

Medical ethics in peacetime and wartime: the case for a better understanding

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Abstract

Health-care workers face ethical dilemmas in their decision-making in every clinical intervention they make. In times of armed conflict the decisions may be different, and the circumstances can combine to raise ethical tensions. This article looks at the tensions in peacetime and in times of armed conflict and examines the types of cases that doctors and other health-care workers will face. It also discusses the common ethical decision-making framework and the role of communication within both clinical care and ethical analysis.

Keywords: ethical dilemma, ethical analysis, decision making, consent, confidentiality, communication, trust.



Health-care workers worldwide follow the same ethical codes and principles, developed to protect patients from abuse and to make clear the limits that those professionals will apply to their decision-making. A broad understanding by the whole community, including those in positions of power and authority, of what those rules are and their universality is an essential tool in ensuring compliance even in the most difficult circumstances.

Clinical practice in any circumstance raises ethical dilemmas for the doctors, nurses, and other health-care professionals caring for patients, and for those organising the delivery of care. There is a wealth of material on medical ethics in literature published over many centuries; the last half of the twentieth century and the beginning of the twenty-first have brought a particularly rich collection of new material on the subject.¹ Increasingly the usefulness of that material to clinicians in their everyday work has risen as advice and, indeed, explanation of ethical principles has been linked to cases both real and theoretical. This enables the clinician to consider the principles, the background, and the case within a clinical framework, making it easier to translate and adapt those concepts to the clinical situation facing him or her.

But these materials have been based on clinical care in normal circumstances, or in cases where the delivery of care is not threatened or challenged by armed conflict or other situations of violence. In ‘normal’ practice clinicians often have time to stop and think about the decisions inherent in offering care, and indeed to take advice from others. In conflict situations such opportunities for reflection are almost always more limited. The very fact that the situation is unstable, possibly threatening and certainly different to everyday practice makes reflection more difficult, and the challenges that are faced are either subtly or substantially distorted by the conflict or unrest. Doctors in these circumstances will rarely have the opportunity to discuss their concerns contemporaneously with others, or to consult on the approach needed. It is therefore even more important that they are aware of ethical principles and feel able to identify and analyse the ethical challenges they face.

Many may face these circumstances for the first time, and wonder if ‘normal’ ethical rules apply. They may be confronted with others from outside the clinical environment who demand particular actions from them, and may be unsure of whether those actions are ethically acceptable in these circumstances. They may

1 British Medical Association (BMA), *Medical Ethics Today: the BMA's Handbook of Ethics and Law*, 3rd edition, BMJ Books, London, February 2012; J. R. Williams, *World Medical Association Medical Ethics Manual*, 2nd edition, WMA, Ferney-Voltaire, 2009; International Committee of the Red Cross (ICRC), *Health Care in Danger: the Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*, ICRC, Geneva, 2012.

also fear for their own safety and that of others – their families and other health-care professionals as well as patients.

Demands, for example, for access to detailed patient information made in peacetime will usually be accompanied by time to consider whether such demands fall within legal requirements or indeed legal exemptions to the right to confidentiality. In times of armed conflict and serious unrest, other factors may come into play. Those demanding the information may say it is essential to them in order to provide safety and security to the health-care workers, the institution, and the broader environment. Where do the rights of the patient, and the duty of the doctor to uphold those rights, lie in such cases? How does the health worker cope emotionally with being told that he or she may be the cause of risk to others?

Similarly, while health-care workers use the concept of triage, especially during major epidemics or after mass casualty events such as multi-vehicle road crashes, in many such cases they are able, by careful use of resources, to arrange treatment for everyone. In conflict situations resources are more likely to be exhausted, it may be difficult to replenish them, and triage decisions are more likely to be literal life or death decisions. In addition, health-care workers are more likely to face pressure to give priority to one group over another in these situations, and that pressure may also be accompanied by threats to the workers, the institution, and other patients. How far should health workers go to protect confidentiality when it might put others, including themselves, at serious physical risk?

In conflict situations, workers may become exhausted by a constant stream of patients. While this can happen in other emergencies, few are as long or sustained, and the opportunity for rest and recovery may be far more limited. What should doctors and others do when they are tired? Or when they are running out of equipment or drugs? Or when they are faced with cases beyond their clinical competence?

Health-care workers can face related challenges at other times. In some countries attacks on health-care institutions, their workers, and their patients are tragically commonplace. Discussions with doctors around the world make it clear that organised criminal gangs and disgruntled family members may attack health-care professionals seeking compensation for injuries caused to friends, family members, or others, or simply to extort money. These are criminal activities in situations where there is no specific conflict or general unrest, but where violence within society as a criminal act is common. Ethical understanding and an ethical aid to local engagement with social leaders are as necessary here as in situations of conflict.

In all these situations the help and support of others may be present, as it would be in normal times, but it can equally be unavailable. Health-care workers can be or feel very isolated in their decision-making. A solid ethical framework to decision-making can help them to feel supported and to know that their decision would be supported by colleagues around the world.

The ability of health workers to understand and adapt ethical principles becomes an invaluable tool. It helps to ensure that ethical standards do not slip, and

in doing so that patients are protected from unintended or unthinking exploitation. It helps to reinforce the professionalism of the health-care workers and the trust that must exist between doctor and patient. And it helps when decisions have to be made that breach general ethical principles in order to protect other lives. Most importantly, it also forms the basis of discussions and negotiations with others on the way in which the health-care institution and its staff and patients should be treated.

The idea that ethics is a luxury which has no importance during emergencies must be challenged; ethics is the principal construct that ensures that medicine remains a force for good, designed and delivered within a humanitarian framework to protect the interests of the vulnerable, the ill, and the injured.

Whenever and wherever health care is delivered, there must be an ethical framework which will delineate the principles surrounding that care delivery. Health care is delivered to people in need, who may be afraid, whose lives might be at risk, and who are almost always more vulnerable than those delivering the care. Those delivering care will have different levels of power relative to those to whom they offer care. The delivery of care is bounded by ethical principles that limit the freedoms of those offering care and which offer patients a framework within which they can expect to see care offered. The ethical principles are designed to ensure that there is no abuse of that power differential and that both parties to the therapeutic relationship understand the basis upon which decisions will be made.

Medical ethics in peacetime and wartime

General definition: what is medical ethics?

There are many definitions that explain what is usually understood by the concept of medical ethics. It can be most readily understood as a set of principles which apply to professional work and which set boundaries to the freedom of a health-care professional in their decision-making. Increasingly, it is also seen as an agreement between those health-care professionals and the societies they serve. These boundaries are not set by the professions working alone but are negotiated with society, taking into account social mores and values, the law, systematic belief systems, and the expressed fears, hopes, and expectations of society generally. Beneath all these variables is a remarkably consistent value-based set of principles. Given that law changes and develops regularly and that it impacts upon ethical rules, there is a continual adjustment of some ethical boundaries; generally speaking, these changes are minor. In countries where the development of law, through parliament, is substantial, there is usually a lively multi-party dialogue about how a potential law fits into publicly accepted limits on health-care practice. Governments that wish, for example, to legislate on the management and confidentiality of information will be required by health-care professionals to ensure that the new law does not undermine accepted norms, including legal protections for patient/doctor confidentiality.

