

# BMA

## Doctors working in conflicts and emergencies – an ethical toolkit





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## Executive summary

Medical ethics doesn't change in times of armed conflict – doctors' core obligations are the same as in times of peace – but those working in conflicts and other emergencies can be under great stress. Familiar ethical challenges can be intensified, and ethical guidelines designed for less demanding environments might be less helpful.

This toolkit helps doctors and other health professionals in humanitarian contexts to live and work with the ethical problems they are likely to face. Rooted in international humanitarian law and medical ethics, it gives brief, practical guidance.

It enables health professionals to fulfil their primary obligation to patients, and highlights the central importance of medical impartiality – that patients must be treated based on need, and that medical skills must not be used to the detriment of patients.

The guidance focuses on areas known to be challenging. Using real-life scenarios, it looks at ethical issues arising where there are threats to delivering care to appropriate standards; pressures to push clinical competence to the limit; transferring the injured, sick or wounded to substandard health facilities; and identifying an acceptable lower limit of quality.

Printed in a format that can be slipped into a pocket or rucksack, it is designed to be read both in advance of deployment and while working in the field.

## Introduction

Medical personnel working in conflicts and emergencies, such as war zones and humanitarian crises, often face challenging ethical problems. These problems are not new, but they can be intensified: there may be little time to respond, and extremely limited resources. Physical insecurity, the threat of violence and rapidly changing circumstances can lead to disorientation and doubt. Physical, mental and emotional exhaustion and relentless demand from the sick, injured or dying can overwhelm good judgment and ordinary ethical intuition.

In these situations, health professionals might find that ethical guidance designed for less demanding contexts does not help. For some, the trauma of conflict is complicated by doubts about whether they did the right thing – and these doubts can inhibit decision-making, with significant consequences.

This guide aims to prepare you for the problems you might face. We strongly recommend reading it before you are deployed; it can be enormously reassuring to know that other people have faced similar problems and found constructive responses.

No guidance can be exhaustive. We offer brief practical hints and suggestions for the field, and have opted for brevity: the guide is designed to be accessible and portable.

Despite the unpredictability of conflicts and emergencies, problems can be identified in advance. This guide is structured around areas known to be challenging, including:

- threats to delivering care to appropriate standards, often linked to a shortage of resources
- pressures to push clinical competence to the limit – and beyond
- pressures to transfer the injured, sick or wounded to substandard health facilities
- identifying an acceptable lower limit of quality: at what point do you draw the line?
- conflicts between professional ethics and the employing organisation: what happens when operational goals clash with medical ethics?

Medical personnel want to do the best for their patients. In practical terms, doing 'the best' for a sick or injured person in a highly-resourced setting can be different to doing the best during a conflict. Many working in these settings report feeling acute discomfort because they cannot do more. They worry that they cannot treat people, or even save lives, as they would 'back home'. While these comparisons are understandable, your obligation is unchanged: to do the best for patients with available resources.

This toolkit is designed for humanitarian health professionals. Doctors working in the military may confront similar ethical challenges, as detailed in our armed forces toolkit ([www.bma.org.uk/advice/employment/ethics/armed-forces-ethics-toolkit](http://www.bma.org.uk/advice/employment/ethics/armed-forces-ethics-toolkit)).

## **The protection of health services and staff during conflicts: law, ethics and humanitarian action**

Humanitarian action seeks to prevent or alleviate human suffering arising out of disaster or conflict. It is driven by the belief that all people have equal value and those in need have a right to assistance. By its nature, humanitarian action involves working in challenging circumstances.

During conflicts and serious disasters, infrastructure can be devastated, and local structures of law and order compromised or non-existent. There may therefore be problems with enforcement, but international law and codes of medical ethics do not fall silent. These are the main principles.

### **International humanitarian law**

Health staff and their services are specifically protected during armed conflict by international humanitarian law (IHL). It seeks to limit the humanitarian impact of conflict, and provides legal protection for those who are not, or are no longer, engaged in conflict. It also restricts the means of warfare. The bulk of the protections afforded to healthcare staff and services are set out in the Geneva Conventions and their additional protocols, including:

- the protection of the wounded and sick, of healthcare personnel and facilities, and of medical transport
- the respect and protection of healthcare staff carrying out duties compatible with medical ethics
- the use and protection of emblems such as the red cross and red crescent.

## **International human rights law**

International human rights law (IHRL) sets out the rights, freedoms and entitlements that all citizens can reasonably expect of governments. They are legal rules that oblige governments to act, or refrain from acting, in certain ways. Human rights are inherent to all human beings – unlike IHL, they do not specifically regulate armed conflict.

Relevant rights protected by IHRL include:

- the right to life
- the right to be free from torture or cruel, inhuman or degrading treatment or punishment
- the right to equal protection before the law.

## **Medical ethics**

In our context, medical ethics refers to the professional standards, obligations and codes that regulate medical practice and the relationship between doctors and patients. Unlike IHL and IHRL, medical ethics is not rooted in law but in the professional obligation to promote patients' wellbeing. Although health professionals in conflicts and emergencies can come under great stress, standard ethical norms nonetheless apply. Information about these norms can be found in the appendices.



## **Fundamental principles: the World Medical Association's regulations in times of armed conflict and other situations of violence**

'Medical ethics in times of armed conflict is identical to medical ethics in times of peace,' states the World Medical Association (WMA). There are no exceptions. The principles that govern medical care do not change, although in times of conflict it can be difficult to see how to apply them.

The WMA's regulations in times of armed conflict are given in full as an appendix to this guidance. We recommend familiarising yourself with them in advance.

These are some core ethical principles drawn from the WMA's regulations. They are designed as a moral compass – although they cannot solve all the ethical dilemmas you may face, they are a useful rule of thumb.

