, or at least they were in this survey.

3.3.2.2 Where medical peace work is conducted

76% marked that they had peace work experience from Norway (see: Appendix IV, fig.6a). When asked about other countries, 41% filled in one or several country names in the open space, 12% without having marked experiences from Norway in the question before. Neither the answer Norway, nor any other country was given by 10% of the participants. There exists some doubt, as to whether these ten respondents actually belonged in the survey target group. The analysis of the 90% positive answers (Norway and/or other countries) revealed that 55% of the participants only had experience from countries with high Human Development Index³⁵, 20% had (additional) experience from countries with medium HDI, while 15% had (also) peace work experiences from countries with low HDI rank (see: Appendix IV, fig. 6b). The figures above give strength to the point that peace work is also conducted in Norway and far away from war-zones, as the majority of respondents had gained their experience at home.

³⁴ Analogue to the three medical institutes at the Faculty of Medicine, University of Tromsø, <http://uit.no/medfak> (accessed: 2004-11-25)

³⁵ Human Development Index (HDI) as defined in Human Development Report 2004, <http://hdr.undp.org/2004/> (accessed: 2004-11-25)

While 33% related their peace work experiences to a ‘teaching institution’ and/or a ‘peace organisation’ respectively, 30% gained their experience when working for a ‘humanitarian organisation’. 24% marked ‘surgery or hospital’. Between 14% and 5% of the participants related their experience (also) to their work in a ‘research institution’, a ‘human rights organisation’, the ‘community or health administration’, a ‘solidarity group’, and/or the ‘Norwegian armed forces’. In the open space, two respondents added ‘a religious group’, while ‘refugee assistance’, ‘medical association’, ‘development assistance’ and ‘women’s movement’ were all added once. (See: Appendix IV, fig. 7)

3.3.2.3 Qualities required by medical peace practitioners

Prioritized peace skills

Confronted with the question “Which skills do you personally regard as most important for medical peace work?”, 89% marked ‘communication and dialogue’ in the list of 17 given answers. Communication and dialogue are essential skills in medical care, too (e.g. for confidence building in the physician-patient relationship, for revealing the patient’s history, or for important multi-disciplinary team work). It is obvious that communication skills must be learned during the medical formation. Equipped with these skills, physicians might have an advantage in peace building. To offer communication skills training in sessions of medical peace education might therefore improve both, the conventional health work as well as medical peace work.

On second position, the majority of the participants also prioritized good skills in ‘respectful behaviour in local culture and context’ (59%). During the interviews, ‘culture and conflict sensitivity’ was further depicted as “tactfulness, diplomacy, discretion, honesty, listening to local context, social skills, or respectful meeting”. Again, it seems that this quality is similarly relevant for medical practice as it is for peace work.

Further prioritized was ‘teaching of knowledge and involvement’ (53%) and ‘knowledge building / research’ (46%). Included in the ‘teaching’-category were interview answers like “equipping people with tools, ability of communication of knowledge, health education on ‘conflict hygiene’, advocating skills, pedagogical skills, and encouraging attitude change and involvement”. Teaching and advocacy skills, as well as research skills are particularly important for public health, dealing with health education and health-promoting policy. Medical peace work has indeed a lot to do with public health, and it needs the mentioned skills for peace education and ‘data-to-policy’ work.

40% of questionnaire responders regarded ‘team work’ as one of the most important peace skills; for 36% it included ‘community mobilization’. Both are also classically

required in the health sector for best–possible health output either for individual patients or for the society. During the interview analysis ‘community mobilization’ also categorized terms like “grass-root work, development of attitudes in local community, building of good local communities, encouraging involvement”. It might be a cornerstone for the peace movement when struggling for attitude and behaviour change, pressing government and decision makers through mass actions from above. Idols in non-violent action, like Mahatma Gandhi or Martin Luther King, succeeded in their struggle due to their capacity of mass mobilisation.

Which skills were not prioritized? Interestingly, central skills in peace building like **‘conflict and stress handling’, ‘conflict analysis’, and ‘process facilitation / mediation’** received less support in the questionnaire. It is possible that positive examples of health diplomacy are little known.

It is also surprising that ‘diagnosis and documentation of violence’ was down-prioritized, as it appears central in medical peace work (see Medical Friend Circle in 2.3). This particular finding challenges further exploration or education.

An overview of prioritized peace skills is presented in figure 8, (see: Appendix IV). Added to the given answer alternatives were self-insight, social intelligence, self-learning, understanding of inequality, and languages.

Prioritized peace knowledge

As knowledge for good medical peace work 57% of the participants prioritized the ‘connection between physical, psychological and social health’. It was followed by 43% who quoted ‘the local context (culture, geography, language, etc.)’ and 40% ‘global health issues’. Further marked by more than one third of the respondents were ‘root causes of conflicts’ (38%), ‘psychology/sociology of aggression, violence and identity’, as well as ‘international law and human rights’ (35%), and ‘strategies for conflict resolution on macro and micro level’ (34%). (See: Appendix IV, fig. 9)

One participant added knowledge about ‘disarmament work’, while another complemented with ‘culture dependent concepts of health, aggression and conflict handling’.

Prioritized peace values/attitudes

The most needed attitudes and values for medical peace work were for 65% of the participants ‘compassion, humanitarian attitude’, and for 63% ‘respect for others’ culture and knowledge traditions’. Also regarded as important by the majority were ‘tolerance,

respect for diversity' (57%), 'optimism, belief in improvement' (53%) and "responsibility for others' health and life" (51%). (See: Appendix IV, fig. 10) Supplemented as important value/attitude were 'love' and 'courage'.

3.3.2.4 Recommended education strategies

Prioritized teaching forms

The forms of teaching the important peace qualities deemed best were 'exchange programmes for students' (67%), 'supervised field work' (64%), and 'experience-based lectures' (63%), followed by 'group work with case studies, problem-based learning' (47%). 'Practical exercises, role play', 'processes that encourage involvement' or 'recommended reading list' were seen as less important. (See: Appendix IV, fig. 11) It is striking that practical modes of learning were preferred by the questionnaire responders, but only few corresponding learning possibilities were offered by the interview partners (3.2.2.4)

Requested actions

'Institutional cooperation with poor / conflict prone countries' (58 %) was seen as most essential to strengthen the medical peace education in Norway. 52% of the participants also selected 'more focus on social medicine, medical anthropology, global health, etc.', while nearly half of the respondents (47%) went for 'increased peace perspective in clinical training (general practice, psychiatry, etc.)' or 'dedicated course in peace medicine within the compulsory curriculum' (46%). (See: Appendix IV, fig. 12) Less in demand were 'inter-disciplinary seminars', 'competence centre for medical peace work and peace education', 'research scholarship, doctoral degree in peace medicine', 'articles in the journal of the Norwegian Medical Association', 'internships abroad', or 'specialist courses within general practice, public health, psychiatry, etc.'. Added by one person was 'inter-disciplinary co-operation with the Faculty of Social Science for elective courses'.

Prioritized conflict issues

The participants were asked to prioritize the 22 identified "absolutely important conflict issues for medical peace education". As depicted in figure 13 (see: Appendix IV), the most preferred conflict issues in such teaching comprised 'human rights violation and torture' (68%), 'poverty and development need' (65%), 'refugee/migration problems' (62%), 'dilemma in humanitarian aid' (56%) and 'cultural intolerance, racism' (52%). All, apart

from the last, had been leading conflict issues in the interview sessions. It should be pointed out that the top five conflict issues do not include the term 'war', nevertheless they can easily be related to primary, secondary or tertiary intervention in war-torn areas. They might support the presented theory that peace work is not only regarded as preventing /minimizing violent behaviour, but also as transforming violent structural and cultural aspects (see 1.1.2.1).

Still more than 40 % of the respondents selected 'war and terror', 'globalisation', 'distribution of resources and North/South research priorities', as well as 'small arms and landmines'. These were followed by 'ethical dilemmas in clinical practice and research'.

Out of these preferences, it can be assumed that for most of the participants, peace work primarily concerns international work. Yet, several topics (e.g. human rights violation, refugees, racism) are not uncommon issues in the daily work of Norwegian physicians. They present a strong argument for teaching these peace-issues in the core curriculum, and not to limit such kind of peace education to those who prepare for work abroad or for those who want to challenge global health barriers. It is backed by the 40% of respondents who wish to prioritize questions of medical ethics in such education.

Considering the conflict issues that were marked by less than one third of the respondents, it can be speculated that 'weapons of mass destruction' have lost the attention of health professionals. This does not mean that the immanent danger of these weapons (in particular nuclear weapons) is lower than 20 years ago, but the risk perception among medical personnel, as in the population in general, seems to have decreased. Despite of that, it can be acknowledged that IPPNW continues to be one of the central and most persevering players in the nuclear disarmament movement.

Another global issue less prioritized in the survey is the topic of 'ecological degradation'. This issue might be less recognized as peace-relevant, as the controversies in Norway regarding the 2004 Nobel Peace Prize³⁶ might confirm.

As other important conflict issue on macro-level, one respondent suggested the 'destruction of infrastructure and security' and another 'HIV/AIDS'.