Clearly the academic discipline of philosophy has had a major influence, and such formal analyses are an increasing part of modern ethical discourse. Ethical rules have historically emerged over time. Early rules of health-care ethics such as the Hippocratic oath or the prayer of Maimonides set out lists of acceptable, and unacceptable, actions for doctors. These were constant, except for the variability introduced by successive translations, for many centuries. The connection to broad philosophy is hidden in these texts, and much of the early twentieth-century literature on ethics takes the same position, setting out lists and rules of behaviour but not describing the reasons behind those limits, or the debate which led to their emergence. Frequently such texts would say explicitly that doctors would know automatically what was ethically right. In practice few doctors were able to analyse medical situations sufficiently to expose the ethical challenges involved, but they often learned where the boundaries lay within relatively narrow medical fields.

Nevertheless, the power of these ancient codes is considerable, and the Hippocratic oath in particular remains a descriptor of the binding ethical principles that surround modern medical practice. In many but not all medical schools, part of the process of becoming a doctor is taking the oath. Despite the fact that a significant number of doctors do not formally swear this or a similar oath, the public perception is that all doctors are bound by it. More modern codes are largely derived from these and similar ancient codes. The Declaration of Geneva² of the World Medical Association (WMA) and its associated International Code of Medical Ethics³ are overarching broad codes which cover the work done by health-care professionals in all circumstances. None of these isolate times of war or work in warfare as being different, or imply that ethical principles and rules change as circumstances vary.

In much of the world the major descriptor of ethical principles is 'Primum non nocere', or 'Above all, do no harm'. A variety of different expressions are used to outline other factors, such as 'patient-centred' or 'person-centred' medicine. At the same time, law surrounding medical practice has also largely been based upon supporting the rights of patients.

Ethical analysis often requires an assessment of the best interest of the patient. How best interest or benefit is assessed is also culturally sensitive. Western society tends to use concepts that are heavily biased towards the rights of individuals and self-determination. Balance enters the equation, as the rights of the individual are not the only rights that need assessment. Society (and hence other individuals) also has rights, and these can be in conflict with the rights of the individual. In the Western tradition, the best interests of the individual are a holistic measure, looking at the person within their family, workplace, and social and cultural setting. But what those best interests or benefits actually are should depend upon the views and beliefs of the individual, which in themselves will be culturally predicated. Much modern work deals with the importance of ensuring that the assessment of best interests is based upon what the patient believes is best for him or herself,

2 WMA Declaration of Geneva, adopted September 1948, last revised May 2006.

3 WMA International Code of Medical Ethics, adopted October 1949, last amended October 2006.

not another person's judgement, especially of whether a life severely limited by illness or injury is 'worth living'.

Doctors look after patients in every possible circumstance, in every country in the world. While the circumstances vary very widely, it is commonly said that the ethical rules or obligations are identical. Indeed, the WMA states that medical ethics is identical in times of peace and of war.⁴ There are also frequently asked questions about the balance between law and ethics. Again, the WMA takes the apparently simple approach that ethics trumps law, meaning that when law and ethics collide, doctors should obey ethical precepts.

The reality is far from simple. While ethical principles can and do remain constant, they are, in essence, merely a framework surrounding the decisions that need to be made in clinical practice. Those decisions themselves are significantly affected by and related to the circumstances in which the clinical practice takes place. This is most clearly seen when an analysis is undertaken of the clinical circumstances in which the doctor is making decisions. In every case, doctors and others considering the ethical issues will use analysis to consider the various elements involved. Very often different duties, values, or principles will be in conflict with one another. It is only by examining the whole picture, including the specific circumstances of the case and of the conflict situation, that the best answer can be found.

In times of armed conflict these decisions will differ because of the specific threats and circumstances of warfare. Crucially the decisions that the doctor has to make will sometimes be very different from those in times of peace. On other occasions the decisions will be identical and the circumstances of the conflict will have no impact on the decision-making. In all circumstances doctors have to make decisions about which patient to treat first. Such decisions are especially likely to occur when the number of patients exceeds the number of trained health-care professionals or when resources are scarce. This dilemma may affect an emergency room doctor faced with multiple casualties from a road traffic crash, in the same way that it may affect a doctor dealing with multiple injured from a roadside explosive device during an armed conflict. The circumstances are remarkably similar, even if more commonly occurring in conflict situations.

Much of the historical discussion of ethics in the health-care sector has been written under the heading of 'medical ethics'. The implication is that it applies to medical doctors, and some would understand this as implying that other rules might apply to other health-care professionals. Modern discourse tends to use the title 'health-care ethics', with the necessary implication that it applies to all health-care professionals. In practice both titles cover all health-care professionals. Differences are sometimes seen in some discussions, and these often reflect the various roles of health-care professionals, which can lead to a different point of view affecting the analysis.

4 WMA Regulations in Times of Armed Conflict and Other Situations of Violence, adopted October 1956, last revised October 2012.

Same general ethical principles in peacetime and wartime

The statement that ethics is the same in war and peace does not mean that the decisions doctors make will be identical. The dilemmas that they face will often differ, but the general principles that will be applied to the decisions will be the same.

In essence, the principles are designed to respect the rights of the individual who is currently the patient, ensuring they are enabled to take control of decisions about them and the treatment they will receive. While historically many principles will relate to the etiquette of medical practice, increasingly ethics also looks at decision-making in relation to complex and high-risk medical procedures or to public health.

In modern conflict settings, especially in the presence of the armed forces of developed countries, the medical capability is such that very severe injuries can be treated. As lives become increasingly salvageable, the sequelae of that salvage become important. This mirrors decisions in peacetime, though the nature of the injuries which are commonly seen, and of the people in whom those injuries are seen, may be very different. In civilian practice the balance between the genders is likely to be more even and a wider spread of age groups will be seen with injuries. During armed conflict, proportionately more of the injured will be members of armed forces, and therefore young and previously fit men. The impact that devastating injury may have on them and their future life choices may be very different to the impact of such injuries in a different cohort. The very fact of their relative youth and previous fitness may make them more able to survive appalling trauma. Is enough thought given to the psychological consequences of the devastating injury they have survived? While this is not a primary concern for the medical professionals at the time of the original emergency treatment, it is certainly their role to seek to ensure that the importance of psychological support is well understood.