- A doctor's primary obligation is to their patient.
- The primary goal of medical care is to preserve health and save life. It is unethical to use medical skills, knowledge or personal health information in ways that conflict with this purpose. This includes any form of involvement in torture or any form of cruel, inhuman or degrading treatment or the use of personal health information to facilitate interrogation.
- Doctors must always provide treatment impartially. Treatment decisions must be made based on clinical criteria and must not be influenced by

clinically irrelevant factors such as nationality, ethnic origin, race or combat status.

- Health facilities and the privileges granted to health professionals must not be used for non-medical purposes.
- Doctors working in conflict zones retain the same duties of confidentiality.

## Medical impartiality

*You are working in a combat zone in a remote part of Afghanistan. Following a firefight, you are treating several seriously wounded insurgents. During their treatment, a small patrol of soldiers from your home country is hit by an IED. They are brought to your humanitarian field hospital and following brief triage, your medical colleague assesses that their injuries are not life-critical. Among the wounded is a friend of yours from earlier training. Their commanding officer is insistent that his soldiers are prioritised until they can be evacuated to a military hospital. What do you do?*

Doctors must practise medicine impartially, without regard for factors such as a patient's nationality, class, ethnicity, religion, gender or political belief. The only distinctions that matter are clinical: the patient's need and their ability to benefit from any intervention.

The duty to respect medical impartiality is set down in international humanitarian law, including the Geneva Conventions. This means:

- the wounded and sick must be provided with medical care and attention, to the extent possible, with the least possible delay, and without any adverse distinction, on any grounds other than medical ones
- neither the wounded and sick, nor healthcare personnel carrying out their exclusively humanitarian task, must be attacked, ill-treated or persecuted for providing care.

The impartial exercise of medicine can bring health professionals into conflict with authorities or armed groups whose priorities may be radically different. Health professionals working in disasters and conflicts may have to challenge authorities and explain their core moral obligations.

Although medical impartiality is well established, tragically it is often breached. This includes direct targeting of health professionals or health facilities or the use of force to prevent treatment of certain individuals or groups. It can also involve the use of medical personnel or transport for military purposes, or the improper use of medical emblems such as the red cross or red crescent. The threat of follow-up attacks on health professionals caring for the wounded can also hamper effective care.

In the scenario, despite pressures from a senior member of the military, as a doctor your primary obligation is to provide care based on need without unwarranted discrimination. The seriously injured enemy should be given priority over your colleagues with non-life-threatening injuries.

Doctors who are asked to act in ways that contradict their core professional obligation should politely but firmly decline, making it clear that unwarranted discrimination breaches both international humanitarian law and professional codes of ethics.

## Problem areas

### Politics and culture

*You are working for an NGO on the border between Pakistan and Afghanistan. There are tensions between your organisation and village elders, over concerns that the NGO is bringing Western values into the area and undermining traditional Islamic values. Local health needs are significant, and the facilities you work in are a vital part of the NGO's regional strategy.*

*You admit a young woman with stomach pains and vaginal bleeding. She is accompanied by her elder brother. On investigation you identify that she is in the first trimester of pregnancy and a termination is indicated on health grounds. She is competent to make decisions and, terrified, requests an abortion. She pleads with you not to tell her brother or ask for his agreement as she fears for her life.*

*Although you have the facilities to provide an abortion, you may not be able to go ahead without local staff members being aware, and there have been concerns about confidential information leaking out. If the local community learns about the abortion, your NGO would likely be asked to leave the area and may be the target of reprisals.*

### Cultural differences

Although health professionals are bound by the same ethical principles, such as the requirement to respect their patients, the way principles are expressed can differ between cultures. This can lead to confusion. Cultural differences should be approached with openness and sensitivity, although not uncritically. Harmful practices can develop anywhere, and health

professionals must keep in mind that patients' interests are central to medical practice.

By focusing on patients and listening to their views, wishes and expectations, it is normally possible to work through apparently conflicting values to identify how best to help them. For example, if your patient indicates that she expects the full participation of her family when deciding about medical treatment, facilitating their involvement respects rather than undermines her interests.

Cultures are dynamic and changeable, subject to internal disagreement and debate. Not every member of a culture shares the same views. For example, there have been concerns about how international health professionals should respond to harmful practices such as female genital mutilation. Rather than accepting the practice out of respect for culture, international organisations have worked with local groups and village elders opposed to it. We should not assume, because of a person's religion, nationality or ethnicity, that they hold certain beliefs or values. The focus should be on the individual, and harmful practices should be resisted.

Many Western health professionals expect that competent adults will make their own healthcare choices, supported with advice and information. Some countries place less emphasis on individual freedom of choice – there may be an expectation that families will participate in decision making, or decisions are deferred to the head of the family. Health itself can be viewed differently, with more emphasis given to spiritual or religious wellbeing.

Understanding and being sensitive to social stigma is essential: victims of sexual violence can, in many cultures, be ostracised – or worse – and may be reluctant to seek help or to disclose information.

In the scenario at the beginning of this section, a decision was made to prioritise the health interests of the patient. The NGO in question is strongly supportive of women's reproductive rights. Following careful discussion, the woman accepted that there may be some risks involved – and the NGO also recognised and accepted its own risks – and a termination went ahead.

### **The acceptability of imported healthcare**

Politics and culture can also influence the acceptability, and therefore the success, of healthcare from external agencies such as the military or international humanitarian organisations. This is sometimes called 'imported healthcare'.

It can have unintended consequences. During conflicts and emergencies, functioning local health systems can be under pressure. Local health professionals may be working with minimal resources in traumatic circumstances; they may be without pay and exposed to serious risks, with difficulty maintaining their own health and wellbeing. Well-financed healthcare delivered by foreign professionals on overseas wages can create tension. Where the local healthcare economy is run commercially, free imported services can threaten the financial wellbeing of local providers.

Imported healthcare can also lead to difficulties with local people who do not receive it. Some

interventions deal with specific illnesses or health problems. This can look like favouritism and create resentment and accusations of injustice and discrimination.