Obviously under-represented in the 'top ten' list are conflict issues dealing with inter-personal violence (domestic violence, bullying in schools, etc.) and self-induced violence (suicide). Without doubt, micro-level violence is in terms of mortality, morbidity and

³⁶ In October 8th, 2004, the Norwegian Nobel Committee announced its decision to award the Nobel Peace Prize for 2004 to Wangari Maathai, who is most known for her environmental activism.

consumption of health service resources a more important health problem than collective violence (Krug, Dahlberg et al. 2002). Inter-personal and self-induced violence should therefore be adequately addressed in the core curriculum of Medical and Public Health Schools.

The fact that medical peace practitioners focus on global issues, is in accordance with the predominant³⁷ depiction of peace work as belonging to war and occupation. From a peace study perspective this is insufficient. The micro level is not only linked to the macro level, but is in itself an important issue for peace research and education. (See 1.1.2.1)

3.4 Medical peace education in the literature

3.4.1 Searching for articles on peace-related medical education

‘Medical peace education’ was not a searchable term in the recognized medical database MEDLINE, using the WebSPIRS program³⁸. Yet, ‘education-medical’ existed as a Major Heading (MJME) with 55357 entries. It embraces, when exploded, undergraduate, graduate and continuing education, as well as internship and residency.

Searching terms	Total hits
“medical peace education”	0
“peace in TI,AB”	1640
“(social harmony) in TI,AB”	8
“(social well-being) in TI,AB”	412
“(peace OR social-harmony OR social-well-being) in MJME”	0
“explode education-medical in MJME”	55357

Table 15: Medline search on peace or medical education

Even if in 1640 articles the term ‘peace’ was searchable in title and/or abstract, not more than seven remained after crossing with ‘education-medical’ as Major Heading [“(peace in TI,AB) AND (explode education-medical in MJME)”]. After inspection of titles and abstracts two articles were deemed relevant. A similar search with ‘social well-being’ led to one relevant article. The identified articles represent conflict issues that can be attributed to direct, structural, and cultural violence on both macro and micro level.

³⁷ At least in the western tradition. The author experienced during a stay in Sri Lanka in May 2004, that health professionals, known for their ‘peace work’, dealt mainly with ‘social harmony’ (e.g. building up psycho-social counselling) and ‘inner peace work’ (e.g. introducing yoga into schools and health service).

³⁸ Using WebSPIRS®5 at www.ub.uit.no/fag/medisin/ (accessed 2004-11-05)

Searching terms	“Explode education-medical in MJME”		
	“AND” (Hits)	After inspection of titles and abstracts	Conflict issues
“peace in TI,AB”	7	2	Reduction/prevention of macro and micro level violence, conflict resolution, medical ethics, human rights and humanitarian law (Santa Barbara 2004) --- Law of armed conflicts, medical ethics, human rights, double loyalty for military doctors (Baer and Gilgen 2002)
“(social-harmony) in TI,AB”	0	0	
“(social well-being) in TI,AB”	2	1	care of the socially disadvantaged, social responsibility, concern about patients’ social well-being (Potts 1994)

Table 16: Medline search on conflict issues in medical peace education

As neither the terms ‘peace’ or ‘social-harmony’, nor ‘social-well-being’ exist in MEDLINE as main headings (MJME), the Medical Subject Heading (MeSH) database³⁹ was therefore screened for terms related to the suggested definition on ‘peace work’ (see 1.1.1).

The search for peace-work-related MeSHs revealed that different forms of violence (homicide, domestic violence, terrorism, torture, war, etc.) are found in the hierarchic tree-system under the Major Topic Heading ‘**social-problems**’, while terms of positive peace work were described by MeSHs like ‘**human-rights**’ (child advocacy, informed consent, social justice, women’s rights, etc.), ‘**conservation-of-natural-resources**’ (sustainable development), ‘**interpersonal-relations**’ (dissent and disputes, intergenerational relations, interdisciplinary communication, negotiation, etc.) and ‘**conflict-psychology**’.

The identified Major Topic Headings, as well as the corresponding sub-ordinate MeSHs, were afterwards searched as Major Heading (MJME) in MEDLINE and combined with ‘education-medical’. Each MeSH was separately searched, e.g. [“(explode child-abuse / prevention-and-control in MJME) AND (explode education-medical in MJME)”]. This finally provided a good overview of the frequency of scientific articles on different contents of medical peace education. (See table 17)

³⁹ See MeSH database www.nlm.nih.gov/mesh/meshhome.html (accessed 2004-10-23)

Most MEDLINE-articles were linked to interpersonal relations, in particular to physician-patient relations (874) and interdisciplinary communication (51). Further important as a Major Topic Heading is ‘Human-Rights’, as it brought up 92 articles about patient rights, especially on the issue of ‘informed consent’ (75). The third most fruitful MeSH was the issue of ‘violence prevention’ which identified 50 articles on medical education, 37 of which discussed issues of domestic violence.

		“Explode education-medical in MJME”	
Searching term “Explode ‘...’ in MJME”	Total hits	“AND”	
‘Social-Problems / prevention-and-control’	9240	59	
•Civil-disorders -Riots	16 8	0	0
•Homicide -Euthanasia	111 0	0	0
•Human-rights-abuses	5	0	
•Poverty	70	0	
•Suicide -Suicide-assisted -Suicide-attempted	2504 11 415	9	0 0
•Violence -Domestic-violence -Child-abuse -Elder-abuse -Spouse-abuse -Terrorism -Bioterrorism -Torture	5267 2829 1684 309 439 841 644 2	50	37 7 2 7 2 1 0
•War -Biological-warfare -Chemical-warfare -Nuclear-warfare -Psychological-warfare -War-crimes -Holocaust	263 222 46 13 0 6 0	2	1 0 1 0 0 0
‘Human-Rights’	38420	162	
•Child-advocacy	1859	4	
•Civil-rights -Privacy -Access-to-information -Genetic-privacy	5371 1779 469 431	19	2 0 0
•Freedom -Personal-autonomy	2028 1434	6	3
•Patient-rights -Confidentiality -Duty-to-warn -Genetic-privacy -Informed-consent -Patient-access-to-records -Right-to-die -Treatment-refusal	22242 7286 507 432 10121 201 2433 3230	92	11 1 0 75 0 3 4
•Social-justice	1819	8	
•Women's-rights	3579	11	
‘Conservation-of-natural-resources’	4751	1	

•Conservation-of-energy-resources	556	0
'Interpersonal-relations'	58784	1328
•Dissent-and-disputes	424	4
•Intergenerational-relations	721	5
•Interprofessional-relations	11192	347
-Interdisciplinary-communication	491	51
-Physician-nurse-relations	503	9
•Negotiation	838	6
•Professional-family-relations	2816	25
•Professional-patient-relations	32780	894
-Physician-patient-relations	16140	874
-Researcher-subject-relations	87	0
•Trust	289	4
'Conflict-psychology'	2841	14
Total (without doubles)	110912	1550

Table 17: Medline search on peace-related MeSHs and medical education

In total, there were more than 100.000 entries, when exploding the identified five Major Topic headings [“(explode social-problems /prevention-and-control in MJME) or (explode human-rights / all subheadings in MJME) or (explode conservation-of-natural-resources / all subheadings in MJME) or (explode interpersonal-relations / all subheadings in MJME) or (explode conflict-psychology / all subheadings in MJME)”]. 1550 were left standing when combined with ‘education-medical’. The MJME-indexation of these 1550 articles points to the research focus in peace-related medical education, at least in Northern America. It might be a mirror for the conflict issues dealt with in correlating teaching efforts.

None or only a few articles appeared when searching with MeSHs dealing with ‘homicide prevention’, ‘prevention of human rights abuses and torture’, ‘prevention and control of poverty’, or ‘war prevention’. Similarly neglected issues are also ‘social justice’, “women’s rights”, ‘sustainable development’ and ‘disputes’.

3.4.2 Covering prioritized peace qualities and teaching methods

Four relevant review articles were found, when combining ‘medical education’ and the above described peace work related Major Topic headings together with ‘objectives or methods’. They deal with ‘interpersonal violence’, ‘human values’, ‘interpersonal skills’ and ‘medical ethics’ respectively.

Searching term	“(education or teaching or learning) near (objectives or methods) in TI,AB”	
“(Explode education-medical in MJME) and (Explode ‘...’ in MJME)”	“AND”	After inspection of title and abstract
‘Social-Problems / prevention-and-control’	3	1 (Alpert, Sege et al.

		1997)
'Human-Rights'	1	0
'Conservation-of-natural-resources'	0	0
'Interpersonal-relations'	58	3 (Branch, Kern et al. 2001), (Novack, Volk et al. 1993), (Miles, Lane et al. 1989)
'Conflict-psychology'	1	0
Total	63	4

Table 18: Medline search on objectives and methods in medical peace education

The retrieved four documents are mainly concerned with conflict issues on the micro-level. They were supplemented with central references in their bibliographies, with citing articles, and with central articles found earlier in the process of this thesis (see descriptive summary of key articles on medical peace education: Appendix V).

Objectives and methods in teaching global peace issues were found in documents on the McMaster, the WHO and the IFMSA/IPPNW experiences. Applying the distinction of different teaching frameworks, as outlined in chapter 3.1, the key articles were grouped into 'micro-level violence prevention' (Viol. Prev.), 'medical ethics and human rights' (Ethics, HR), and 'global public health and peace building' (PtH, HBP). Described teaching objects and methods from these articles were then related to the requested peace qualities and teaching methods found in interviews and questionnaire (Quest.). The coverage of these qualities and methods in the teaching frameworks is presented in table 19 and 20.