One scenario that arises in conflict situations that is not seen elsewhere is when the environment becomes so dangerous for the carers, and for their patients, that continuing to keep delivering care becomes untenable, and the hospital, first aid centre, dispensary, or other facility has to be closed. This is a situation that some care providers, such as the ICRC and MSF, have faced: real threats to their staff, including of abduction or of injury or death, are such that it is unacceptable for the institution to continue to expose the staff to them. These threats are compounded by the fact that if there are attacks on health-care workers, their non-clinician colleagues and their patients are also implicitly at risk.

Impartiality

One of the fundamental tenets of medical practice in peace and war is that of impartiality. In terms of medical ethics, this means that health-care workers must treat patients on the basis of need and not on the basis of ethnicity, religion, gender, age, or any other factor that might lead to unfair discrimination. It also overlaps

with medical neutrality, as referring to the non-involvement of health-care workers in political parties and issues related to the conflict within their workplaces. Doctors and other health-care workers are, of course, free to be as politically involved as any other citizen provided they do not let it impinge in any way upon their clinical role.

While the concept is the same in war as in peace, the reality is that in war the health-care worker is more likely to face real challenges to their impartiality. The military doctor, faced with two casualties needing urgent attention – one of whom wears the uniform of his own troops and the other that of the enemy – is likely to find it difficult not to be swayed by a loyalty to the person he serves alongside. But a doctor in peacetime confronted with two victims of a road traffic crash might face the same dilemma: one might be a friend, neighbour, or family member, and the other, the person who caused the accident. It is equally inevitable that the latter doctor's impartiality will be threatened.

The ethical rule is clear and simple. Care should be offered based upon need; the person most in need is treated first. This is the basis of triage in both wartime and peacetime.

Adapting decisions to armed conflict configurations

Ethical teaching is based upon understanding a system of analysis and using that system (and there are many competing systems) to examine the decision that is to be made. No one system is better than the others; each has strengths and weaknesses and each has devotees and opponents. What matters is that the individual is able to use one system to examine an issue. As different situations arise, he or she can then unpick the clinical circumstances, identify the ethical tensions, analyse them, and seek to find the best resolution. There are usually no right or wrong answers, but there are solutions that adhere more or less closely to general ethical principles.

In armed conflict the nature of the problem is likely to vary, as set out in some of the examples given earlier in this paper. As a general rule, however, there are some differences likely to be faced more commonly during armed conflict than at other times.

Health-care workers may well be personally conflicted because of loyalty to a cause, a group, or an ideology, in a way that will rarely impinge on their practice in peacetime. Separating out personal beliefs and prejudices is essential within any ethical decision; in conflicts when those beliefs may well include seeing those with the same loyalties or ideologies at risk of serious injury or death, it is much more difficult to remain neutral. Without neutrality, specific tasks such as performing triage (see below) become impossible, as does a fair assessment of the reasonableness of requests such as for the release of patient data.

A strong grounding in an ethical system, and an understanding and knowledge of ethical codes and principles, can help those under pressure to maintain the necessary clarity of vision and analysis.

Although, as stated earlier, ethics in peace and war are essentially the same, the pressures are different. Failure to treat a particular individual rarely threatens the

life of the health-care professional in peacetime; in time of armed conflict, however, this might occur. But there are situations in peace as in war when health-care workers are at risk as they undertake their duties. Health-care workers entering the scene of a natural disaster, such as a collapsed building, to render care may be at risk as much as those continuing to provide care while their institution is being bombarded, but as in war, the former are not expected to ignore their own safety. In peacetime doctors are expected to listen to advice, such as whether the risk level of entering the collapsed building is low or high, and not to take serious risks. While they are expected to accept some risk – for example, treating people with contagious diseases exposes health workers to some risks – they are also expected to take steps to minimise that risk (in the case of contagious diseases, by using barrier nursing methods, vaccines, and so on).

How are ethical rules made?

Ethical rules have historically emerged over time. Early rules of health-care ethics such as the Hippocratic oath and the prayer of Maimonides set out lists of acceptable and unacceptable actions for doctors. Many more modern codes are largely derived from these.

For much of the last three decades, ethical debate has been widespread but doctors have fought to keep the development of ethical rules and norms as a medically led process. This is gradually breaking down as doctors recognise that given the nature of ethical codes, as a bargain with the society they serve, it is at the very least helpful to involve others in developing such codes.

Those who should be involved can be classified in a variety of ways. One simple mnemonic consists of eight ‘P’s. The profession of medicine (the first ‘P’), is inevitably involved. Doctors must contribute; they will know best what a treatment or diagnosis involves, and must ensure that the adaptation of the ethical principles fits with normal clinical practice. Practitioners (the second ‘P’) should also be involved. The same ethical principles should bind all health-care professionals, especially those working together to offer care to the patient. Doctors, nurses and others have a different view of the clinical process, seeing it from slightly different perspectives, which helps in ensuring the matter is examined from all directions. Similarly, patients (the third ‘P’) or their representatives should be involved, and their perspectives should be considered. Public views (the fourth ‘P’) involve a wider group, including non-patients, potential patients, and carers. While most of the world’s countries are not theocracies, priests (the fifth ‘P’) or other religious leaders can also add to the debate, bringing in a view informed by the dominant faiths and the constraints they might offer. The importance of religious views will vary widely between different cultures, but an understanding of how the main religious groups might view a medical ethical dilemma is an important part of any debate. As some areas of debate will touch on the interface between law and ethics, lawmakers and law ‘managers’ are also relevant interlocutors. Generally this means the involvement of parliamentarians (the sixth ‘P’), but also of other policy people; those who work on legislative initiatives are especially important participants. Throughout this

mnemonic the public have appeared in various guises. They are most often informed through media stories, making the press (the seventh 'P') another contributor. The final 'P' is one of process; partnership is the aim of the best medical practice. Good ethics means a partnership of equals between health-care professionals and their patients; the ethical consideration process must work toward this end.

At the patient-doctor interface these different individuals and groups are not seen or heard from, but doctors, including those offering treatment in conflict situations, should consider how they can contribute to the development of ethical thinking. Doctors who have worked in conflict often contribute to, for example, journals considering surgical approaches to trauma, based upon their conflict experience. They should equally consider how they can contribute to journals of medical and health-care ethics.

Legal considerations

While law and ethics are different, both establish a set of principles which set limits on the freedom of medical personnel, and others, to undertake actions.

National laws increase in number every year. Many are written by governments in pursuit of a variety of policies. These can encompass areas which have a strong impact on medical practice, such as confidentiality and the management of data, or the age of consent. Other areas of law may have no immediately apparent impact upon medical practice.

While doctors recognise the importance of law, it is a common statement that ethics 'trumps' law. By this doctors mean that the law might allow doctors to do something which ethical analysis will state is unacceptable, and that ethics is the more important regulatory principle for them as health-care professionals.