External agencies can also meet resistance from the state or other authorities. This can take several forms. In civil conflict the providers of imported healthcare, even where they are acting impartially, may be perceived by both sides to support opponents. In extreme circumstances, depriving people of basic public goods and services is a political weapon. Where states are oppressing certain groups, healthcare providers can meet political resistance. When healthcare comes from 'the West', memories of colonialism can undermine its acceptability.

Medical personnel working alongside the armed forces can face other challenges. They may be seen as agents of an occupying or hostile power. Healthcare can be viewed as propaganda – part of a 'hearts and minds' campaign – and treated with suspicion.

Where possible, advance consideration must be given to factors likely to influence the acceptability of imported health services, including:

- What are the unmet health needs, and are the resources to be imported adequate?
- What are the organisation's primary goals? This is important where, for example, the health services are provided by military forces. Although health professionals must be impartial, a link to occupying or combat forces may generate resistance from local populations.



- Have you established a relationship with relevant local authorities? How do they see imported healthcare?
- Have influencing factors been assessed on the ground? These include whether local authorities are able or willing to meet the health need; whether aspects of the organisation might affect the acceptability of services (for example, does it have a religious affiliation? How might this be perceived?); and what the authorities' political, social or military goals are during the crisis.
- Are there legal considerations?
- How are local health professionals likely to respond?
- Will imported healthcare work alongside local providers? Are there opportunities to work together productively?
- What will happen after the services are withdrawn, and how should this be managed? What ongoing obligations do healthcare providers owe to the populations they have served during a crisis?

### **Pressures on clinical standards**

*Because of severe targeting of health professionals and facilities, a decision has been made to withdraw temporarily from the country. You oversee a large, well-resourced hospital treating civilians, militia and some of your own injured colleagues. As part of the withdrawal, many of the wounded will be transferred to a local hospital. You have real concerns about the standards of care at the local hospital. It is likely that the most seriously ill will die if transferred. What do you do?*

Many ethical challenges in conflict zones involve pressure on clinical standards. Shortages of medical

resources, including skilled medical personnel, can have severe consequences. They may mean you are called upon to undertake interventions where you lack appropriate skills. There may be pressure to transfer patients to facilities you know to be substandard, to use non-standard interventions or to treat in circumstances of compromised hygiene. Resource shortages may also involve making non-treatment decisions for seriously ill people who might have been rescued in different circumstances.

Another frequent challenge is where your unit or hospital provides a limited range of services and your patient requires an intervention only available in a private facility, but neither your patient nor your organisation has the resources to pay for it.

Clinical standards have many dimensions. In modern medicine, it can be tempting to associate them with advanced technology and technical resources. Although military medical services may offer standards of care comparable with developed countries, for many working in conflict zones, this would be a luxury. But there is more to good patient care than technology; it also involves relationships of trust and respect. These aspects of care must not be neglected in conflict zones or emergencies – they may be more necessary where fewer technological interventions are available.

Effective medical treatment nevertheless requires a basic standard of care. It involves the skilled application of medical resources. In situations of conflict and extreme resource shortages, it can be difficult to identify whether an acceptable standard is met. Familiarise yourself with established clinical

standards before deployment – the ICRC and MSF provide a range of guidance materials for health professionals working in conflict settings.<sup>1</sup>

Guidelines cannot address all the problems you might face. In difficult circumstances, it can be helpful to refer to basic principles. Consider a woman in obstructed labour requiring an emergency caesarean section. Ordinarily, in well-resourced settings, she would be referred to an appropriate surgeon. Without skilled intervention, both she and the child will die. You have some surgical experience, though not for some time and not in obstetrics. Should you intervene?

There is no simple answer to this question. If you are not an obstetrician and may be called upon to manage obstructed labour, you should read relevant guidance beforehand. MSF has developed a detailed guide for non-specialised health professionals on obstetrics in remote settings.<sup>2</sup> It says the priorities should be: *to overcome the fundamental threat of pathology – that is, save the mother, protect her from any functional sequelae of the pregnancy, and deliver the child in the best possible condition.*

- 1 See, for example, MSF's clinical guidelines: [medicalguidelines.msf.org/viewport/MG/en/guidelines-16681097.html](http://medicalguidelines.msf.org/viewport/MG/en/guidelines-16681097.html) and the ICRC's resource centre: [www.icrc.org/en/resource-centre](http://www.icrc.org/en/resource-centre).
- 2 Médecins Sans Frontières (2007) *Obstetrics in remote settings: practical guidance for non-specialised health professionals*. Paris: MSF. [www.gmc-uk.org/guidance/ethical\\_guidance/21177.asp](http://www.gmc-uk.org/guidance/ethical_guidance/21177.asp).

In circumstances where you are uncertain if you have relevant skills, the question is whether you have a reasonable belief that the intervention is likely to deliver an overall benefit to the patient. Given the consequences of non-intervention may be catastrophic, what kinds of benefit can you bring? If you do not have a reasonable belief that you will bring overall benefit to the patient, you should not proceed. Health professionals can find non-intervention challenging – particularly if, in other circumstances, the patient could have been helped – but the ethical justification for intervening lies in the benefits you can bring to patients.

The scenario at the start of this section introduced additional complicating factors. The decision to leave the country was taken by head office. Consequently, the doctor has been asked to transfer patients, including some who are very seriously wounded, to facilities they know to be substandard. The more seriously ill patients are likely to die. Given that their primary professional obligation is to promote patients' welfare, there is a serious conflict between their professional ethics and institutional demand.

In these circumstances you need to identify the scope of your decision-making responsibility. What decisions can you make and how far does your influence extend? You also need to justify the decision. There is an important difference between deciding to transfer a seriously ill patient where it is not in his interest because other patients who are more seriously ill require assistance, and the decision to transfer a patient due to withdrawal.

If you are asked to make decisions that are likely to lead to significant avoidable harm to patients, you must take up the matter urgently with your management. Although practically speaking it can be very difficult, doctors must not acquiesce in unethical decisions. The impact of the decision on patients must be made clear to those in a relevant position of authority. You should keep contemporaneous records of your concerns and the steps you have taken to address them.

