

Ethical Dilemmas for Physicians in Time of War

Malke Borow JD

Division of Law and Policy, Israel Medical Association, Ramat Gan, Israel

KEY WORDS: physicians, war, ethical dilemmas, dual loyalty, torture

IMAJ 2010; 12: 172–173

Although the World Medical Association in its *Regulations in Times of Armed Conflict* [1] states that "medical ethics in times of armed conflict is identical to medical ethics in times of peace," as a rule, medical ethics and war are more akin to oil and water. This is not to say that medical ethics cannot and should not be upheld during times of conflict, but simply that the existence of conflict throws all our previously held notions regarding medical ethics into disarray. The very existence of certain wars and all forms of terrorism and their accompanying effects vitiate the context of an ethical society.

As one researcher points out, "medical ethics in peacetime is not identical to medical ethics during war for two reasons. First, the hallmark principles that drive bioethical decision making in ordinary clinical settings are largely absent...second, the principles of contemporary just war may simply override bioethical concerns" [2].

Dr. Fred Rosner in his article appearing in this month's issue [9] notes this dichotomy when he states that "During times of war, physicians are sometimes faced with the conflict of their professional duties to ensure the ethical principles of beneficence, non-maleficence, patient autonomy and self-determination, within the framework of the proper ethical conduct in the practice of medicine and the obligation and duties

placed upon the physician by the state in times of war." It is the recognition of this conflict that is so notably absent from the recent Goldstone Report, which instead portrays the recent war in Gaza as one dimensional in its complexity, or lack thereof.

In wartime, military physicians must juggle the interests of the patient with the interests of the state [3]. In the case of a country's soldiers, the interest of the state is to heal the patient as quickly as possible in order to put him back in harm's way, whereas the best interest of the patient might be to stay off the battlefield [4]. Patient autonomy is not discounted but is sometimes overridden by other considerations [3]. In the case of a country's enemies, the physician's obligation is, once again, to his individual patient and yet, here as well, collective considerations may override individual ones. For instance, a patient posing a security risk might need to be secured, although the basic ground rule is that prisoners and detainees should be treated without being restrained unless there is a real danger of escape or if the individual or the medical team is in danger [5].

The conflict of interest physicians often face in times of war is commonly referred to as "dual loyalty." As defined by the International Dual Loyalty Working Group (a non-governmental body comprised of ethicists, physicians and lawyers), dual loyalty is "a clinical role conflict between professional duties to a patient and obligations, expressed or implied, real or perceived, to the interests of a third party such as an employer, insurer or the state" [6]. The fact that the definition includes perceived obligations makes it clear that at times it is the doc-

tor, not the state, who actually imposes these obligations on himself. This is because as much as medicine strives to be apolitical, and in practice all patients are or should be treated equally, physicians do not operate in a vacuum and are themselves products of the societies in which they live.

Even the Dual Loyalty Working Group recognizes that the physician's obligation to his or her individual patient, although primary, is not inviolable. Thus, there are situations where elevating state interests over individual interests might be justified. We see this in the civilian context; for instance, in cases of court testimony, health professionals' breach of confidentiality in order to protect third parties from harm, or notification to public health authorities for health surveillance purposes [4]. However, the Dual Loyalty Working Group, although recognizing the legitimacy of certain exceptions, states that "in all circumstances where departure from undivided loyalty takes place, what is critical to the moral acceptability of such departures is the fairness and transparency of the balancing of conflicting interests and the way in which such balancing is or is not consistent with human rights" [6].

Similarly, Edmund Pellegrino, chair of the U.S. President's Council on Bioethics, asserts that medical ethics are the same for civilian and military physicians, "except in the most extreme contingencies." In other words, the same code of medical ethics applies to all physicians; however, there might potentially be "extreme contingencies" that would justify temporary suspension of this ethical code [7].

Of course, the necessary question in such a situation is who decides what

constitutes such a contingency. To allow the military commander to decide is an abrogation of medical ethical duty since such commander's primary responsibility is to protect his/her forces and defeat the enemy, rather than uphold medical ethics. On the other hand, the doctor might make a decision while unaware of security concerns or military necessity. The best option in such a case would seem to be to allow a senior medical official to make such decisions, or, if this is not possible, having such decisions be made jointly by both medical and military personnel, with the medical opinion having greater weight.