In many countries this can lead to a conflict between statute law and the regulations established by the medical regulatory body, which might in and of itself have a quasi-legal weight. Doctors who break the limits set by a regulatory body, but stay within the law, may find their careers ended through erasure from the medical register, which gives them license to practise, or another serious punishment.

In general, where doctors collectively see that a law would require them to breach ethical standards, they should campaign to have that law changed. This is a task for collective bodies of doctors such as medical associations. A major role that medical associations fill around the world is to advocate on behalf of their members, including advocacy to ensure that doctors are able to practice in accordance with ethics and law.

In addition to statute law, emerging case law and common law, including from judgments in courts, also sets limits. Recent cases in many jurisdictions relate to consent to medical treatment,⁵ especially in terms of end-of-life decisions. There is also law in every jurisdiction on confidentiality of personal data. These laws vary

5 For case law relevant to the question of medical consent, see references in BMA, above note 1, especially chapters 2, 3, and 4.

widely, while the ethical principles are the same throughout the world. So, while in some jurisdictions the law might allow the sharing of patient data with or without the patient's consent, in others such activity is prohibited.

There is also an increasing body of decisions relating to human rights. Many countries have national legislation that addresses the human rights of their citizens and is subject to decisions by international and regional judicial or quasi-judicial bodies. More specifically, there is an increasing body of case law and literature on the 'human right to health'. While this is not an absolute right to access to health-care, 'Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity'.⁶ This non-derogable right encourages non-discriminatory state approaches to health-care access.

In times of armed conflict, international humanitarian law (IHL) also comes into play. This body of law consists of treaty rules (mainly the four Geneva Conventions from 1949 and their Additional Protocols), and customary rules which bind all states. IHL contains a number of rules related to the provision of health care and addresses the protection of health-care personnel, units, and transport.⁷

In many ways, ethics codes have achieved a status similar to customary law. The acceptance of certain standards by doctors throughout the world gives those codes international status, so that they cover all doctors whether or not each individual doctor has sworn to follow them.

Specific ethical challenges in times of armed conflict and situations of violence

Triage

Triage is the process that enables the sorting of patients into priority order for treatment. It is classically used when a service is overwhelmed by the arrival of multiple casualties, and is designed to ensure that medical needs are addressed effectively.

In civilian practice – and increasingly in warfare, in facilities serviced by well-equipped military field hospitals – triage identifies those in most urgent need of immediate lifesaving treatment, those in moderate need, and those effectively needing first aid. This can include the identification of those who are likely to die

6 See Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), adopted on 11 August 2000, E/C.12/2000/4, para. 1 (emphasis added).

7 For a summary of IHL and human rights law rules related to the respect and protection of health care, see ICRC, 'Respecting and protecting health care in armed conflicts and in situations not covered by international humanitarian law', Legal Fact Sheet, 31 March 2012, available at: www.icrc.org/eng/resources/documents/legal-fact-sheet/health-care-law-factsheet-2012-03.htm (last visited November 2012).

regardless of treatment. These patients may receive no active attempts to preserve life, but should always receive care, including pain control. In more classical conflict situations a variance of this was to identify and prioritise those needing first aid in order to render them suitable for an immediate return to active fighting. This can mean that those in immediate need of life-sustaining treatment may find a delay in obtaining such treatment, while those in lesser need are helped so they may return to active duty. Many modern military forces would deny that this situation ever arises nowadays, but in practice most military medics will recognise that there are times of military emergency when getting soldiers back to the active front may be essential, not least because it will help to save other injured people by protecting the hospital or treatment centre.

Triage systems developed by military medical personnel are the basis of systems used in non-military situations, especially of emergency. Again the concept is one of identifying those for whom treatment is futile (an increasingly rare concept), those needing immediate treatment, those needing serious medical intervention soon, and those requiring little more than basic first aid.

The ethical concept is that those in most need are prioritised. It can readily be understood that identification of need is in itself time- and therefore resource-consuming. Triage systems understand this and usually place the most experienced clinician as the triage lead, the person who assesses and categorises the arriving injured people. This maximises efficiency and reinforces the concept of need driving priority.

The decision not to use resources on those who are inevitably going to die is also consistent with ethical principles; resources are always limited, even in peacetime or in developed countries. Using resources where they cannot provide benefit to the patient is always a potential denial of resources to others who might benefit from them. Equally, it exposes the patient who cannot benefit to risks; the treatment itself might be uncomfortable, diminish their dignity, or do them some other harm.

While the ethical principle is exactly the same in all situations, the key difference in wartime is one of resources; it is rare outside armed conflict for well-resourced countries to experience so many people competing for care at one time that access by one means denial to another. So the reality of triage is more about sorting patients into groups that will experience different levels of care from different types of health-care workers. In armed conflict situations it is all too common for health-care personnel to have more patients with urgent needs than can readily be managed; triage thus becomes life-determining.

The challenges for doctors working in a culturally different environment

The law, including individual rights, can vary between countries and even within countries. The law is based upon country- and culture-specific rights and duties, as well as local enactment of international law. Where law and ethics come together, there are often local differences from international standards. Those working as doctors within a conflict zone may come from countries where human rights are

widely respected, where autonomy is the basis of most medical decision-making, and where men and women are treated equally. They may find themselves in a culture – and treating patients from that culture – where decisions are made by local leaders or by heads of families, and where women are not fully entitled to act autonomously.

Doctors who are trained to understand that patients have the right to make all decisions about their own health will find it difficult to work in cultures where such decision-making is given to a civic leader or to, for example, the husband or father of a woman. Ethical practice requires the patient's agreement, but local law and custom might require that of someone else.

It is clearly important, not least because of the essential importance of trust in the relationship between the doctor and the patient, that the doctor does not act in a way that will shock or otherwise unsettle the patient. In matters such as consent (see also below) this is easily resolved by discussion with the patient and with the appropriate cultural surrogate decision-maker.

Ignoring different cultural norms can impact on trust. One example is the treatment of women by male health-care workers in societies where such treatment is either generally unacceptable or only acceptable with specific permission from, for example, the husband. Most Western societies do not share this cultural norm, and health-care workers treat all patients on a needs-based priority system. Adjusting to this cultural norm is ethically acceptable and is likely to reinforce trust as it demonstrates respect for local cultural traditions.