This issue will be discussed further in the section Tensions between professional ethics and institutional demands.

### **Consent, refusal, respect and dignity**

*You are working for a humanitarian organisation treating large numbers of civilian casualties in a surgical unit. On arrival, the casualties undergo an initial medical assessment and are given a consent form to sign before being seen by the duty doctor. The form is in English. Most patients clearly do not speak English and most surgical staff have only a basic knowledge of the local language. The unit is under huge pressure and there isn't time to ensure that every patient has access to either an interpreter or a doctor who speaks the local language. You are concerned about whether, ethically or legally, this amounts to consent.*

Doctors trained in Western medicine are familiar with the concept of consent – the legal and ethical obligation to seek informed and un-coerced agreement from patients prior to any medical intervention. In disasters and conflict settings, particularly where services may be overwhelmed,

consent can come under extreme pressure, and language and cultural differences can make communication difficult.

In the above scenario, consent will not be valid. Although a signed consent form may be evidence that some exchange has taken place, if a patient cannot understand the procedure, they cannot consent to it.

Where urgent treatment or examination is required, it may not be feasible to wait for an interpreter. In these circumstances, non-verbal communication can be used, alongside visual aids such as medical cards. It is important to be as sensitive as possible to non-verbal clues from patients, including any indication that they do not want an investigation or treatment.

Care must be taken when using interpreters, and where possible, patients should be asked in advance if they accept the proposed interpreter. It is ordinarily inappropriate to use other patients as interpreters as this can undermine confidentiality and may expose patients to security risks.

### **Refusing treatment**

*A local civilian woman has arrived at your medical facility with life-threatening injuries. She has capacity and is refusing treatment because she does not want to expose any part of her body in the presence of male health professionals. Can you proceed?*

Although it is difficult to stand aside when seriously ill patients can be saved, a competent refusal of treatment must be respected, even if it may result in death or serious harm. In situations like this, you

may be able to address the patient's concerns: if treatment by a female doctor is possible, it should be offered. Simple practical measures, such as introducing partitions in treatment areas, or using gowns or other coverings, may help. In the end, though, treatment must not be forced on a patient who is competent to refuse.

### **Dignity and respect**

As this scenario shows, there is far more to good healthcare than strictly clinical concerns. Dignity is not easy to define, but it is associated with a respect for human agency and self-determination that goes beyond meeting basic human needs. The obligation to seek consent is rooted in respect for the patient's freedom and choices, including wider aspects of personal identity often linked with religion or culture. Where resources are limited and people are in great need, it can be even more important to recognise these aspects.

### **Prioritisation and working with scarce resources**

Ordinarily, healthcare is imported due to a lack of local health resources. But imported healthcare is also likely to be restricted. A common challenge is prioritisation: given the scale of health needs, where should limited resources be focused?

Armed conflict can devastate health infrastructure. In addition to the pressure injured civilians and combatants can put on health services, conflict can disturb public health structures: water can be contaminated; epidemics of previously managed infectious diseases can erupt; food shortages, breakdowns in sanitation and the degradation

of transport and communication systems can all undermine health. It can be difficult to decide whether to prioritise clinical interventions or to use some resources securing basic conditions for health.<sup>3</sup>

Different organisations have different priorities – both long-term and for a specific mission or intervention. Some might be planned with only limited knowledge of the circumstances on the ground, and on arrival, other urgent priorities can develop.

Even in less extreme circumstances, the question of choice – how should we allocate limited resources? – presents challenges. In conflicts and emergencies, where reliable information can be scarce, and where decisions must be made urgently, the difficulties can be formidable. Given their importance, decisions need to be defensible: they have to be reasonable in the circumstances. This is particularly important if they might be challenged later. Below are a number of factors that should be taken into account.

### **Assessing health need**

Before allocating resources, an initial assessment of health needs should be made. In emergencies this may be difficult and an assessment is likely to be provisional at best, but without reasonable attempts, informed prioritisation decisions are impossible. Ongoing data gathering and communication with appropriate authorities are vital.

3 For an excellent discussion on the degradation of urban structures during protracted conflict, see [www.icrc.org/sites/default/files/topic/file\\_plus\\_list/4249\\_urban\\_services\\_during\\_protracted\\_armed\\_conflict.pdf](http://www.icrc.org/sites/default/files/topic/file_plus_list/4249_urban_services_during_protracted_armed_conflict.pdf).



Liaison with other service providers can help to put together a more informed picture of health needs, as well as avoiding replication and reducing the risk of inter-agency conflict.

### **Identifying priorities in advance**

Organisational priorities must be defined as clearly as possible in advance, with scope for flexibility to respond to unforeseen changes. Health is seldom distinct from other basic human needs – food, housing, clean water, security – and there can be pressure to extend the mission’s remit: what is sometimes called ‘mission creep’. Similarly, imported healthcare professionals working in interventions designed to tackle specific issues – also known as ‘vertical interventions’ – can feel moral pressure to respond to other urgent needs. This can lead to confusion and a rapid exhaustion of available resources.

### **When need is overwhelming**

Sometimes, in emergencies, the needs of individual patients may have to give way to maximise overall benefit to groups or to populations of patients. Decisions may need to favour reducing overall mortality and morbidity over the needs of the most ill. This can be challenging, even traumatic. Ordinary moral intuitions can be turned on their head; people who would otherwise have been saved may not be treated.

Careful thought needs to be given in advance to how best to support health professionals in these circumstances. It is vital to ensure that you are, as far as reasonably possible, prepared for them. Training in the practical and ethical aspects of triage (see below) is essential.

## **Triage**

Triage is a method for prioritising when more individuals have life-threatening conditions than can be treated with available resources. It involves categorising the sick or injured according to their needs or the probable outcomes of medical intervention, as well as identifying those who – even with the best efforts – are unlikely to survive, and should therefore receive only palliative care.

