

Toolkit for Doctors Working in Situations of Violence

A contribution of the
World Medical Association
to the
Health Care in Danger
Initiative of the
International Committee
of the Red Cross

HEALTH CARE IN DANGER **IT'S A MATTER OF LIFE & DEATH**



THE WORLD MEDICAL ASSOCIATION, INC.

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PROPOSAL FOR A TOOLKIT FOR DOCTORS WORKING IN
SITUATIONS OF VIOLENCE**

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This toolkit for doctors working in situations of conflicts and other emergencies has been developed for the WMA by the British Medical Association within the framework of the project Health Care in Danger (ICRC).

Introduction

The World Medical Association believes that medical ethics is identical in times of armed conflict to those in times of peace. In stating this the WMA recognizes that the tensions within the ethical decision making that doctors, nurses and other health workers experience will differ as they are strongly affected by the clinical, social and environmental situation, including the presence of armed conflict.

Some examples of relevant ethical codes are made at the end of this document under further reading. This includes a set of Ethical Principles recently agreed between the WMA, ICN, FIP and ICMM.

All health care workers share responsibility for protecting the ethical rights of every patient, including where they are working on public health issues, the rights of the community at large, and as health workers they must balance their duties to their patients, the public, their colleagues and to themselves. In doing so they are guided by ethical standards set out in codes and in explanatory documents by national and international bodies, such as the World Medical Association and the International Council of Nurses as well as other health care professional groups such as midwives and pharmacists. These standards take note of national and international laws but are held by many health care professionals, including the World Medical Association to have a higher status especially over domestic laws. While the WMA and ICN have no disciplinary power, their guidance is regarded as binding on doctors and nurses by courts and tribunals around the world.

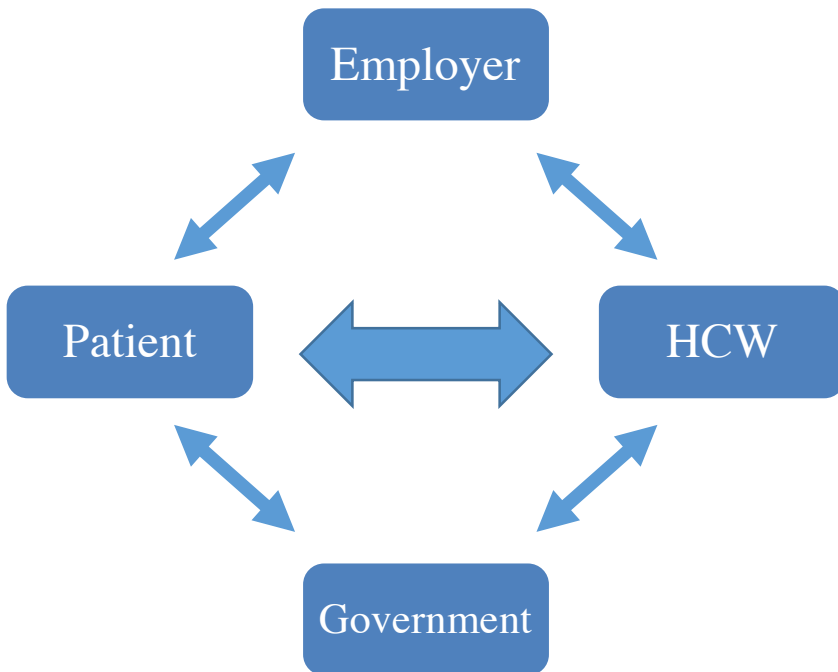
Ethical standards do not tell doctors, nurses and others what to do. Rather, they provide a framework for recognizing the ethical conflict and for examining it, in a manner that recognizes the duty the health care worker owes to the patient and to society. This framework guides the decision making process, and should help to provide consistency.

Some countries have codes of medical ethics, which may be legally binding on health care workers. But even these cannot be specific and complete for every clinical situation. Doctors and nurses are expected to be able to adapt those codes to the specific circumstances in which they and their patients find themselves. This booklet carries out the same function for those working in situations of armed conflict.

It is recognized that during armed conflict, circumstances will arise that individuals have not experienced before. This guidance is designed to help health workers become comfortable with examining clinical situations for areas of ethical challenge, and to applying frameworks of ethics decision making to those challenges. It is hoped that it will be read before those challenges are real. The guidance has been written around a series of clinical cases, to demonstrate where the conflicts and challenges arise. None of these cases is based upon a single specific case, all are based upon real cases experienced in many different countries and situations.

Throughout this document, the term health care workers is used to describe the people involved in making decisions, with the patient, about the care of individuals and communities. In some cases the teams of health care workers will be led by a doctor, in others by a nurse and in some by another worker including an administrator, or public health specialist.