More problematic is when a local norm would ask a health-care worker to do something ethically unacceptable. Female genital mutilation (FGM, also known as infibulation or female genital cutting) is common in parts of North Africa. It is prohibited by law in many countries – for example, in Europe – and is ethically unacceptable in the advice from the WMA and the International Federation of Gynaecologists and Obstetricians. But when offering health-care to people in parts of North Africa riven by conflict, expatriate health-care workers might be asked to undertake FGM as it is 'better' that it is done with clean medical instruments and with appropriate skills than by a local village leader with no access to antiseptics, treatment for haemorrhage, or other necessary medical resources. Some also say it helps to build trust that the imported health workers respect this local tradition, but here the ethical issue is clear: this is a practice which has no place in medicine, and which is dangerous, damaging, and has no benefit to the girl concerned (there is an additional factor that the patient is usually a child and is denied the right to take part in the decision). The role of the health-care worker here is one of attempting to educate the population so that this practice is discontinued, and to educate especially on the medical reasons for its discontinuation. Discussions should also emphasise the value placed on not doing harm to anyone, something which is valued in most traditions.

Attitudes to sexual violence vary widely; in many cultures, such issues cannot even be discussed. Any person reporting them will be unlikely to be treated sympathetically and may even find their life endangered. Standards recognised in law in many nations, including definitions of rape that include rape within marriage,

are not universal. People who have been harmed and who are in need of medical support may receive no support within their community; health-care professionals may find this a very difficult dilemma. Their role is to treat the victim to the best of their ability, and they need to be aware of the cultural norms around this issue so that they do not inadvertently endanger their patient. Anger about such abuse is common, but doctors should ensure that such anger is kept under control until they are away from the situation and can advocate appropriately without endangering their patients or colleagues.

Medical officers should ask before deployment for information about and training in relation to any local cultural practices that they are likely to encounter. Discussion before deployment will make responses to these challenges easier and more uniform.

Lack of resources and sending patients back to under-resourced areas

A major ethical constraint that affects the delivery of medical care can be a shortage of resources. Such resources may consist of trained personnel, including doctors, or physical resources, including operating rooms, drugs, dressings, hospital beds, and essential equipment such as anaesthetic machines. The concept of triage is used to allocate such resources on the basis of need.

In times of armed conflict, and especially of asymmetric warfare, military doctors may find themselves looking after patients from an opposing force in the knowledge that the follow-up care these patients will receive when returned home is likely to be significantly less than would be available to patients from the doctors' own forces. The differences might be a matter of life and death; for example, dialysis or similar life-sustaining treatment may not be available, or they might relate to post-injury rehabilitation including physiotherapy and the provision of prostheses.

Doctors who undertake life-saving treatment during acute injury may not be able to take into account the treatment options that might be available later, but where possible should amend their treatment plan to take such factors into account. In other words, when selecting the treatment option, doctors should bear in mind the consequences of that treatment and the longer-term needs it will generate for the patient.

Consent

It is a mainstay of treatment in the developed world, and especially in Europe, the Americas, and 'Australasia', that any and all treatment must only go ahead with the real and valid consent of the patient or of an appropriate surrogate decision-maker as allowed by local laws. Not all societies treat consent with this degree of respect. Patients may be used to others deciding for them, or to a paternalistic medical profession that tells them what will be done. Helping patients to understand why they are being asked to consent, and how and why their decision will be respected, can be challenging if it is culturally surprising.

There will be circumstances where the patient cannot consent – for example, because of the seriousness of his or her immediate injury. In such cases medical treatment can continue to sustain the life of the patient, but as soon as the patient regains an ability to participate in decision-making, he or she must be told what has been done and given the opportunity to make future decisions. Very many patients arriving at conflict-area field hospitals will have already received some emergency first aid, which might include powerful analgesics such as opiates. Some will have had their consciousness clouded by this treatment, and indeed by shock associated with the injury, and may be temporarily less competent. While treatment can continue, as much involvement as possible by the patient in decision-making should be enabled.

Where language is the principal barrier to consent, attempts should be made to find a translator or to otherwise enable communication. In circumstances where the delay in getting such translation might endanger the life of the patient, treatment might go ahead, but as with patients suffering some diminished capacity, attempts must be made to explain what was done, and why, as soon as is feasible.

There may also be some patients who make decisions with which the doctor disagrees. The fundamental point is that a patient has the right to refuse treatment, even life-sustaining treatment, provided they are competent. The fact that they disagree with the recommendation of the doctor does not make them incompetent and cannot be used as an excuse for so classifying them. As with such cases in non-conflict-area practice, attempts should be made to discover why they are refusing treatment. Is this about fear? Is this because of a lack of trust in the doctor, or the medical system, or for some other reason which means that they need extra time and help with understanding and coming to trust the advice they have been given?

Doctors and other health-care professionals in all areas of practice find the refusal of life-saving treatment the most ethically and spiritually challenging event. The fact of being challenged does not mean that a retreat from ethical core values is acceptable, nor does it mean that doctors should immediately withdraw from attempting to help the patient. Rather, doctors should continue to attempt to help the patient and to gently persuade him or her to allow more such help to be given. At the very least, they should explore what the individual would find acceptable so that help can be offered.

Doctors cannot be forced by anyone, including the patient, to offer a form of medical care which they believe to be inappropriate or contrary to the interests of the patient. An example given in general ethics texts is that a patient with abdominal pain cannot demand that a doctor amputate his big toe. Such a treatment would clearly not help the patient and it would be unethical to provide such a treatment; the same would apply in conflict situations.

While consent is a process, with offers of information and exploration of issues, it often ends with a consent form being signed by the patient. The intent is that this form signifies that the patient has understood the information being offered, including their right to refuse a recommended treatment, and is agreeing to

a specific treatment being undertaken. In conflict situations where it is likely that the injured might come from a variety of groups speaking different languages, consent forms should be available in these languages or at the very least translated before being signed by the patient. Medical language cards in other locally common languages can be an invaluable aid to the process of getting agreement between patient and doctor on future treatment. Given the frequency of functional illiteracy in all cultures, doctors should be able to undertake the process without recourse to the words on a consent form.

There will be circumstances in conflict as in peacetime practice where the patient is unable to consent because of, for example, the nature of the illness or injury that has brought them to the care giver. In these circumstances, life-sustaining treatment can be given. The health-care provider should be sure it is 'mainstream' care – that is, what any other care provider would offer in the circumstances – and should tell the patient as soon as possible what was done.

Consent is also relevant regarding media intrusion. Some areas of conflict are used by politicians and others in the public eye as media opportunities. In some cases the celebrity might seek to be photographed or filmed metaphorically mopping the brows of the sick and injured. While some patients might welcome the opportunity to meet someone famous, very many will not, especially at a time when they are suffering. Even being filmed by the media in the absence of a celebrity requires the free consent of the patient. It should never be assumed that the sick and injured will welcome what many will see as an intrusion into their private matters.