Any system of triage must be simple enough to be practical in emergency conditions, and flexible enough to respond to rapid changes in available resources. In disaster triage, priority will normally be given to those whose conditions are the most urgent, the least complex and who are likely to live the longest, thereby reducing overall morbidity and mortality.

## **Doing the best with very limited resources**

Resource shortages can be felt in many ways. In some circumstances, limited medical resources can mean you must limit yourself to basic interventions. The challenge is not judging the limits of clinical competence but accepting the frustrations of being unable to deliver care to the same standard as in better-resourced settings. Lack of follow-on support, less-than-sterile circumstances and a limited range of medicines can all present challenges. While you should ensure information about resource shortages is communicated to decision-makers, your primary obligation is to deliver the best care possible.

## **Witnessing abuses of fundamental rights and interests**

Health professionals working in emergency and conflict settings often encounter human rights abuses. You may witness abuses directly, or see their effects in the physical, mental or emotional trauma of your patients. You might witness involvement or complicity in abuse by fellow health professionals. In extreme cases, you may be under pressure to condone or even participate in breaches of fundamental rights.

We stress throughout this guidance that those working in emergency or conflict zones are subject to the same ethical principles as all other health professionals, while recognising that extreme circumstances can put those principles under pressure. It is self-evident that health professionals who are called upon to condone or participate in such abuses must not do so. Although in extreme circumstances moral disorientation can set in, there is never any justification for involvement in abuses of fundamental rights.

Health professionals have an important role in protecting vulnerable individuals. Violations of fundamental rights must not be ignored – failure to act can blur into complicity. We set out below several factors to consider if you identify abusive behaviour.

### **Protecting the vulnerable**

Where abuse is taking place, your primary concern should be the wellbeing of vulnerable people. If people are at risk of immediate harm and you can protect them, without exposing health professionals or patients to unreasonable risk, then you should.

This may involve taking direct action, or giving information to relevant authorities so they can act.

### **How reliable is the information about abuse?**

Evidence of abuse is not always clear-cut. In conflict settings and emergencies, information can be unreliable and claims contested. Before considering how to respond, you need to establish, as far as possible, the facts. Where information may be used later to bring perpetrators to justice, it must be as reliable and objective as possible. There are clear differences between eyewitness evidence, reported evidence, and deductions from the clinical presentation of injuries or the sequelae of psychological trauma.

Keep in mind, though, that recording and disclosing information about abuses during conflicts or emergencies can put both patients and health workers at risk of reprisal. While the desire to speak out about abuses is understandable, you must take great care to ensure individuals and organisations are not exposed to avoidable harm.

There is also a risk that disclosure can prejudice the mission's presence in-country, with potential consequences for the population you are seeking to assist.

### **Keeping records**

Keeping clear, factual and contemporaneous records of your concerns, including any action you take, is vitally important. Record keeping can help establish timelines, corroborate witnesses and support testimony – and ultimately, bring perpetrators to justice. It can also help you personally: memory can

be unreliable, particularly during times of crisis, and it can be helpful to have a clear account of events to fall back on. Given the sensitivity of this information, it is important to ensure its safety and security.

### **Data, privacy and confidentiality**

*You are working in a camp for displaced people near a conflict zone where serious and sustained violations of human rights and international humanitarian law have taken place. You have treated several women for the effects of violent sexual assault. During discussion, you learn that some of the perpetrators have infiltrated the camp, and the women know their identities. You ask them for permission to inform those who run the camp with a view to removing the men and seeking prosecution. The women do not want you to say anything as they fear for their lives. If you do nothing, there are likely to be further abuses in the camp.*

All health professionals owe a duty of confidentiality to patients, irrespective of their age, status or the nature of their illness or injury. This includes information acquired during conflicts or emergencies.

However, statistical information can have several uses. It can improve your mission's resource allocation and planning; assist research into health in emergency and conflict settings, supporting future responses; and provide invaluable insights for governments, aid agencies and others responding to the crisis. Information from patients can also help identify human rights abuses and their perpetrators, helping to bring them to justice. Health professionals are often among the first to reach victims of terror or oppression.

### **The importance of confidentiality**

During times of armed conflict, anxieties about confidentiality can become intense. Patients and those close to them may be anxious about their security and reluctant to disclose information that might identify them to aggressors. Health professionals may be perceived as agents of the state or aggressive powers, and be treated with suspicion.

Patients must be told that their health information is confidential: it will not be released to those who may be seeking to harm them. The Geneva Conventions protect the sick and wounded from denunciation to authorities who would harm them. Although duties of confidentiality are not absolute, as we discuss below, in all but the most exceptional circumstances health information should not be released where it will put individuals at risk.

When recording data in conflict settings, consideration must be given to security. Wherever possible, data should be encrypted, password-protected and kept remotely from regions of conflict.

### **Research, planning and audit**

Gathering health data during conflicts and emergencies can have longer-term benefits. It can provide an evidence base for the effectiveness of interventions, help planning and oversight, and improve our understanding of the effect of conflict on individuals and societies. Useful data can include the numbers of sick or injured, the nature and causes of their conditions, their age, gender and status, and the outcomes of health interventions. It can look at the public health effects of conflicts and emergencies, such as outbreaks of infectious diseases.

Although there is seldom a problem with recording and processing such statistical data, great care must be taken where individuals can be identified. If you are recording or using information from which individuals might be identified for purposes other than providing direct care, you must seek consent.

Although your primary duty is to provide care to the sick and injured, where possible you should consider how relevant health data can be recorded and disseminated.

### **Victims and perpetrators of abuse**

Difficulties can arise if you identify victims of abuse who do not want their data released, often because of fear of future reprisal – it can affect your ability to care for them and risk re-traumatisation. This can be particularly challenging where there is a reasonable likelihood that the information could help protect others who are at risk of harm, or assist in the prosecution of serious criminal activity.