	Quest. N=97	Viol. Prev.	Ethics, HR	PtH, HBP
Peace skills				
Communication and dialogue	86	•	•	•
Respectful behaviour in local culture and context	57	•	•	•
Teaching of knowledge and involvement	51		•	•
Knowledge building, research	45			•
Team work	39	•	•	•
Community mobilization	35	•	•	•
Conflict and stress handling	32	•	•	•
Conflict analysis	31	•		•
Careful listening	30	•	•	•
Diagnosis and documentation of violence	27	•		•
Broad networking	27			•
Building of self-confidence, Strengthening of self-healing capacity	27			•
Creativity, improvisation	25			•
Public work, use of media	18			•
Evaluation of own involvement and its consequences	18		•	•
Group leadership and organizing	15	•		•
Process facilitation, mediation	12	•	•	•

Peace knowledge				
Connection between physical, psychological and social health	55		•	•
Local context (culture, geography, language, etc.)	42	•	•	•
Global health issues	39	•	•	•
Root causes of conflicts	37	•		•
Psychology/sociology of aggression, violence and identity	34	•		•
International law and human rights	34	•	•	•
Strategies for conflict resolution on macro and micro level	33	•	•	•
Medical ethics and national guidelines	30	•	•	•
Dynamics and complexity of conflicts	27		•	•
Quick construction of a stabilizing health service	27	•		•
Health impacts of different types of violence and weapons	24	•	•	•
Health as bridge to peace	23	•	•	•
Risk factors and violence-preventive measures	22	•	•	•
What is needed for a stable and peaceful society	16		•	•
Peace values and attitudes				
Compassion, humanitarian attitude	63	•	•	•
Respect for others' culture and knowledge traditions	61	•	•	•
Tolerance, respect for diversity	55	•	•	•
Optimism, belief in improvement	51			•
Responsibility for others' health and life	49	•	•	•
Solidarity	42	•	•	•
Patience	41			•
Peace, non-violence	39	•	•	•
Equity, partnership	35	•	•	•
Being inquisitive	33		•	•
Truth, honesty	32		•	•
Commitment, involvement	29	•	•	•
Confidence in local capacities	28	•		•
Neutrality, impartiality	25			•
Modesty	3			•

Table 19: Coverage of requested peace qualities in different teaching frameworks

It is striking that the objectives of the five key documents in the PtH / HBP group (see Appendix V) more or less explicitly address all requested peace qualities. As the articles are mainly based on existing courses and training, it might be argued that the teaching, requested by the interview partners and questionnaire participants, is possible and does already exist. Even if this group represents the most appropriate teaching frame for medical peace education, it must be recognized that the other two framework groups also cover many of the prioritized skills, knowledge fields and values. They too would therefore probably function well as frameworks for the requested peace education. Many peace qualities seem to be equally important for addressing micro-level conflicts (Viol. Prev. and Ethics, HR), as they are for macro-level content (PtH, HBP).

	Quest. N=97	Viol. Prev.	Ethics, HR	PtH, HBP
Teaching methods				
Exchange programmes for students	65			
Supervised field work	62	•	•	
Experience-based lectures	61	•	•	•
Group work with case studies, problem-based learning	46	•	•	•
Practical exercises, role play	30	•	•	•
Processes that encourage involvement	28	•	•	•
Recommended reading list	11	•	•	•
Incorporation principles				
Institutional cooperation with poor / conflict prone countries	56			•
More focus on social medicine, medical anthropology, global health, etc.	50		•	
Increased peace perspective in clinical training (general practice, psychiatry, etc.)	46	•	•	•
Dedicated course in peace medicine within the compulsory curriculum	45	•	•	•
Inter-disciplinary seminars	35	•	•	
Competence centre for medical peace work and peace education	31			•
Research scholarship, doctoral degree in peace medicine	28	•		•
Articles in the journal of the Medical Association	28	•		
Internships abroad	17			
Specialist courses within general practice, public health, psychiatry, etc.	17	•		

Table 20: Coverage of recommended teaching strategies in different frameworks

Most of the above listed teaching methods and incorporation principles are recognized in the key documents of all three framework groups (see Appendix V). The top-prioritized teaching method ‘student exchange’ is, however, not mentioned in the key articles. As all other strategies are covered by at least one group, there may be good reasons to learn from each other. For the PtH / HBP group, for instance, this would mean learning from the micro level frameworks on how they organize ‘supervised fieldwork’, to copy the strategy of strengthening already existing key disciplines, or to use inter-disciplinary seminars.

3.4.3 Limitations of the literature review

The methodology of the MEDLINE-search was wide in scope, but narrow in focus. The selection of peace-related MeSH-terms from the MeSH database, with 22568 entries, was dependent on the author’s understanding of the term ‘peace work’. Violence-related MeSHs were deliberately combined with the Subheading ‘prevention-and-control’,

ignoring other Subheadings. In addition, the search was limited to Major MeSH Descriptors (MJME). This meant neglecting articles with the same MeSH in the Minor MeSH position (MIME). Further, there exists the possibility for some publication bias due to the dependency on the correct indexation of the scientific articles. The use of several medical databases could have reduced this bias and would have contributed to increased accuracy of this search. Additionally, the use of the EMBASE-database, which focus more on European research in medicine, would probably have provided more information about medical peace education outside Northern America.

4 Summary and recommendations

The Background

Given the fact that violence and war are serious health problems, that health professionals can play an extraordinary role in peace-building, and that health workers are at risk of contributing to violence and harm, it makes sense to include peace-issues into medical curricula and post-graduate training.

The Need for New Theory

The study of existing medical peace work and teaching frameworks disclosed the need for more systematic research and theoretic concepts in this field. Despite clear links between peace and health, few health professionals are currently involved in peace science, and little work is done from the side of peace researchers to involve the health sector within this field of knowledge. Even if peace education has been identified as essential for health professionals, very little practical experiences exist. Publications on medical peace education are sporadic.

Peace Medicine as a Comprehensive Concept

This paper is therefore a call for ‘peace medicine’ as an academic discipline within both peace and health science. It could fill the gap between peace and health in practice, teaching and research.

The new discipline should be inclusive and able to embrace existing peace-health-initiatives, as well as stimulating new ones. However, it should also be clear in its vision and objectives, enabling evaluation and effectiveness.

If a holistic peace concept is applied, it would include behavioural, structural and cultural factors on a societal and individual level. Violence could be seen as an unnecessary insult of basic needs, peace as its opposite and as a capacity of conflict handling.

Based on such a perspective, it is suggested that medical peace work should challenge all man-made barriers to health, both on macro and micro level. Medical qualities, tools and opportunities could be used for preventing or reducing direct, structural and cultural violence, for promoting peace on all levels, and for strengthening the conflict-handling capacity of individuals and societies. The vision is health, the way to go peace.

Other Peace-Health Frameworks

Existing peace-related teaching frameworks in medicine were identified as ‘violence prevention’, ‘suicide prevention’, ‘medical ethics’, ‘medicine and human rights’, ‘peace through health’, ‘health as a bridge to peace’, ‘global health’, ‘ecosystem health’ or ‘health and human rights’. All apart from the latter seem to be limited to certain levels of the peace medical concept described above. ‘Health and human rights’ appears as a similarly comprehensive framework for medical peace work.

The range of medical peace qualities and educational strategies

In order to explore medical peace qualities and teaching strategies, interviews were conducted with representatives of 25 organizations/institutions that involve medical personnel in peace work or that deal with peace research and education. The informants attributed physicians a special role in peace work, especially in dialogue promotion and bridge building, teaching and advocacy. Reasons for that possibility were seen in assets such as the medical ethos, the social status, access to people and conflict zones, or medical and scientific background knowledge.

The interviews revealed a wide range of medical peace skills, knowledge and values/attitudes, which cover many different forms of peace work. Examples are peace skills like communication and context sensitivity, didactic competence, stress handling and inner peace, or expertise in physical, mental and social healing. Identified peace knowledge stretches from peace building examples, international regulations and global health initiatives, to expertise in health effects of violence and weapons, and an understanding of the connection between bio-, psycho- and social health.

Values/attitudes may range from responsibility for others, equity, respect of diversity, neutrality, to the mind-set of being inquisitive.

Interview partners listed existing learning possibilities, which often were of a general nature. Particularly addressed to medical personnel were mostly organization-intern briefings, but some respondents also mentioned specialization courses and conferences, or student teaching and research possibilities.

The proposed strategies for medical peace education covered a wide range, too. Field practice, interdisciplinary seminars or consciousness work were seen as functional methods of teaching. Suggested examples of implementation were mainstreaming of existing courses, the arrangement of dedicated modules or research possibilities. The effectiveness of such education should be measured by indicators like the satisfaction of participants, increased involvement, or an attitude change and less violence in society.

Experienced practitioners or specialists from different peace-related disciplines were among the most recommended teachers.

As conflict issues that absolutely should be addressed, the interview partners suggested examples from direct, structural and cultural nature, as well as macro and micro level. These ranged from human rights violations and torture, to poverty and North/South research priorities and ethical dilemmas in clinical practice.

Medical Peace Practitioners' priorities

The information gained through interviews was reprocessed into an online-questionnaire, completed by 97 self-selected medical peace practitioners. About one third of them had experience from peace work in developing countries; while the majority had their experience from Norway. This may illustrate that peace work is primarily conducted at home, and far away from war, misery and weapons of mass destruction. In addition, only one third of the participants had gained their experience in relation to a peace organization. Other important arenas for peace-work are teaching institutions, humanitarian organisations or hospitals and surgeries. The latter might confirm that peace work is not exclusive, but present in the everyday life of medical practitioners. Peace qualities should be part of medical education.