Dual obligations

In some roles doctors find that they have a duty to their employer as well as a duty towards the patient. In general terms the duty to the patient comes first, but key for the doctor is recognising that there is a potential conflict. A military doctor might find that he or she is asked by local commanding officers about the health of members of his or her forces. The doctor owes a duty of confidentiality to the individual patient, but is also a member of that forces group and has a responsibility to ensure they are not put at risk because of that confidentiality. The doctor also has a legal duty to keep senior officers informed of the state of health of the troops. In practice this tension is understood and dealt with by telling the commanding officer whether or not a specific individual's health concerns will prevent them from carrying out their duties, not what those health concerns are. It is entirely legitimate to ask the patient/soldier whether he consents to information being given to the commanding officer, but he has the right to refuse, unless there is a specific legal duty to tell.

Different legislatures regard confidentiality and the rights of soldiers differently; in some circumstances the soldier might have given up the right of confidentiality. Doctors need to know the local law that applies to such situations. While the ethics is clear – there is a duty of confidentiality – this might be overridden by law.

Obligations to an employer cannot override law and ethics. No employer can require a doctor to break the law – for example, to cooperate with or ignore human rights abuses – or to breach ethical obligations to treat patients with consent and maintain their confidentiality.

While employers of health workers in conflict zones, including the military, may ask their employees to breach ethical standards on confidentiality, on neutrality, on non-discrimination, or other areas, the fact of being asked is not a requirement to obey, and ethical standards should be followed. A health worker asked to prioritise members of his or her troops or followers, for example, must point out that care is offered based upon need, and that triage is an expression of this when the number of casualties or presenting patients exceeds the capacity to treat everyone immediately. As with other ethical dilemmas, such pressures should be discussed in advance of crises so that employers or others seeking to affect health-care decisions are aware of the ethical principles that will be followed.

There are examples of good practice in many armed forces settings. In the UK forces there is a clear statement from the Chief of the Defence Medical Services (the most senior medical officer in the three parts of the armed forces) that doctors concerned about an ethical issue should raise it with their local field commander, but if the field commander does not act appropriately, the doctor should then raise the issue through the medical chain of command.⁸

Confidentiality

Medical confidentiality is a poorly understood concept. It is not an absolute right in any country, but is a weighted right; that is to say, doctors obtain sensitive and highly personal information from patients for the purposes of making a diagnosis and suggesting treatment. Any other use of that information is subject to the agreement of the patient to its sharing. Indeed, even sharing with other health-care professionals should be done with care and only as essential to the care of the patient. This means that rather than offering full access to the complete record, doctors should consider what the health-care professional needs to know to do his or her job.

There are of course exceptions to confidentiality. These are principally where the patient agrees, where it is required by law, and where there is a compelling public interest reason.

It is assumed for the purposes of this article that laws are passed in accordance with good practice and that laws would not expect a breach of confidence which doctors generally felt to be unacceptable or inappropriate. If such unacceptable laws are in place, it is the role of the medical profession to campaign for their repeal.

8 Ministry of Defence, *Medical Support to Persons Detained by UK Forces Whilst on Operations*, Joint Service Publication 950, leaflet 1-3-4, March 2011.

Public interest disclosures need to be considered on an individual basis. In advice to UK military doctors, the British Medical Association advises that they should:

- Consider how the benefits of making the disclosure balance against the harms associated with breaching the patient's confidentiality;
- Assess the urgency of the need for disclosure;
- Consider whether the patient can be persuaded to disclose voluntarily;
- Inform the patient before making the disclosure and seek his or her consent, unless doing so would increase the risk of harm or prejudice the reason for disclosure;
- Document the steps taken to seek or obtain consent and the reasons for disclosing without consent;
- Reveal only the minimum information necessary to achieve the objective;
- Be able to justify the disclosure; and
- Document both the extent of and the grounds for disclosure.⁹

In civilian practice a doctor might disclose to a driver licensing body the fact that a person continues to drive when they are medically unsafe to do so, if the patient refuses either to stop driving or to tell the agency themselves. The risk of harm to themselves and to others justifies the breach of confidence, which is specific and limited. In military practice, where a soldier is expressing suicidal or homicidal ideation and has access to weapons, the doctor may be able to justify disclosure to a commanding officer. In this case he might limit the information by expressing concern about an individual and recommending they be taken away from access to weapons for the immediate future or medically 'downgrading' the soldier's fitness for duty.

Experimental treatment

Health-care professionals are aware of the times within clinical practice when patients are least able to voice their own opinions or to act autonomously. The history of medicine in the twentieth century was one of unethical and abusive medical experimentation, including during attempts to better understand the natural history of disease and to develop new treatments. This led to the Nuremberg code, and eventually to the development through the WMA of the Declaration of Helsinki.¹⁰ In conflict situations there are a variety of groups who are especially vulnerable to abuse. These include wounded enemy combatants and civilians from a defeated group or state. Ensuring that their rights are not ignored is one element of avoiding unethical, and almost certainly illegal, human experimentation.

The nature of health care in conflict is such that many patients will be seen in a short time with injuries that are fairly specific to the nature of that

9 BMA, *Ethical Decision-Making for Doctors in the Armed Forces: a Tool Kit*, London, 2012.

10 WMA Declaration of Helsinki, *Ethical Principles for Medical Research Involving Human Subjects*, adopted June 1964, last amended October 2008.

conflict situation. Health-care professionals may well start to develop new ideas for treatment options. Development of new treatments should follow the same path as in peacetime. Truly experimental treatments require research ethics approval. Modifications from well-established and understood norms require careful consideration, and doctors with ideas for such changes should discuss them with colleagues and ensure that they are rigorously assessed. Those wounded in conflict are not experimental animals; they are people with all the rights that flow from that, including the right to willingly participate in or decline involvement in research trials.

There is a vast literature on human experimentation, including on the methodology for obtaining the necessary ethical clearance to the research. In brief, this methodology requires the researchers to apply to an appropriate local research ethics committee for approval. That group will want to be certain of matters such as the soundness of the underlying science, the freedom of participants to refuse involvement, confidentiality, follow-up, and safety. Those engaging in research should make themselves aware of local approval structures; understanding the detail of the Declaration of Helsinki is an excellent start to writing a research protocol. It should be readily understood that the intention of the ethical principles is to prevent abusive research and to give the public confidence that if they are asked to participate in research it will be properly designed, delivered, controlled, and monitored.

Trust and language

The basis of all medical treatment is that patients and health-care professionals, especially doctors, trust one another. Doctors trust their patients to tell them the truth, to give accurate medical histories, and to cooperate with the care they are offered. Patients trust doctors to do their best for them, and not to unfairly discriminate against them on any grounds. Fair discrimination, however, is not only ethically acceptable but is a requirement of good practice; this means discrimination based upon need.

Trust is earned. Given that many patient–doctor relationships are established at the time of a health-care emergency, the earned trust is generic; it relates not to that patient with that doctor, but to that patient and his or her experience of doctors in general. Trust may not be present if the patient has had previous negative experiences of medical interventions, or comes from a culture where that trust has not generally been earned. Given that in many conflicts young soldiers will have little personal experience of or interactions with health-care professionals and may also see them as part of an establishment against which they are rebelling, trust may not exist.