Important as they are, duties of confidentiality are not absolute. In some circumstances, information can be disclosed without consent where it may be necessary to prevent serious harm to others, or to bring perpetrators of serious crimes to justice. Decisions about disclosing information in these contexts can be difficult, particularly in unstable situations. You might like to consider:

- Is the disclosure likely to put the patient at risk of serious harm?
- Is it necessary to protect others from serious risks or to prosecute serious crime?
- To whom will you disclose the information and with what anticipated effect?

- Have you discussed the possibility of disclosure with the patient, its goals and likely outcome, and done everything reasonable to secure consent?
- What is the likelihood that the disclosure of information will achieve the desired goal?
- What is the likely impact of the disclosure on patient and community trust?
- Have you discussed the issues, as appropriate, with colleagues?
- Is the disclosure of information proportionate to its goal?

### **Disclosure to news media**

When working in conflict and emergency settings, you may be asked to provide information to news and media outlets. Testimony by health professionals is regarded as objective and authoritative. You may also feel that speaking to the media can help improve the situation on the ground. However, it can put people at risk and lead to reprisals. Before disclosing information to the media, a risk assessment is vital. Information likely to put people at risk of serious harm should not be disclosed, and in all but the most exceptional circumstances, information should be anonymous.

### **Security, mass casualties and follow-up attacks**

Risks to safety and security are among the biggest challenges you are likely to face in conflicts and emergency settings. These can be naturally-occurring threats such as aftershocks, civil disorder or the instability of built or natural environments, which can make it difficult to gain safe access to the sick and injured. During conflict, it can be the deliberate targeting of health professionals and their facilities by combatants.



Health professionals can find it extremely difficult if they are prevented from helping the sick and injured. Following an attack, for example, where a significant number of casualties require life-saving treatment, speed is critical. It is essential, however, that you take all necessary precautions to ensure your safety. Sadly, health professionals can be valuable targets, and by responding rapidly to the injured you can expose yourself to follow-up attacks. Booby traps or secondary IEDs can be left to target emergency and rescue services. It is critical that you work closely with security services to identify and respond appropriately to risks.

Although working in conflicts and emergencies can take great courage, if you become injured or traumatised, you will be unable to work effectively. Health professionals who become injured or sick impose an additional burden on colleagues and health systems that are already likely to be under stress. The obligation to look after your own health and safety is therefore more than self-interest and common sense.

This includes taking appropriate steps to ensure your general wellbeing. Be alert to cumulative factors such as fatigue, stress or burnout – which can insidiously undermine your ability to perform to professional standards – and take reasonable efforts to identify and protect yourself from environmental hazards such as infectious diseases.

In many unstable emergency or conflict settings, it can be difficult to make informed judgments about risk. The situation might be evolving rapidly or information may be scanty. This calls for careful

judgment based on as much information as is available. To some extent, the degree to which you are willing to expose yourself to risk is a matter of conscience. But you must bear in mind that jeopardising your own wellbeing would put at risk those you could otherwise help.

### **Tensions between professional ethics and institutional demands**

*You are working for a humanitarian agency in southern Asia. There are serious ethnic tensions in the state where you are working, and a minority ethnic group is subject to brutal abuse from the government. In your view, you are witnessing a programme of ethnic cleansing that verges on genocide. You speak with senior colleagues and ask that the organisation speaks out. Current policy is to remain silent to maintain access to the vulnerable minority whose health needs are extreme. The message comes back from headquarters that they are not going to change this: maintaining access is too important.*

In addition to responsibilities to patients, few health professionals are entirely free of competing obligations or constraints. Those working in publicly-funded health services usually have some responsibility for cost that can limit the care they provide. Mostly, these constraints lie in the background. For others, such as those working in the military, competing obligations can be pronounced.

Health professionals working in these circumstances are said to have dual loyalties: there can be significant tension between the obligations to third parties and obligations to patients. At times, these tensions can be difficult to manage. Failure to manage them

properly, or an excessive or misplaced loyalty to employing institutions, underpin many violations of medical human rights.

Although you may not face such pronounced divisions if you work for a humanitarian agency, there are occasions when the goals of the organisation may put pressure on your obligations to patients. This can include the requirement to limit care to single interventions in accordance with institutional goals and priorities, even where patients have multiple pathologies.

The political goals of some humanitarian agencies, such as maintaining a country presence to advocate on behalf of marginalised groups, can conflict with other legitimate, health-based claims on limited resources. Humanitarian agencies can also face the dilemma about whether to speak out about abuses and thereby risk being forced to leave the country, or continue to provide care at the cost of remaining silent. If they leave, they can be accused of abandoning those to whom they owe a moral duty of care. If they remain, they can be accused of complicity with abusive regimes.

### **Forensic health professionals**

Forensic health professionals have a key role in the detection and prevention of human rights abuses, and sometimes work in conflict zones. They can experience significant dual loyalties. Many of the examinations they perform will have both therapeutic and forensic purposes: they work as part of criminal justice or law enforcement systems, but also have a duty of care to the patients they see.

As discussed in the sections on criminal justice and data, this can put pressure on ethical principles such as the duty of confidentiality and the requirement to seek consent to disclose information. Both victims and perpetrators of crimes may need medical examination and care, and yet may be extremely anxious about their information falling into the wrong hands. Before examination, or before any information is volunteered, forensic health professionals should make it clear that part of their role is to collect evidence for prosecution and that confidentiality cannot be guaranteed.<sup>4</sup>

It is essential that forensic health professionals remain scrupulously impartial. Their obligations to the criminal justice system mean that they must avoid the temptation either to adapt reports to protect or promote the interests of those they are examining, or to comply with the aims of their employers.

### **Health professionals and humanitarian agencies**

Although dual loyalties are seldom pronounced, problems can arise when working for humanitarian agencies. Some agencies are influential and well-funded, and have considerable power. They may have competing organisational priorities, and are often sensitive to reputational risk.

4 For further information about forensic medicine in a human rights context, see: [physiciansforhumanrights.org/justice-forensic-science](https://physiciansforhumanrights.org/justice-forensic-science).