From the list of peace qualities that had been suggested in the initial interviews, the participants prioritized communication, culture- and context sensitivity, and teaching expertise as the most important peace skills. The peace knowledge deemed as the most relevant concerned the connection between bio-, psycho- and social health, as well as the local context, and global health issues. When asked about the most needed values and attitudes, the respondents favoured compassion, respect for others' culture and knowledge tradition, tolerance, and optimism. All these qualities can also be seen as important in conventional health work. Their teaching might therefore have a direct and indirect (via peace) health impact.

The teaching methods recommended by the questionnaire participants were mostly practical, such as student exchange and supervised fieldwork. According to the interview findings, little currently seems to be offered in this respect. Considered as the most important steps for improving medical peace education in Norway were: institutional co-operation with the South, strengthening of peace-related disciplines, peace-mainstreaming of clinical teaching, and a dedicated course in the medical core curriculum.

The most important conflict issues to be addressed in medical education were human rights violation and torture, poverty and development needs, refugee and migration problems, ethical dilemma in humanitarian work, and cultural intolerance/racism. Prioritized by Norwegian medical peace practitioners are mainly direct, structural and cultural violence on a global level. Micro-level violence was hardly ever mentioned in this part of the questionnaire. It can therefore be assumed that most participants had international work in mind, when thinking of peace work. Two conclusions may be drawn from this: There is a need for teaching a more comprehensive peace concept, which creates awareness on the importance of micro-level peace work. And, as 'peace' is even by practitioners mostly associated with international work, micro-level issues might, currently, be more successfully addressed in other frameworks, such as violence prevention and medical ethics.

Peace education in medical literature

Despite of the long tradition in peace work among physicians, the term 'peace' is more or less absent in medical literature, in research and teaching.

Peace-relevant publications were found through searches with MeSH combinations in the MEDLINE-database. Yet, these articles most often deal with micro-level peace work; they are related to education on ethical questions, human relations, patient rights and interpersonal violence. Education on global issues, like the prevention or control of poverty, terrorism and war, or issues like women's rights and sustainable development, were hardly covered. It seems likely that not only articles about global peace education are rare in the medical field, but also the teaching itself, both in medical schools, as well as in the physicians' vocational training.

An analysis of key documents revealed that the described teaching objectives comprise the peace qualities that were identified in the interviews and questionnaires. The required teaching is therefore possible and does already exist. The group of 'global health and peace building' approaches were identified as the most appropriate teaching frameworks. Nevertheless, all explored frameworks seem to be suitable for teaching these qualities. This finding supports the assumption that needed peace qualities for macro and micro level are similar.

The described teaching strategies, too, cover mostly what the survey participants recommended. Lessons could be learned from well-established frameworks like 'medical ethics' or 'violence prevention' in order to incorporate more aspects of global peace work into the medical education.

What is needed?

The exploration of medical peace work and peace education disclosed the lack of a theoretical platform and scientific publications. Further research and education experiences are therefore necessary. The definition of this field as a dedicated discipline, the establishment of research centres, the provision of scholarships and academic positions, and the launching of pilot courses could spark this process.

For a wide distribution of medical peace education, the awareness and commitment of decision makers and designated teaching faculties are needed. This requires good information work about the peace-health link, as well as strategic lobbying. The regional and global collaboration of existing working groups could encourage a series of conferences, course possibilities and academic publications. The development of model curricula, of resource web-sites, of distant learning courses, of a teaching handbook, of audio-visual tools and other relevant material would support interested scholars and students in competence building and promotion work.

Peace work is often understood from a very narrow perspective. Teaching and advocacy of a holistic concept of peace and conflict would link peace work to everyday life. It could as such contribute to the personal transformation and involvement of health professionals and others. Finally, this would strengthen the capacity of creative conflict handling, of violence prevention and peace building, and thus contribute to the relief of human suffering and the improvement of health.

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Appendix I: Interview guide

Peace work

1. How does your organisation / institution contribute to peace?

Medical contribution

2. Are or were physicians and medical students actively involved in the ‘peace work’ of your organisation/institution?

3. How many physicians or medical students were engaged in that ‘peace work’ during the last 3 years?

4. Do these physicians/students, in contrast to other professions have a special role in peace work? If yes, which?

Qualifications

5. What skills, knowledge and values are particularly important for the ‘peace work’ of your organisation / institution?

6. In your opinion, what are the qualifications (skills, knowledge and values) that physicians/students need for good peace work?

Peace education

7. Which options do physicians/medical students have to learn these important skills, knowledge and values both within your organisation/institution and outside?

Strategies for improvement

8. In order to improve the peace work capacities of Norwegian physicians / medical students, what would be the best form of teaching these skills, knowledge & values?

9. What would be the best way to evaluate the efficiency of that peace education?

10. How could a more extended peace education be implemented in medical training and specialisation?

11. Who should provide this type of training?

12. What issues should absolutely be included in that peace education?

Appendix II: List of interview partners

Block A

Geir Andreassen	Norges Røde Kors	Norwegian Red Cross
Arild Aambø	Primærmedisinsk Verksted – Senter for Helse, Dialog og Utvikling	Workshop for Primary Health Care – Centre for Health, Dialogue and Development
Geir Dale	Konfliktrådet	The Mediation and Reconciliation Service
Odd Edvardsen	Mine skade senter	Tromsø Mine Victim Resource Center - TMC
Tor Elden	Det Norske Fredskorpset	
Bjørn Oscar Hoftvedt	Den Norske Lægeforeningens Menneskerettighetsutvalg	The Norwegian Medical Association's Committee on Human Rights
Stig Jarwson	Sinnemestringsprogrammet	Anger Mastering Program, Department of Psychiatry, Trondheim
Bernt Lindtjørn	Senter for Internasjonal Helse	Centre for International Health, University of Bergen
Lars Mehlum	Senter for Selvmordsforebygging	Centre for suicid-prevention
Espen Munkvik	Forsvarets sanitet, Militærmedisinsk utdannings- og kompetansesenter	Medical Service of the Norwegian Defence
Kirsten Osen	Norske Leger mot Atomvåpen - NLA	IPPNW-Norway
Søren Pedersen	Redd Barna	Save the Children
Nora Sveaass	Psykososialt senter for flyktninger - PSSF	Psychosocial Centre for refugees
Cathrine Ulleberg	Leger uten grenser	Doctors without borders - MSF

Block B

Frank Aarebrot	Valg og Menneskerettighets-Observasjon	Election and Human Rights Observation - EHRO
Erik Cleven	Senter for konflikthåndtering	Centre for Peace Building and Conflict Management - CCM
Ingrid Denk	Senter for flerkulturelt og internasjonalt arbeid - SEFIA	Centre for multicultural and international work
Norunn Grande	Det Norske Fredssenteret	The Norwegian Peace Centre
Kai Grieg	Raftostiftelsen	The Thorolf Rafto Foundation for Human Rights
Jørgen Johansen	Senter for Fredsstudier	Centre for Peace Studies - CPS
John Y. Jones	Institutt for Globalt Nettverksarbeid, Informasjon og Studier	Institute for Global Networking, Information and Studies - IGNIS
Kåre Lode	Senter for interkulturell kommunikasjon - SIK	Centre for Intercultural Communication
Babs Sivertsen	Norges Fredsråd	Norwegian Peace Alliance
Arne Strand	Christian Michelsens Institutt - CMI	Christian Michelsen Institute
Stein Tønnessen	Institutt for fredsforskning	International Peace Research Institute - PRIO

Medical peace work and peace education

1. Are you a physician or medical student?

2. Which medical specialty do you focus on?

3. Are you male or female?

4. In which age group do you belong?

Peace Work Experience

Peace work can include a wide variety of activities contributing to the prevention or reduction of physical and psychological violence, or of oppressive and exploitative structures. Peace work can also include activities promoting dialogue, human rights, solidarity, and sustainable development.

5. Your experiences in peace work are from?

Norway

Which other countries?

6. Your experiences are / were related to work in ... (Several marks possible!)

- the surgery or hospital
- the community or health administration
- a research institution
- a teaching institution
- the Norwegian armed forces
- a human rights organisation
- a solidarity group
- a humanitarian organisation
- a peace organisation

Other - please specify

Qualifications for medical peace work

7. Which skills do you personally regard as most important for medical peace work?

Good skills in ... (Several marks possible!)

- communication and dialogue
- Careful listening
- diagnosis and documentation of violence
- conflict analysis
- conflict and stress handling
- creativity, improvisation
- knowledge building, research
- teaching of knowledge and involvement
- community mobilization
- public work, use of media
- broad networking
- group leadership and organizing
- team work
- process facilitation, mediation
- respectful behaviour in local culture and context
- building of self-confidence, strengthening of self-healing capacity
- evaluation of own involvement and its consequences

Other – please specify

8. Which knowledge do you personally regard as most important for medical peace work?

Good knowledge about ... (Several marks possible!)

- medical ethics and national guidelines
- the connection between physical, psychological and social health
- psychology/sociology of aggression, violence and identity
- risk factors and violence-preventive measures
- root causes of conflicts

- dynamics and complexity of conflicts
- strategies for conflict resolution on macro and micro level
- what is needed for a stable and peaceful society
- the local context (culture, geography, language, etc.)
- global health issues
- international law and human rights
- health impacts of different types of violence and weapons
- the quick construction of a stabilizing health service
- health as bridge to peace

Other – please specify

9. Which attitudes and values are most needed for medical peace work?

Attitudes and values like ... (Several marks possible!)

