'Do no harm' vs. 'legitimate use of force'

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Should a military doctor obey an order to not treat an enemy combatant? Or certify a sick soldier as fit to fight? Should a nurse take part in interrogations? Ride along on medical caravans to build trust with locals? Violate patient privacy for military ends? These and other questions are being studied by Canadian researchers with the Ethics in Military Medicine Research Group, led by University of Montreal bioethicist Bryn Williams-Jones with colleagues at McGill and McMaster universities.

Their latest paper, published in December in the winter issue of the *Journal of Law, Medicine & Ethics*, compares the ethics codes of the Canadian Medical Association and the Department of National Defence and the Canadian Armed Forces. At issue: the ongoing debate over the "dual loyalty" of military healthcare professionals' and whether the two codes - civilian and military - are "necessarily incompatible."

"To put it bluntly, how can the military profession, whose mission of defending state interests can involve the use of deadly force, be compatible with the medical profession whose primary mission is to heal and save lives?" asks lead author Christiane Rochon. Her conclusion, with co-author Williams-Jones, her PhD thesis supervisor: The two codes are not mutually exclusive. In fact, they support each other, with the military one turning out to be even more comprehensive than the medical profession's.

The researchers studied the issue for three years, interviewing over 50 Canadian military health professionals - physicians, nurses,

physiotherapists, medical technicians, almost all of them high-ranking officers. "We wanted to understand the perspectives of health professionals working in a range of very challenging environments, from combat missions to humanitarian and peacekeeping missions," Williams-Jones told UdeM Nouvelles.

"They have a lot of tools to help them think through the ethical challenges they face, but those tools are not specifically adapted to their role as health professionals. As non-combatants they face different sorts of challenges." For instance, what is a military physician to do if asked by a commanding officer not to provide care to an enemy combatant? The easy answer: Obey medical ethics codes and international humanitarian law and treat the enemy; health care is a human right.

But some military medical personnel do feel they have a conflicting loyalty to their patient and their employer, and that feeling can be very complex, said Williams-Jones, director of the bioethics program at UdeM's School of Public Health. "It's not just whether they're healer or humanitarian or soldier; it's all of that mixed up."

In combat, a non-professional like a medic is first and foremost a soldier, someone who carries a weapon while dispensing care in the thick of the action. A physician typically operates further back: at a forward-operating base or the main base hospital. As such, the physician may be frustrated in not being able to provide the same level of care as he or she could back home, or by not being able to offer adequate follow-up, or by not being able to treat civilians," the study's authors found.

In combat zones like Afghanistan and Mali, on humanitarian missions in places like Haiti and the Philippines, and on peacekeeping missions in Rwanda or Kosovo, the challenges are accentuated with each new case, telescoped in a short period of time "This isn't M*A*S*H," said Williams-Jones. "Physicians and other personnel are not there for years

at a time; they're going in for maybe six weeks or six months, into a very tense environment and making resource-allocation decisions, deciding who gets care and who doesn't: our soldiers versus friendly soldiers versus enemy combatants versus civilians, children. These are real tensions."

In the military, health professionals are much more aware of their social mission as purveyors of public health than they are normally as civilians treating individual patients, Williams-Jones added. "The physicians come from a very wealthy environment, most working in public hospitals as clinicians who are one-on-one with a patient. But in combat or on a humanitarian mission, they're much more in public-health mode."

The Canadian military has had an ethics code since 1997; it was last updated in 2013. The CMA's dates back much further, with major revisions after the Second World War and in the 1970s and '90s; the latest was in 2004. Unusually for a modern military, the Canadian Forces Code of Values and Ethics says it's more important to respect human dignity (the first principle of the code) than it is to follow orders (its third principle). The Canadian Medical Association Code of Ethics, by contrast, "is more duty-oriented," the study says. The CMA code "is more focused on the physician's relationship with the patient and the medical community, so it is in general more individualistic than the [Canadian military's], which recognizes from the start the social role of the military and its responsibility towards society," Rochon and Williams-Jones argue.

But isn't the military's principle of "legitimate use of force" incompatible with the physician's principle of "do no harm"? No, the authors say. "This is a false dichotomy that does not reflect the military and medical realities of today," they write. "The principle of 'do no harm' in medicine is increasingly recognized as being intimately related to other principles such as beneficence and autonomy (i.e., in debates about euthanasia and

assisted suicide). "In the same way, the use of force (and so doing harm to others) by soldiers is heavily circumscribed and controlled by international laws [...] For example, recent international peacekeeping missions have been heavily criticized for not allowing soldiers to intervene when witnessing rape, murder, and even genocide (e.g., in Rwanda). "[...] These kinds of situation have shown that the appropriate use of force needs to be evaluated in relation to other principles (e.g., preventing harm to civilians, justice) and so is not by definition negative or wrong."

Those perceptions are also a generational thing. In their interviews with the researchers, younger health professionals most often didn't identify any significant ethical challenges they faced, whereas those with 15 or 20 years experience said they had many. One thing they did agree on: They need more "downtime" to discuss ethics as a team and hash out solutions. To that end, the researchers hope to get new funding to develop practical working tools - case studies, situation-specific and targeted ethics training, special versions of ethics guides annotated for military medical personnel, such as the one the British Medical Association published in 2012 called Ethical Decision-Making for Doctors in the Armed Forces.

The goal, concluded Williams-Jones, is simple: To make sure "that people have the ethics skills to handle situations on the ground. Ultimately, that's the most important thing."

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