In point of fact, a prominent jurist and ethicist stated that the phrase "dual loyalty" is an oversimplified expression that cannot truly capture the conflict faced by military physicians [7]. In his view, basic human rights violations such as torture or experimentation without consent can never be justified; other, more subtle conflicts such as the best interest of a specific patient vs. best interest of the military (for instance, in certifying soldiers as fit to be redeployed to the scene of conflict) must be approached with extreme caution and even apprehension.

There are certain behaviors that are considered "beyond the pale" for doctors to be involved in whether in wartime or peacetime, among them torture. As an editorial in a leading medical journal stated, "Everyone must understand – doctors don't "do" torture" [8]. For this purpose, doctors need to be able to recognize torture and report it

when necessary. The Istanbul Protocol is one such effort to achieve this goal, providing international guidelines for the documentation of torture, for investigating cases of alleged torture, and for reporting such findings. Even here, however, the line can be murky. As has been previously stated, no one would think of sanctioning a doctor who actively participated in torture. But what if treating – and then reporting – a patient who has been tortured might place the patient in greater danger. Clearly, national medical associations have a major role in supporting and defending doctors who abide by the guidelines of the Istanbul Protocol and other international declarations on this matter, but the regime in which the doctor practices is, *de facto*, unquestionably relevant. In some, reporting ethical violations might result in death. In others, mechanisms are set up to assist doctors faced with morally questionable situations [10].

Walking the line between "medical professional" and "military official" is not an easy one and, yet, perhaps it is specifically physicians, fortified with a strict ethical foundation, who are best able to navigate the two worlds. Being a physician does not, unfortunately, provide immunity from ethical violations; the Nuremberg trials and the London bombings were evidence of that. But the threshold is higher. What remains crucial is that one's role as physician be perhaps balanced with – but certainly not subsumed by – one's obligation to the state. As George Annas, a widely published national expert in the field of

health law, bioethics and human rights said: one must be a physician "first, last and always" [7].

Correspondence:

Adv. M. Borow

Director, Division of Law and Policy, Israel Medical Association, P.O. Box 3566, Ramat Gan 52136, Israel

Phone: (972-3) 610-0444

email: malkeb@ima.org.il

References

1. The World Medical Association Regulations in Times of Armed Conflict. Adopted 1956, revised 1957, 1983, 2004 and 2006.
2. <http://www.wma.net/en/30publications/10policies/a20/index.html>
3. Gross ML. Bioethics and Armed Conflict. Cambridge, MA: MIT Press, 2006.
4. Gross ML. Medical ethics during war. *Lahey Clin Med Ethics* 2008; 15(1): 1-3 http://www.lahey.org/Pdf/Ethics/Ethics_Winter_2008.pdf (accessed 3 Sept 2009)
5. Blachar Y, Borow M. Health professionals and dual loyalty: a World Medical Association and Israeli Medical Association perspective. In: Goodman R, Roseman MJ, eds. *Forced Feedings and the Role of Health Professionals*. Cambridge, MA: Signature Book Printing, 2009: 173-85.
6. Israeli Medical Association Ethics Committee Position Paper on Restraining Prisoners and Detainees in Hospitals. Tel Aviv, 1997.
7. Physicians for Human Rights and University of Cape Town. *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (Physicians for Human Rights and University of Cape Town Health Sciences Faculty, 2002). Available at
8. <http://physiciansforhumanrights.org/library/documents/reports/report-2002-duelloyalty.pdf>
9. Annas GJ. Military medical ethics – physician first, last, always. *N Engl J Med* 2008; 359: 1087-90.
10. Hall P. Doctors and the war on terrorism. *BMJ* 2004; 329: 66.
11. Rosner F. Ethical dilemmas for physicians in time of war. *IMAJ Isr Med Assoc J* 2010; 12: 133-5.
12. Shoenfeld Y, Shemer J, Keren G, Blachar Y, Eidelman LA, Borow M. British medical journals play politics. *IMAJ Isr Med Assoc J* 2009; 11: 325-7.

“When dealing with passions one must beware of treating them passionately. A historian who chooses to become the enthusiastic spokesman of one side to a conflict inevitably risks a blurring of vision and a subversion of his credibility”

Benjamin Kedar (born 1938), Czeck-born Israeli historian

“The scientific mind does not so much provide the right answers as ask the right questions”

Claude Lévi-Strauss (1908-2009), French anthropologist whose analysis of kinship and myth gave rise to structuralism as an intellectual force. Called the "father of modern anthropology," he is particularly well known for his rejection of history and humanism, his refusal to see western civilization as privileged and unique, his emphasis on form over content, and his insistence that the savage mind is equal to the civilized mind.