- responsibility for others' health and life
- peace, non-violence
- truth, honesty
- modesty
- patience
- commitment, involvement
- compassion, humanitarian attitude
- neutrality, impartiality
- solidarity
- respect for others' culture and knowledge traditions
- being inquisitive
- equity, partnership
- tolerance, respect for diversity
- confidence in local capacities
- optimism, belief in improvement

Other – please specify

Strategies for medical peace education

10. What would be the best teaching form for the relevant skills, knowledge, attitudes/values? (Several marks possible!)

- Experience-based lectures
- Practical exercises, role play
- Group work with case studies, problem-based learning
- Supervised field work
- Recommended reading lists
- Processes that encourage involvement
- Exchange programmes for students
- Other – please specify

11. What is needed to strengthen the medical peace education in Norway?
(Several marks possible!)

- Inter-disciplinary seminars
- Increased peace perspective in clinical training (general practice, psychiatry, etc.)
- More focus on social medicine, medical anthropology, global health, etc.
- Dedicated course in peace medicine within the compulsory curriculum
- Internships abroad
- Specialist courses within general practice, public health, psychiatry, etc.
- Research scholarship, doctoral degree in peace medicine
- Competence centre for medical peace work and peace education
- Articles in the journal of the Norwegian Medical Association
- Institutional cooperation with poor / conflict prone countries
- Other – please specify

12. Which conflict issues should be prioritized in such teaching? (Several marks possible!)

- Ethical dilemmas in clinical practice and research
- Double-loyalty in public health, military-, prison service, etc.
- Workplace environment
- Discrimination against women
- Bullying in schools
- Suicide

- Domestic violence
- Youth violence, gang fights
- Cultural intolerance, racism
- Refugee/migration problems
- Human rights violation and torture
- Globalization
- Privatization and patent rights
- Ecological degradation
- Poverty and development need
- Distribution of resources and North/South research priorities
- War and terror
- Religious fundamentalism
- Weapons of mass destruction
- Small arms and landmines
- Dilemma in humanitarian aid
- Myths about Norwegian peace engagement
- Other – please specify

Thank you for your help!

In order to finish, click on the button “Save” below in the main frame.

If you have any comments to the survey, please feel free to write them here:

Appendix IV: Results of the online-questionnaire

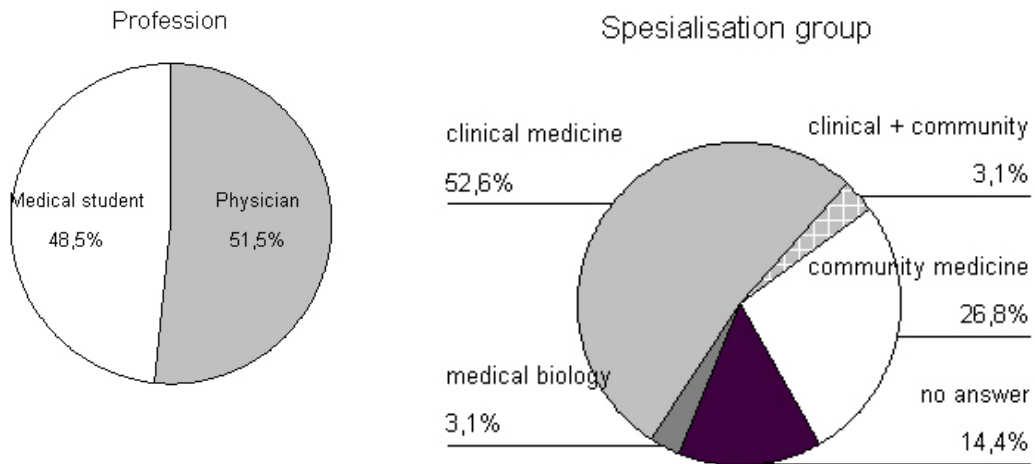


Figure 4a and 4b: Medical career of questionnaire responders

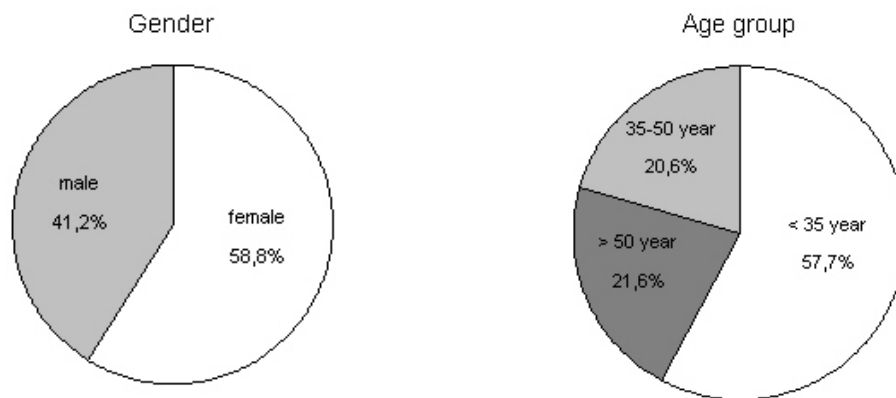


Figure 5a and 5b: Gender and age group of questionnaire responders

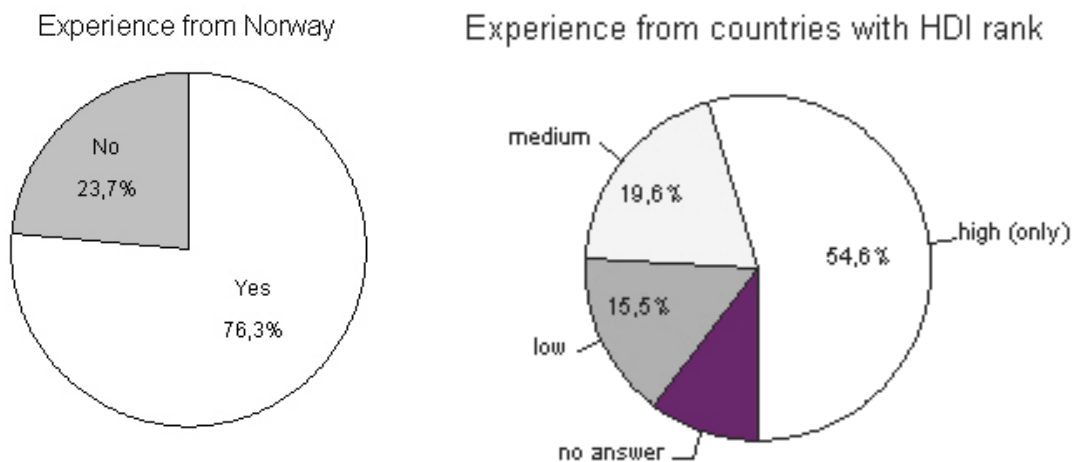


Figure 6a and 6b: Countries attributed to responders' peace work experiences

Peace Work Experience related to

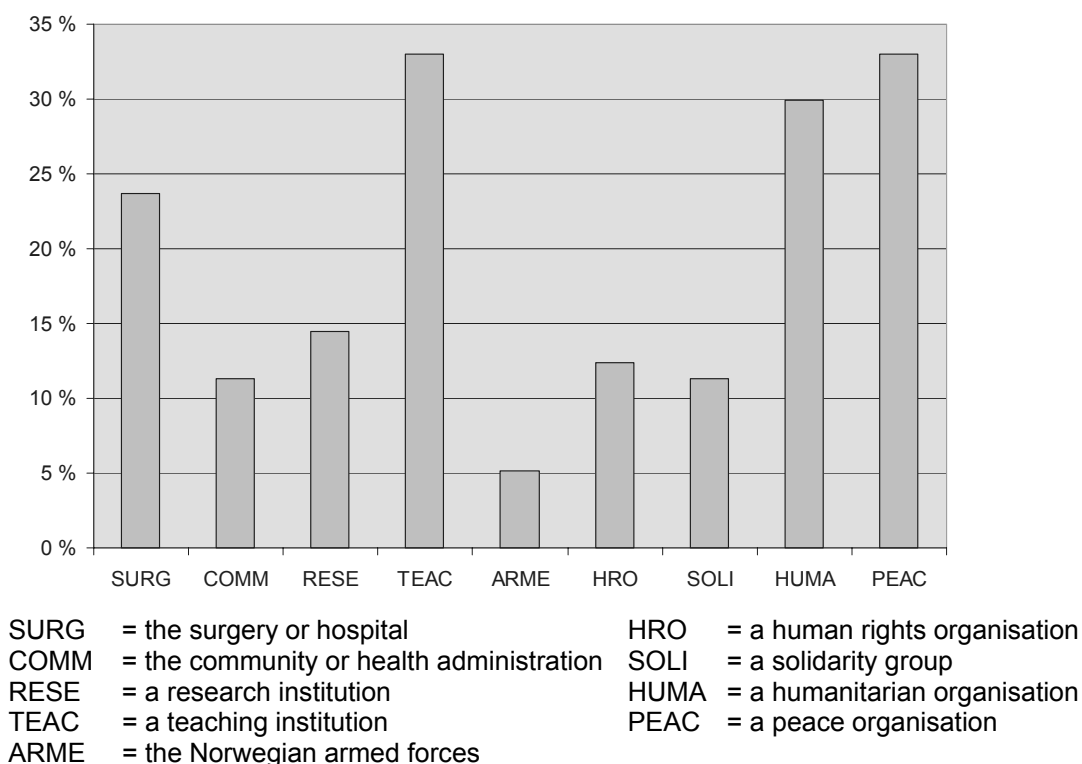


Figure 7: Working frame attributed to responders' peace work experiences

Most important skills

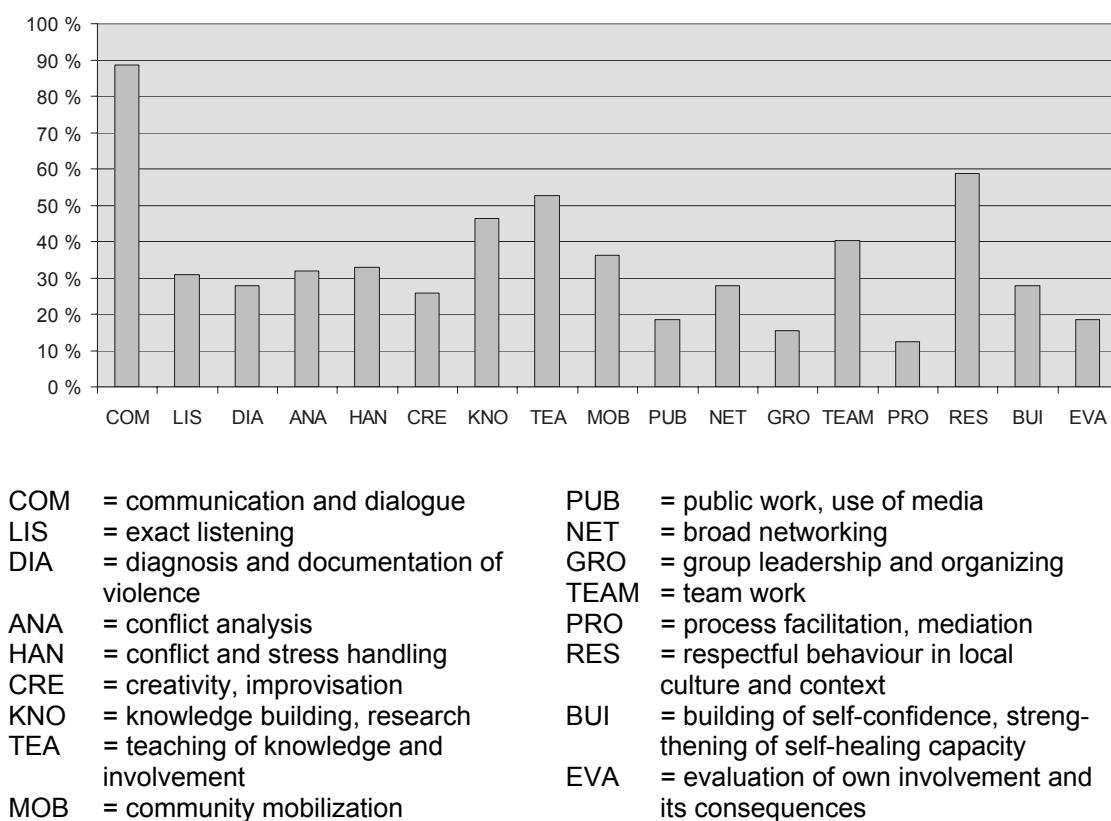
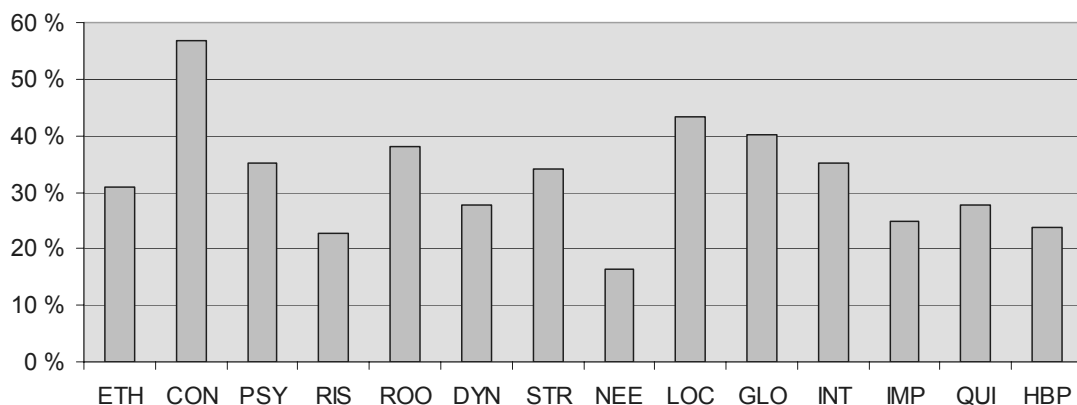


Figure 8: Most important medical peace skills for questionnaire responders

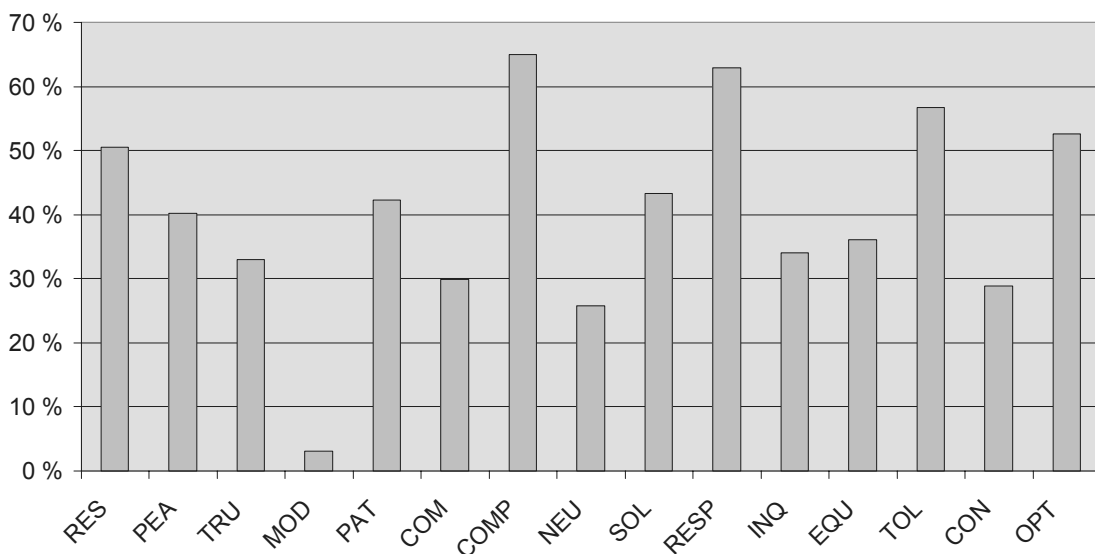
Most important knowledge



- ETH = medical ethics and national guidelines
- CON = connection between physical, psychological and social health
- PSY = psychology/sociology of aggression, violence and identity
- RIS = risk factors and violence-preventive measures
- ROO = root causes of conflicts
- DYN = dynamics and complexity of conflicts
- STR = strategies for conflict resolution on macro and micro level
- NEE = what is needed for a stable and peaceful society
- LOC = the local context (culture, geography, language, etc.)
- GLO = global health issues
- INT = international law and human rights
- IMP = health impacts of different types of violence and weapons
- QUI = quick construction of a stabilizing health service
- HBP = health as bridge to peace

Figure 9: Most important medical peace knowledge for questionnaire responders

Most needed attitudes and values



- RES = responsibility for others' health and life
- PEA = peace, non-violence
- SOL = solidarity
- RESP = respect for others' culture and knowledge traditions

TRU = truth, honesty	INQ = being inquisitive
MOD = modesty	EQU = equity, partnership
PAT = patience	TOL = tolerance, respect for diversity
COM = commitment, involvement	CON = confidence in local capacities
COMP = compassion, humanitarian attitude	OPT = optimism, belief in improvement
NEU = neutrality, impartiality	

Figure 10 Most needed medical peace values / attitudes for questionnaire responders