A common tension arises between providing aid and advocating on behalf of the vulnerable. A degree of co-operation with governments may be necessary to secure access to those in need of assistance, but it can be difficult to identify the point at which this becomes support for, or complicity with, abusive regimes. (For further discussion on complicity, see the following section.)

A high-level decision to abandon a mission due to fears about complicity can be distressing for health professionals on the ground, who may have developed close professional links with individuals and communities. There are no easy solutions to these problems, and responses must consider organisational priorities, ethical commitments and political realities. Crucially, however, decisions must be supported by good reasons and be defensible in the circumstances.

### **Coercion and complicity**

*You are working in a temporary camp for displaced people in a state that is engaged in civil war. The camp is effectively run by local militia, and they have been rounding up migrants and extorting money from them, often with the use of extreme violence. Although you can provide care, you become increasingly concerned that you are simply facilitating further violence and coercion. Some of your colleagues are considering leaving because they feel they are complicit in the abuse.*

Coercion and complicity are complex but distinct concepts. Coercion involves the use of pressure or force on individuals and organisations working in disaster or conflict settings to prevent them

acting appropriately. It can be subtle or explicit, and the point at which co-operation and reasonable accommodation blur into morally unacceptable complicity is seldom obvious. Complicity can range from participation in or support for unethical practices, to appearing to lend credibility to abusive regimes.

Given that humanitarian agencies often work in areas of social and political instability, it is likely they will need to accommodate state demands to some degree. In order to deliver aid, for example, it might be necessary to work alongside military personnel or agree to security restrictions.

Working in unstable settings can also expose them to corruption. It can be extremely frustrating to see vital medical supplies and equipment diverted from their intended recipients. How far agencies should go in tolerating corruption, as a price for delivering aid, is a fraught question. Where medical supplies are diverted to military uses, they can help sustain conflicts. This can deepen humanitarian crises and call into question the agency's impartiality. Given the vulnerability and complexity of supply lines it can be very difficult to achieve operational goals without accepting some attrition.

Many humanitarian agencies have an explicit commitment to protecting and promoting human rights. As we have discussed, regimes can act coercively by threatening to expel humanitarian agencies that speak out about abuses or actively support those subjected to abuse or discrimination. Agencies that remain silent about abuses to continue providing aid are sometimes accused of complicity.

On the other hand, they may also be criticised if they speak out and are forced to leave.

None of these dilemmas is easily solved and they remain subject to debate. Responses will always depend on individual circumstances. Humanitarian agencies can ease the problem to some extent by, for example, working with independent human rights agencies so that information about abuses can be reported. However, learning to live with morally complex situations is an important part of humanitarian work.

In some cases, health professionals are put under personal pressure to become involved in abusive practices. They may be pressurised, for example, to provide pain relief for amputation under Sharia law, or provide sterile equipment for re-infibulating a woman following labour. Although the use of pain relief and sterile equipment might help individuals, health professionals should nevertheless avoid becoming involved in practices for which there is no clear clinical or moral justification.

### **When do you abandon a mission?**

Health professionals in conflicts and emergencies will be accustomed to working with uncertainty and instability, doing their best with limited resources, accepting risk and recognising constraints. However, it can be extremely difficult to consider abandoning a mission altogether. Where people are suffering, the desire to continue can be strong and abandoning a mission can feel like failure.

The justification of any emergency or humanitarian intervention rests in the good that it can deliver.

Where this good cannot realistically be achieved, or the likely costs or risks exceed the benefits, its justification may fall away.

The safety of health professionals and others involved in the delivery of healthcare are fundamental to success. As discussed earlier, health professionals and health facilities can become targets during conflicts. Working in the aftermath of natural disasters can also put you at risk where there is civil unrest, for example, or where the security or public health infrastructure has been destroyed.

Difficult as such decisions are, there may be times when it is simply too risky to continue with a mission and it may be necessary to withdraw, at least until the security situation has stabilised. In addition to your own wellbeing, bear in mind that becoming sick or injured would put a further burden on health services that may already be under extreme stress.

There are other reasons why you may have to withdraw. As mentioned, regimes can impose conditions on humanitarian agencies for granting access to the sick and injured. Agencies may be told, for example, that if they speak out about abuse they will be removed from the country. Where the nature of the abuse is severe, such as ethnic cleansing or genocide, it may be necessary to speak out even if the mission must then be abandoned.



## Conclusion

Those who work in conflicts and emergencies are motivated by the highest humanitarian principles. They bring health benefits to the sick and injured in some of the most challenging circumstances imaginable. These conflicts and emergencies can present more than just clinical challenges: at times, they involve both moral uncertainty and intractable ethical dilemmas.

This guidance is designed to help you identify and work constructively with the ethical problems you may face. Guidance of this kind can never be exhaustive. It focuses instead on several areas where ethical tensions are known to arise. It aims to prepare you in advance for the difficulties you may encounter, and to provide key principles and pointers to guide you in the field.

Two themes underpin this guidance. The first is medical impartiality: treatment should be provided based on clinical need. Non-clinical factors such as religion, ethnicity or political or national affiliation are irrelevant. Allied to this is the requirement on non-medical authorities to refrain from interfering with those providing medical care.

The second theme is the obligation to do the best out of available resources. Healthcare in conflicts and emergencies is very much the art of the possible. You may not be able to deliver care to the standards you would expect in more conventional settings, but you must do the best you can for patients with what you have. This can make the difference between life and death.

## Further advice

The website of the International Committee of the Red Cross has a wealth of material in this area. Of particular importance is its work on healthcare in danger: [healthcareindanger.org/resource-centre](https://healthcareindanger.org/resource-centre).