Where patients and health-care workers come from opposing sides in a conflict, the trust can be undermined by suspicion, and indeed by fear, coercion, or violence. This should be understood and directly addressed in communications between patient and doctor.

The health-care professional may then find themselves during an emergency having to spend an unexpectedly large amount of time explaining who

they are, how they reach decisions, what they can offer, how they will support the patient, and how the patient will be helped and enabled to make his or her own decisions.

Good communication is always essential in any patient–doctor relationship. Given that the role of the doctor is to make a diagnosis and, based upon his or her clinical experience and knowledge of the evidence, make a treatment recommendation, an ability to discuss options with the patient is clearly essential. In the absence of inherent trust, that communication will be both more difficult and even more important. In conflicts where international forces are present, including in so-called peacekeeping roles, major providers of health care are unlikely to speak the same language as local people, who will constitute a variable but often high percentage of the wounded. In some conflict situations, communication will be inhibited by such language difficulties. While translators can help, they may not be readily accessible to all, or indeed at all hours of the day or night when the need for them arises. Translators may be employed to work primarily in areas away from the clinical front line and may struggle with explaining all of the nuanced clinical information.

Other combatants, or in some cases family members, village elders, and others might be enlisted to help with translation. This can be very dangerous; the doctor cannot know how accurate the translation is, nor can they know whether the patient is comfortable talking through these individuals. Nor can the doctor know whether the informal translator is conveying the subtleties and nuances of his role and in particular the respect he will pay to the patient's decision-making.

If, for example, the patient is seeking medical advice after a sexual assault, an incident which occurs commonly in conflict as well as in peacetime, confidentiality is a prerequisite for those seeking help. In many societies the victim may be blamed as much as the aggressor, and the assault may bring shame on his or her family or even threaten his or her life. Asking family members to translate is clearly inappropriate in these circumstances. Other informal translators are equally unacceptable as they may have connections to the victim's family and social setting that are unknown to the health-care worker. Professional translators should be trained to understand their role as well as to ensure that they are able to translate the necessary medical language.

This essay has already discussed consent, based upon the concept that nothing should be done to an individual without their prior agreement or consent, freely given. If the health worker cannot communicate to the patient what the diagnosis is, what the treatment options are, and what the consequences of that treatment or its refusal might be, and subsequently answer the patient's questions, then consent cannot be given. Treatment given in these circumstances is probably illegal and constitutes battery. It certainly is unethical. If only an informal translation is available, neither the doctor nor the patient can know if what is passed on is accurate and complete; incomplete or inaccurate information is likely to undermine trust.

Much of communication is non-verbal. This is often highly culturally and socially specific; signs taken as assent or dissent in one population may not read

directly across in another. Where this is added to linguistic difficulties, serious misunderstandings can arise.

In cases where health-care workers are going to treat those with whom they have no common language, they should ensure that translators are provided and should rely as little as possible on informal or family-based assistance. When only such informal assistance is available, they should attempt to ensure that the patient is satisfied with the person providing help.

Attacks on health-care institutions, personnel, and patients

Attacks against health-care institutions, personnel, and patients are becoming increasingly common and are the subject of the major ICRC project Health Care in Danger.¹¹ Those working in conflict zones must be aware of the risks they and their colleagues face. They are not expected to continue despite all dangers, but should bear in mind their safety and that of others. Developing trust and understanding with the local community may play a major role in avoiding such attacks.

Specific ethical challenges for military doctors working outside their area of competence

Military physicians work as clinicians in a variety of clinical sectors. They may also work in fields of warfare and undertake roles which are less traditional, or within areas otherwise seen as specialist, and for which they have received less training. It is often while undertaking roles for which they are less well prepared, through postgraduate and continuing medical education, that doctors might make errors of ethical judgement.

Within the traditional clinician role, military doctors face dilemmas that differ from those of routine civilian medical practice. These will include coping with different cultural expectations, matters of trust, confidentiality, assessments of capacity, and dual obligations. There are also issues of triage, complicated by factors such as the pre-morbid role of the patient and the options for treatment outside the military setting. The nature of work during armed conflict is such that there may be occasions where the doctor feels that the necessary treatment for the injured or sick person is outside his or her area of competence. The doctor might, for example, be a good general surgeon but with little experience in dealing with chest injuries or head injuries, and be presented with such a patient.

The ethical duty of the doctor is to work within his or her level of competence and not to take on, or agree to undertake even if ordered by others, something outside that area of competence. If the doctor who feels less than competent to undertake a task also recognises that the injury is such that only immediate intervention can save the life of the patient, or potentially prevent very

11 For more information, see the website of the Health Care in Danger project: www.icrc.org/eng/what-we-do/safeguarding-health-care/solution/2013-04-26-hcid-health-care-in-danger-project.htm (last visited May 2013).

serious sequelae, and he is the only person present or able to be present within a reasonable timescale, then the doctor might decide that his semi-skilled intervention is a better option for the patient than no intervention at all or the intervention of someone even less skilled. The decision is based upon an honest assessment of what is best for the patient, and of the alternative options available. The well-being of the patient is, as always, the first consideration of the doctor.

If this was a commonly seen injury then the chain of command should have provided a suitably experienced practitioner. Those working in areas where specific injuries are commonly seen should also take reasonable steps to increase their own skill sets to deal with such injuries.

Detainees

In armed conflict situations, doctors and other health-care workers may find themselves caring for enemy combatants and non-combatants, and may unexpectedly become responsible for prisoners. In most such circumstances the doctor or other health-care worker is in that location because he or she is, for example, a skilled field surgeon with probably no experience or training in the mixed public health and primary care role needed when caring for the health of detainees.

The key factor to remember is that persons deprived of their liberty as a result of armed conflict are protected by IHL.¹² Doctors in the armed forces asked to look after detainees should understand their IHL obligations,¹³ as well as the rules binding the detaining authorities in order to protect detainees.

As patients, those detainees still enjoy the right to ethically proffered medical care; they have the same rights to consent, to refuse treatment, to expect confidentiality, to be treated by competent practitioners, and so on.

One area that doctors should be considering is the public health and preventative care needs of prisoners. Doctors need to be aware in detail of the conditions of detention and consider what the medical implications might be. Tuberculosis is a common disease around the world. Overcrowded prisons, especially with dampness and poor ventilation and with inadequate nutrition for the prisoners, become very rapid breeding grounds for cross-infection. Doctors need to look closely at these conditions, and if they suspect a prisoner might be a potential source of infection, to seek ways of protecting other inmates.