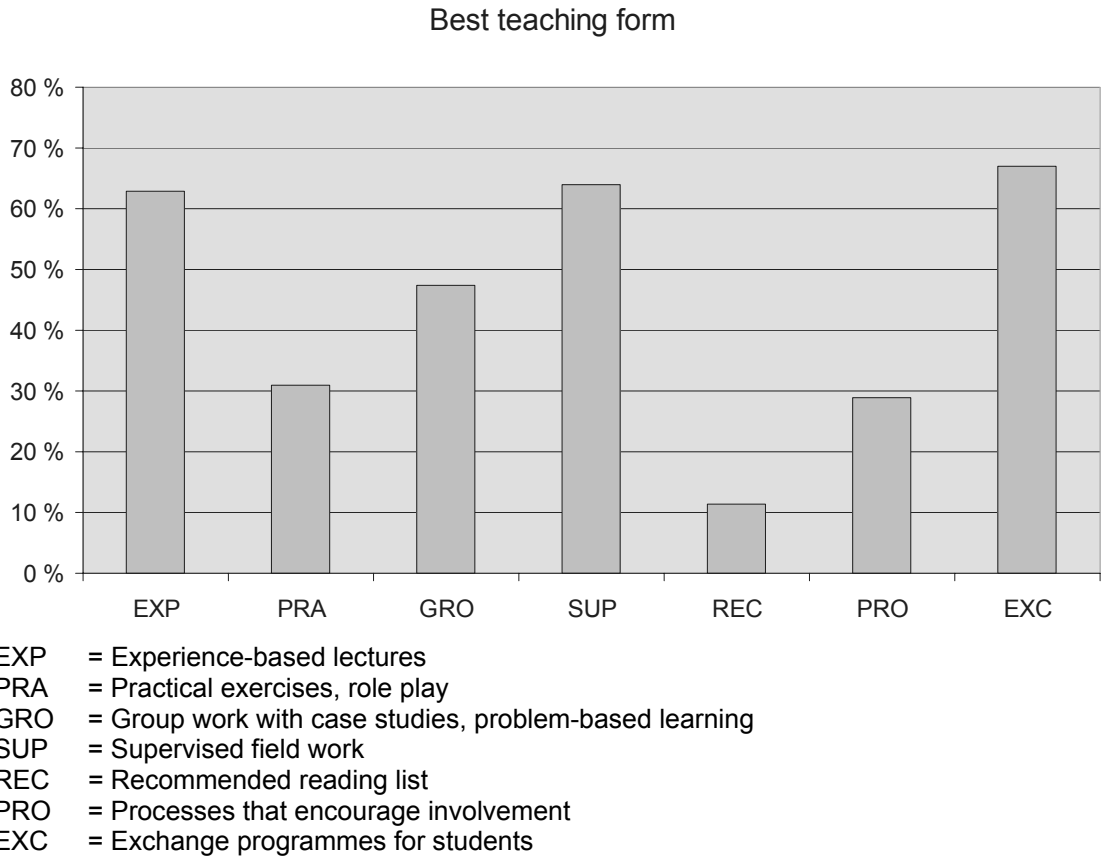
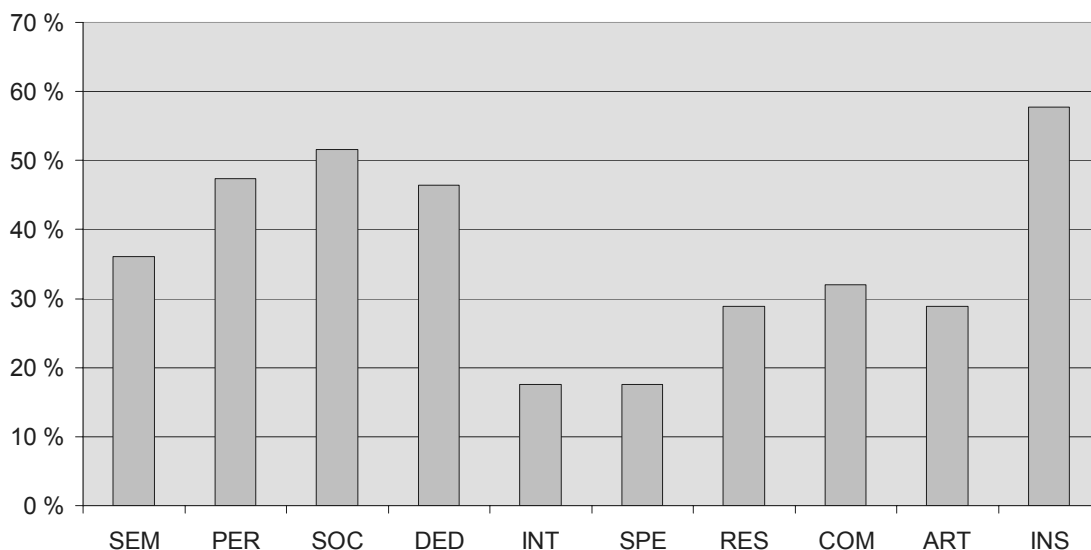


Figure 11: Best teaching form according to questionnaire responders

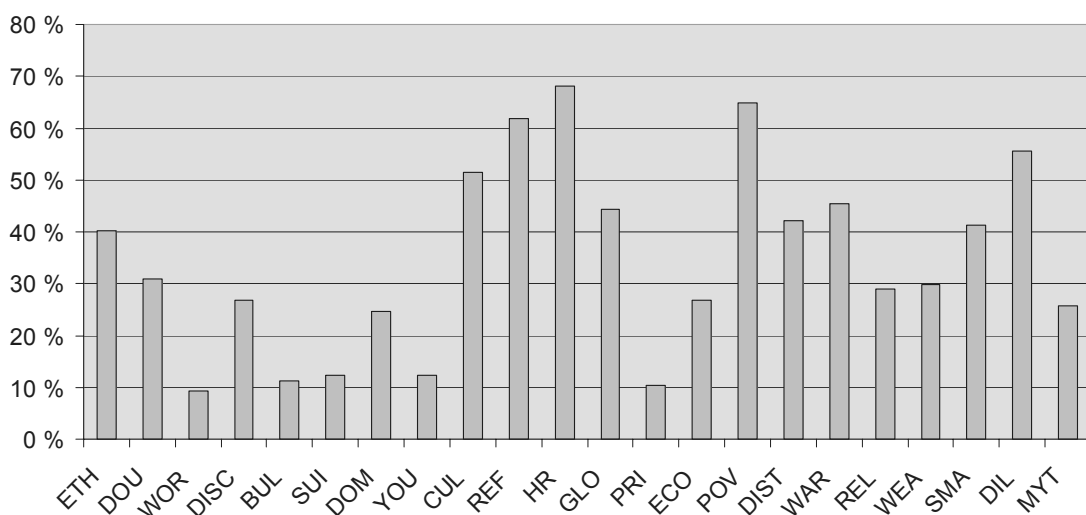
Needed to strengthen the medical peace education in Norway



- SEM = Inter-disciplinary seminars
- PER = Increased peace perspective in clinical training (general practice, psychiatry, etc.)
- SOC = More focus on social medicine, medical anthropology, global health, etc.
- DED = Dedicated course in peace medicine within the compulsory curriculum
- INT = Internships abroad
- SPE = Specialist courses within general practice, public health, psychiatry, etc.
- RES = Research scholarship, doctoral degree in peace medicine
- COM = Competence centre for medical peace work and peace education
- ART = Articles in the journal of the Norwegian Medical Association
- INS = Institutional cooperation with poor / conflict prone countries

Figure 12: Most needed for medical peace education in Norway according to questionnaires

Prioritized conflict fields



- ETH = Ethical dilemmas in clinical practice and research
- DOU = Double-loyalty in public health, military-, prison service, etc.
- GLO = Globalisation
- PRI = Privatisation and patent rights
- ECO = Ecological degradation
- POV = Poverty and development need

WOR	= Workplace environment	DIST	= Distribution of resources and North/South research priorities
DISC	= Discrimination against women	WAR	= War and terror
BUL	= Bullying in schools	REL	= Religious fundamentalism
SUI	= Suicide	WEA	= Weapons of mass destruction
DOM	= Domestic violence	SMA	= Small arms and landmines
YOU	= Youth violence, gang fights	DIL	= Dilemma in humanitarian aid
CUL	= Cultural intolerance, racism	MYT	= Myths about Norwegian peace engagement
REF	= Refugee/migration problems		
HR	= Human rights violation and torture		

Figure 13: Prioritized conflict issues according to questionnaire responders

Appendix V: Descriptive summary of objectives and methods in key articles on medical peace education

Framework (article)	Skills	Knowledge	Values/attitudes	Teaching method
<p>Viol. Prev.</p> <p>Violence Prevention (Alpert, Sege et al. 1997)</p>	<p>Nonthreatening interviewing techniques, respectful communication, ensuring safety for patient, ability to screen for abuse, safety assessment, accurate and unbiased documentation of findings, appropriate and safe access to community resources and the legal system. (p. 45)</p>	<p>Medical opportunities to interrupt the cycle of violence. Understanding the epidemiology of violence and abuse, range of expression of abuse across the life cycle, common clinical presentations, physical and psychological stigmata and sequelae, characteristics of perpetrators, models of intervention, range and effectiveness of community-based and national resources, mandated reporting responsibilities. Basic elements of a patient-centered safety plan. (p. 45)</p>	<p>Compassion, neutrality, sensitivity. (p.44) Seriousness and urgency about violence as a health issue, awareness of roles for medical professionals, importance of working as a member of a multidisciplinary team. (p. 45)</p>	<p>Undergraduate medical education: Integration into pathophysiology of injuries and disease. Electives for intensive learning. Routinizing inquiry and documentation. Standardized patients, interactive CD-ROM-based instruction. Interdisciplinary faculty, incl. community-based advocacy personnel. Community service. Clinical clerkships. Integration in differential diagnostic. Case problems. Inclusion in teaching books in different disciplines. Structured and independent study elective rotations, incl. exploration of ongoing research, surveillance and intervention efforts; participation in medical treatment of survivors; service learning with community-based groups; study of legal and criminal justice issues.</p> <p>Postgraduate Medical Education: Integration into all major clinical disciplines in residence training. Encouraging and supporting research interests. CME courses, journal articles. Tailoring of material for each medical specialty and practice setting. Consultation with experts, review articles in specialty journals, programs at regional and national meetings, hospital grand rounds. Including in risk management courses. Patient/parent information cards. (p. 44-7)</p>