Médecins Sans Frontières has decades of experience providing medical humanitarian aid during conflict and disasters. [www.msf.org.uk](https://www.msf.org.uk)

The Sphere Handbook is an internationally recognised set of common principles and universal minimum standards in life-saving areas of humanitarian response. [www.sphereproject.org](https://www.sphereproject.org)

The World Medical Association has issued many guidelines on medical ethics in conflict and crises. WMA policies and declarations can be found here: [www.wma.net/policy](https://www.wma.net/policy).

## Appendix A:

### General guidelines

Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients. In all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.

The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

- give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's healthcare;
- weaken the physical or mental strength of a human being without therapeutic justification;
- employ scientific knowledge to imperil health or destroy life;
- employ personal health information to facilitate interrogation;
- condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment.

During times of armed conflict and other situations of violence, standard ethical norms apply, not only with regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty,

especially civilian and military prisoners and the population of occupied countries.

The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the necessary care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other similar criterion.

Governments, armed forces and others in positions of power should comply with the Geneva Conventions to ensure that physicians and other healthcare professionals can provide care to everyone in need in situations of armed conflict and other situations of violence. This obligation includes a requirement to protect healthcare personnel and facilities.

Whatever the context, medical confidentiality must be preserved by the physician. However, in armed conflict or other situations of violence – as well as in peacetime – there may be circumstances in which a patient poses a significant risk to other people, and physicians will need to weigh their obligation to the patient against their obligation to other individuals threatened.

Privileges and facilities afforded to physicians and other healthcare professionals in times of armed conflict and other situations of violence must never be used other than for healthcare purposes. Physicians have a clear duty to care for the sick and injured, and should recognise the special vulnerability of some groups, including women and children. Provision of such care should not be impeded or

regarded as any kind of offence. Physicians must never be prosecuted or punished for complying with any of their ethical obligations.

Physicians have a duty to press governments and other authorities to provide the infrastructure that is a prerequisite to health, including potable water, adequate food and shelter.

Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the protection of the public health infrastructure and for any necessary repair in the immediate post-conflict period.

In emergencies, physicians are required to render immediate attention to the best of their ability. Whether civilian or combatant, the sick and wounded must receive promptly the care they need. No distinction shall be made between patients except those based upon clinical need.

Physicians must be granted access to patients, medical facilities and equipment and the protection needed to carry out their professional activities freely. Such access must include patients in detention centres and prisons. Necessary assistance, including unimpeded passage and complete professional independence, must be granted.

In fulfilling their duties and where they have the legal right, physicians and other healthcare professionals shall be identified and protected by internationally recognised symbols such as the Red Cross, Red Crescent or Red Crystal.

Hospitals and healthcare facilities situated in areas where there is either armed conflict or other situations of violence must be respected by all combatants and media personnel. Healthcare given to the sick and wounded, civilians or combatants, cannot be used for publicity or propaganda. The privacy of the sick, wounded and dead must always be respected. This includes visits from important political figures for media purposes and when political figures are among the wounded and sick.

Physicians must be aware that during armed conflict or other situations of violence, healthcare becomes increasingly susceptible to unscrupulous practice and the distribution of poor quality or counterfeit materials and medicines, and attempt to take action on such practices.

The WMA supports the collection and dissemination of data related to assaults on physicians, other healthcare personnel and medical facilities, by an international body. Such data are important to understand the nature of such attacks and to set up mechanisms to prevent them. Assaults against medical personnel must be investigated and those responsible must be brought to justice.

## **Code of conduct: duties of physicians working in armed conflict and other situations of violence**

Physicians must in all circumstances:

- neither commit nor assist violations of international law (international humanitarian law or human rights law);
- not abandon the wounded and sick;
- not take part in any act of hostility;
- remind authorities of their obligation to search for the wounded and sick and to ensure access to healthcare without unfair discrimination;
- advocate and provide effective and impartial care to the wounded and sick (without reference to any ground of unfair discrimination, including whether they are the ‘enemy’);
- recognise that security of individuals, patients and institutions is a constraint to ethical behaviour and not take undue risk in the discharge of their duties;
- respect the individual wounded or sick person, their will, confidence and their dignity;
- not take advantage of the situation and the vulnerability of the wounded and sick for personal financial gain;
- not undertake any kind of experimentation on the wounded and sick without their real and valid consent and never where they are deprived of liberty;
- give special consideration to the greater vulnerability of women and children in armed conflict and other situations of violence and to their specific healthcare needs;

- respect the right of a family to know the fate and whereabouts of a missing family member, whether or not that person is dead or receiving care;
- provide healthcare for anyone taken prisoner;
- advocate for regular visits to prisons and prisoners by physicians, if such a mechanism is not already in place;
- denounce and act, where possible, to put an end to any unscrupulous practices or distribution of poor quality or counterfeit materials and medicines;
- encourage authorities to recognise their obligations under international humanitarian law and other pertinent bodies of international law, with respect to protecting healthcare personnel and infrastructure in armed conflict and other situations of violence;
- be aware of the legal obligations to report to authorities the outbreak of any notifiable disease or trauma;
- do anything within their power to prevent reprisals against the wounded and sick or healthcare itself;
- recognise that there are other situations where healthcare might be compromised but in which there are dilemmas.

Physicians should, to the degree possible:

- refuse to obey an illegal or unethical order;
- give careful consideration to any dual loyalties that they may be bound by and discuss these dual loyalties with colleagues and anyone in authority;
- as an exception to professional confidentiality, and in line with WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment and the Istanbul Protocol, denounce acts of torture or cruel,



inhuman or degrading treatment of which they are aware, where possible with the subject's consent, but in certain circumstances where the victim is unable to express themselves freely, without explicit consent;

- listen to and respect the opinions of colleagues;
- reflect on and try to improve the standards of care appropriate to the situation;
- report unethical behaviour of a colleague to the appropriate superior;
- keep adequate healthcare records;
- support sustainability of civilian healthcare disrupted by the context;
- report to a commander or to other appropriate authorities if healthcare needs are not met;
- give consideration to how healthcare personnel might shorten or mitigate the effects of the violence in question, for example by reacting to violations of international humanitarian law or human rights law.





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