12 In situations of international armed conflict, prisoners of war and civilian detainees are protected by the Third Geneva Convention relative to the Treatment of Prisoners of War, and the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War, as well as by customary rules (see ICRC, *Customary International Humanitarian Law, Vol. I: Rules*, Jean-Marie Henckaerts and Louise Doswald-Beck (eds.), Cambridge University Press, Cambridge, 2005, specifically chapter 37). In situations of non-international armed conflict, persons deprived of liberty for reasons related to the conflict are protected by Article 3 common to the Geneva Conventions, and by the Protocol Additional to the Geneva Conventions of 12 August 1949 and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), as well as by applicable customary rules.

13 For more information about the responsibilities of health-care personnel working in armed conflicts and other emergencies, see ICRC, above note 1.

Given that abuse of detainees is sadly commonplace, it is strongly advised that detainees should be medically examined as soon as possible after their placement in detention and a record kept of any injuries that might, for example, have been sustained at the time of placement in detention. If medical aid is needed, whether for an injury or for another incidental illness, the doctor must ensure that this is provided in a timely manner. Such an examination should ideally be performed by a doctor, but in the absence of a doctor any other health worker, including a first-aider, should be called upon to record the prisoner's condition at the time of detention. Prisoners must, as with all other medical examination or treatment, have the right to refuse. On occasion the prisoner may refuse to be examined. Given that trust between the prisoner and the detaining authorities is unlikely to be high, this is completely understandable. In such cases only the information about what can be seen from an inspection can be recorded, but the doctor should seize the opportunity to try to build some trust, not least by explaining that his role is not as an enemy military officer but as a doctor with an interest solely in the welfare and well-being of the prisoner.

Ideally such examinations of the detainee's current medical condition should be performed every time a detainee is moved from one site to another, upon leaving the site, and upon arrival at the destination to ensure abuse does not occur during the transportation. A regular review of the health of all detainees should be part of the general duties of the medical officer in charge of the detention facility.

Ill-treatment

Doctors are often the first to see evidence of the abuse of detainees, or of vulnerable members of their own forces. Such signs may well be subtle; abused persons often develop skills at concealing their abuse. Health workers may well also be reluctant to suspect abuse, especially where the abusers may be their comrades or friends. The WMA in its Tokyo Declaration has set out ethical *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman and Degrading Treatment or Punishment in relation to Detention and Imprisonment*.¹⁴

In such cases the doctor must understand that their role is not simply to treat the signs and symptoms but to intervene to stop the abuse. This is both good preventative medicine and an ethical requirement. Medical examinations should be repeated from time to time, and whenever a detainee is moved to a new institution, as part of both a general health check and as a preventative against abuse.

As stated above in the case of detainees, doctors must also be aware of the conditions of detention (which may amount to degrading or even cruel or inhuman treatment). Without such knowledge, they will be unlikely to know what diseases or injuries are likely or to be able to ensure that interventions are undertaken to reduce

14 WMA Declaration of Tokyo, *Guidelines for Physicians Concerning Torture and other Cruel, Inhuman and Degrading Treatment or Punishment in relation to Detention and Imprisonment*, October 1975, adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and last revised at the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, available at: www.wma.net/en/30publications/10policies/c18/ (last visited November 2012).

the medical risks. If the doctor does not know that a detainee is being held in a place that is cold and damp, he or she may ignore risks of specific illnesses, including for example tuberculosis. Similarly, if the doctor does not know about the other threats to detainees, including of beatings by guards or by fellow inmates, he or she will be unable to look for and act on the injuries that might be sustained.

In terms of deliberate ill-treatment, doctors have a key role to play. Everyone is protected from torture and cruel, inhuman, and degrading treatment under both IHL and human rights law. Where torture or cruel treatment (involving severe pain or suffering) is perpetrated, doctors are likely to see the results: bruises, burns, other marks, and equally some of the psychological sequelae. At this point they must intervene and voice their suspicions to the local military chain of command, and if the abuse does not stop immediately, to the medical chain of command. Senior officers in both of these chains of command have obligations with respect to the prohibition of torture and ill-treatment; the medical chain consists of officers who also have an ethical duty to ensure a humane treatment of prisoners. Doctors taking such steps must also be protected from attacks by colleagues or others aimed at discouraging such intervention.¹⁵

It is understandable that doctors who are primarily working in the military as field surgeons, anaesthesiologists, and related specialists may find acting as a prison doctor confusing. There should be good learning materials available from their medical military command lines to ensure they have the necessary advice. Keeping in their minds that the welfare of their patient, the detained person, remains their first ethical duty helps to ensure the right instinctive behaviour.

Medicine in armed conflict offers great challenges to doctors, in clinical terms and in ethical terms. Keeping in mind that the patient is the most important person, that his or her duty as a doctor is to care holistically for that patient, will help keep the doctor to remain on the right ethical track.

Conclusion

Medical ethics is an agreed system that both sets limits on the freedom of doctors and other health-care professionals, and forms the basis of what the public can expect from the people they go to for their health needs. It is not a set of simple rules, but involves the need to balance rights and duties to individual patients and to society. Practitioners need to consider every day and in every decision they make what the ethical dilemmas are and how best to resolve them in each particular case.

For ethical principles to work, health-care practitioners need to be comfortable and skilled with using them and with analysing problems in order to apply them. Ethical principles also need to be understood by the people who employ

15 WMA Declaration of Hamburg, *Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*, adopted by the 49th WMA General Assembly, Hamburg, Germany, November 1997, and reaffirmed by the 176th WMA Council Session, Berlin, Germany, May 2007.

and direct the work of those health-care practitioners who are those most able to ensure that the best conditions are in place to allow their application. Health-care practitioners need training throughout their medical careers in ethical analysis based upon real clinical situations. There is a real opportunity for dialogue after such training with those in a position to change the situation to one conducive to high ethical principles being applied.

Untrained health-care professionals can get into real difficulties; it is clear that in the recent UK engagement in Iraq, doctors in charge of detainees were not trained in handling such duties and were not directed to relevant training or policy material. Since then the Ministry of Defence has committed to ensuring that such doctors are trained and aware of the specifics, especially if they are to be responsible for detainees.

Given that, as shown above, it is easy to identify situations in which ethical principles are placed under specific tensions during conflict, it is especially important that those going into conflict zones are aware of these tensions and have help in applying the specific tools necessary. The British Medical Association toolkit and the ICRC publication on the responsibilities of health-care personnel¹⁶ are especially valuable, as both are designed to help people working in just these circumstances. Health-care workers are also advised to read more widely about medical ethics, and to practise using ethical analysis while still in situations where they can get the benefit of advice from others.

Ethics protects the public, but it also protects doctors and other health-care workers who have entered their professions to help others. Ethics, above all, underpins the humanitarian and caring elements of medical practice; it is a tool that aids in ensuring high quality of care to all.

16 See BMA, above note 9; and ICRC, above note 1.