Violence Prevention (Brandt 1997)	Risk assessment and safety planning, screening for family violence, inquiring about violence in patients' lives in a confidential, non-judgmental, and compassionate manner, team approach and community involvement. (p. 52-3)	Understanding of laws governing protection of victims. (p. 53)	Constructive, positive, compassionate, nonjudgmental, empathic, and supportive attitudes toward patients. Relinquishing the patronizing attitudes. Recognizing the patient as the best decision maker in the problem. Respect. Non-hierarchical intra- and interprofessional relationship and co-operation. (p. 53)	Integration into existing courses and clinical experiences. Experiential learning, directly through witnessing of clinical practice, interviewing and participating in care. Indirectly through interdisciplinary faculty with experience. Videotape presentations, role play, standardized patients. At advanced level: practice in community settings (p. 53-4)
Violence Prevention (Krug, Dahlberg et al. 2002)	Detection and report of child abuse and neglect, specific interview techniques and types of physical examination. (p. 72) Skills in detection, sensitive and effective handling of cases of sexual violence. (p. 166) Diagnostic of violence (p. 250)	Symptoms and signs of child abuse and neglect. Available community services. Diagnostic and treatment guidelines. Awareness of risk factors for child abuse. (p. 72) Knowledge and awareness of sexual violence. Contextual root of violence. Risk factors and intervention. Understanding basic legal procedures and how to present evidence, referring and following up, reintegration into society. (p. 167) Violence consequences and prevention. (p. 250)		Separate but integrated courses for students and physicians. Specialisation courses for those with specific interest. (p. 72) Basic training (modules during practical years) and specialized postgraduate courses. (p. 166)
Ethics, HR				
Medical Ethics (Miles, Lane et al. 1989)	Recognize the humanistic and ethical aspects of medical careers, examine and affirm own moral commitments. Ability to	Foundation of philosophical, social, and legal knowledge. (p. 706)	Humanism. (p. 706)	Conceptually coherence, vertical and horizontal integration, multidisciplinary, academic rigor. Authentic demonstration of humane, value-conscious medical practice. Case-centered education, assistance during

	employ the knowledge in clinical reasoning. Interactional skills. (p. 706)			patient care. Small personal groups, including humanities. Variation of methods, e.g. lectures and seminars, small groups, rounds with attending physicians, grand rounds, morning reports, ward rounds with and ethicist, simulated patients, retreats, audiovisual materials, ethics manuals, annotated bibliographies. Topical electives. Written papers. (p. 707-9)
Medical Ethics (Fox, Arnold et al. 1995)	Identification of the moral aspects of medical practice. Ability to obtain a valid consent or refusal of treatment. Ability to decide when it is morally justified to withhold information or to breach confidentiality. (p. 765) Leadership in confronting societal issues that affect the patients, reform social policies. (p. 767)	Proceedings in partially competent or fully incompetent patients. Proceedings in patients refusing treatment. Knowledge of the moral aspects of caring for a patient with poor prognosis. (p. 765)	Improving the health and well-being of the communities (p. 767)	Demonstrating importance through structure and relative prominence in the curriculum. Using case method. Involving interdisciplinary group of teachers. Mainstreaming the curriculum. Application of adult education principles (Create goal-driven curriculum, stage-specific, tailored to local context, promoting active learning through group discussions, games, role-playing, interview with simulated patients, film. Using varied and innovative approaches). Use of feedback and evaluation (qualitative – questionnaires and informal interviews). (p. 763-5)
Human Values (Branch, Kern et al. 2001)	Social amenities, verbal and non-verbal communication skills, observation skills. Sensitivity to patient's values, beliefs, history, needs, abilities, culture and social network. Self-awareness and evaluation of one's interaction. (p. 1070)		Respect for individual, humane care, relieving suffering, being honest and genuine. (p. 1070)	Establishing a climate of humanism, recognize and use seminal events, role model, active learning, practicality and relevance. Multiple strategies. (p. 1068)
Human	Communication,	Human rights standards and	Respect for human rights	Directed group discussions. Brief

Rights (Maxwell and Pounder 1999)	presentation, discussion, teamwork, active listening. (p. 295-6)	supervisory mechanisms, medicine at risks, role of medical personnel and their professional organizations in protection and respect of human rights. (p. 295)	as integral part of medical practice. (p. 295)	introductory presentation. Topic research in large groups, student presentations, teamwork on fictionalized case studies or questions. (p. 295-6)
Inter-personal Skills (Novack, Volk et al. 1993)	Facilitation skills, nonverbal behaviours, patient education strategies, therapeutic skills, communication of empathy. (p. 2101)			Methods: Didactic presentations, student interviews or observation of interviews with patients, use of simulated patients, films or teaching videotapes, role-play, discussions. Principles: faculty as role model, practice with feedback, experimental learning, definition of final and intermediate goals. (p. 2103)
PtH, HBP				
Peace through Health (Arya 2004; Arya 2004)	Analytical skills. Diplomacy. Redefinition of the situation. Teaching, communication of knowledge. Sensitizing, putting a human face on suffering. Maintaining structural integrity of society. Healing of communities. (p. 247-9) Listening to local expertise. (p. 252)	Psychological concepts and human behaviour (violence cycle, PTSD, mental health). Intelligence. Conflict analysis and mediation principles. Public Health (Epidemiology, Prevention). Medical ethics autonomy, confidentiality, obligation to full disclosure, 'primum non nocere'. Physical, mental treatment. Administration of immunization. Construction of superordinate goals. Principle and practice (holistic approach, preventive models, understanding of causation and association). (p. 247-9) Concepts from peace studies theory, public and population health, health and human rights, ecosystem health, medical and professional ethics, link war - ill health and peace - health, effect of sanctions and different	Altruism. Impartiality. Trustworthiness. Personification of enemy. Solidarity. Dissent. Ability to appreciate, listen, empathise and learn. (p. 247-9) Recognize limitation. Relying on local understanding. Being cautious before entering conflicts with specific cultural and religious contexts. (p. 252)	Interactive lectures, case study approach. Guest professionals and academics. Learning through role models. Student presentations. (p. 260) Requested: Textbook, university's chair, international network, student involvement, integration into medical curriculum, online-course. (p. 261)

		weapons. Medical activism. Cultural approach to conflict. Multi-track diplomacy, systems theory, trauma-healing. (p. 260)		
Health through Peace (IFMSA and IPPNW 1999)	Planning future activities, get knowledge and support from other NGOs and IGOs. Expand the network of medical students involved in conflict prevention, disarmament, human rights and peace building. Detecting and reporting human rights violations. Skills in mobilisation, advocacy and lobbying. Improve communication between European medical students active in peace work.	Role of doctors in conflict prevention, human rights protection, disarmament, and peace building.	Dialogue with decision makers, follow up, persistence. Social responsibility. Plan of action. We have the power to change! Identification of own prejudices as way of tolerance building.	Interactive lectures, followed by facilitated focus groups and panel discussions. Student presentations. Skills training with role-play, brainstorming, obstacle games. Demanded: theoretical and clinical training integrated in medical curricula. Research opportunities. (p. 47)
Health as a Bridge to Peace (WHO/EHA 1997)	Activate data-to-policy link, sensitivity to the political, legal, socio-economic environment, to identify opportunities for HBP, problem solving, leadership, to bring the parties to the negotiation table, mediation, to seek out creative opportunities to promote peace. Reliable health data, making cases for policy change, negotiation,	Humanitarian and human rights law, medical ethics. Understanding of political, legal, socio-economical environment. Clear technical principles as basis for negotiations to avoid political manipulation of aid, professional skills and know-how in rebuilding the health sector, positive and negative lessons learned from the field, checklists, conflict dynamics.	Responsibility to promote peace, reconciliation and human rights, act in solidarity to address common collective concerns, equity, right to health, protection of public health assets, independence, impartiality, neutrality, transparency, work with partners, confidentiality.	Institutionalization into the policy framework for WHO, incorporation into specific programming areas e.g. EHA. Briefing kit, guidelines and training materials.

	situation analysis, fact-finding, coalition building, conflict handling, advocacy and sensitization.			
Health as a Bridge to Peace (Rodriguez-Garcia, Macinko et al. 2001)	Problem solving, leadership, mediation, negotiation, diplomacy, identification of appropriate opportunities to bring conflicting parties together and for peace intervention, conflict analysis, communication, neutral brokering, coping mechanisms, multisectoral and community mobilization, sensitivity to local culture and context, persuasion skills.	Political/legal/socio-economic understanding and sensitivity of the conflict. Successful and unsuccessful HBP-cases.	Perceived impartiality.	Requested: Skills training for health personnel. Guidelines, protocols, conceptual frameworks for designing and conducting HBP activities. (p. 71) Case study research. Framework for analysis operating principles, codes of conduct, blueprints for appropriate interventions and skills, information on most effective policies/investments in health in both pre- and post-conflict periods. (p. 78) Media and other information campaigns targeted to health workers. (p. 81) HBP Toolbox with fact sheet on training modules. Introducing HBP into medical and public health curricula. (p. 83-4)
Health as a Bridge to Peace (Gutlove 2000)	Dialogue. (p 17) Constructive communication. (p 20) Active listening. (p 23) Analysis of the current and anticipated state of public health. Generating options. (p 28-9) Consensus building. (p 32) Strategic planning and goal setting.	Concept of conflict management. (p 5)	Curiosity and interest among the parties, listening with an open mind, empathy, compassion, honesty and humility. (p 20)	Context adapted training programs for health personnel. (p. 15)