The ICRC has published a research paper (*include reference*) explaining the pressures that individuals caring for patients face. While the major relationship is between health worker and patient there are also links to the employer and to the system – including national and local government.



Surrounding this complex are all the external pressures, including local, national and international law and regulation, which will impact and affect all the factors inside the ellipse.

Further reading on ethical codes or general ethical frameworks is available from a number of sources, including the WMA. A list of such sources appears at the end of this guidance.

Cases

1. An 18-year old woman is admitted with abdominal pain and vaginal bleeding. You are working in a place where the culture puts a very high value on virginity and her life may be at risk if she is known to have been sexually active, even where this has been due to rape. You are also aware that during the current conflict, sexual violence including rape has been used as a “weapon” or tactic of war.

The overwhelming duty of all health care workers is to seek to help the patient. In this case the clinical care needs to be offered in such a way that it does not undermine the duty of confidentiality. While confidentiality of patient data is not absolute, it is very important. In most countries the duty to keep information confidential applies to the individual; that is each person as an individual has the right to expect that information about them will not be shared with others. In some countries cultural norms allow the sharing of information with family members or local leaders, such as village elders. Failure to share with them would be a very serious breach of ethical and cultural norms, but health workers have a duty to consider whether such sharing could have an impact on the health expectancy of the patient, and if it would, should not share

regardless of the cultural norms. Where there are risks to the future health of individuals such sharing should not take place. Health care workers have a duty to understand the local cultural norms, especially where these will impinge on medical decision-making.

In this case the health care worker should also be prepared to help the patient understand what has happened, and to collect evidence for a potential prosecution if the patient wishes to proceed down this route, but do so in a way which continues to protect the confidentiality of the individual. It is often frustrating for health care workers when patients who have been victims of violence, including interpersonal violence and sexual violence, do not wish to report the matter to the police or other authorities. Health care workers might also feel that reporting of this case might prevent future cases. The role of the health care professional is to help the patient as a person, to recognize her fears and to protect her from further harm. Gathering evidence for use at a later date may be the best possible assistance.

In considering this case, the health worker must communicate with the patient and ensure she is aware that information will remain confidential. In some circumstances patients might not come forward for care, fearing that attending a clinic will be visible within the community and precipitate questions from family members and others. Those organising health facilities should consider the need for attendance to be confidential in the same way that the content of the consultation is, and make suitable arrangements. In these circumstances, arrangements that make reaching the health centre easy for those without independent access to transport can also be essential.

Frequently the patient presenting in this way is under the age of consent, and family members may be very insistent on knowing what has happened. The same guidance applies – it is for the patient to decide who knows what. Even patients who are not competent to consent to treatment have a right to medical confidentiality.

Where clusters of such patients are appearing there is a clear duty to inform the authorities so that they can act, and to do so in a way that does not identify individual patients. At the same time, and to encourage patients to present for help, clinic arrangements should be made in such a way that it will not be obvious to others who is presenting and for what type of care.

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2. The motorcade of the local political leader comes under attack as he is arriving to visit colleagues being treated at your hospital, and the leader is admitted with gunshot injuries. You have witnessed the attack. The media are present in the emergency clinic. You also admit bystanders injured in the same attack including women and children and injured soldiers.

Decisions about who to treat first are based upon an assessment of the need of the individual patients, not on their relative positions in society. In mass casualty events a system of triage is used, to identify those needing immediate care and those who can wait, or who need simple first aid.

The principle behind triage is of equity or justice, that is that treatment decisions including priorities will be based upon need and no other non-medical factors. While in some situations

triage may include a decision not to treat someone who will not survive whatever treatment is offered, and instead to prioritise those likely to survive, this is rarely done. It is legitimate to refrain from offering heroic medical interventions to those who, when assessed, are unlikely to survive whatever is done but they must be offered treatments to deal with pain and suffering. Attempts to perform curative treatments would be classified by some as futile in such cases; while others would argue with the word "futile" the key factor is that the patient would be exposed to interventions that were intrusive and possibly painful for no hope or expectation of benefit. No patient should be abandoned and the emphasis should be on receiving suffering, usually pain.

All health care workers face, from time to time, pressures to treat one person before another, with such pressures often coming from family members or others intimately involved with the injured or sick person. Such pressures must be resisted, not only because it leads to inequity in treatment decisions but because the basis of general acceptance of priority setting by health care workers is that this is always done on the basis of need and no other measure of merit. Although individuals may protest and express distress when their loved one is not rated first, there is a generalised acceptance, provided they see that no one jumps ahead of the queue on anything other than medical necessity.

In this case the fact that one of the injured is a local leader does not give him more priority than should be given to the others injured including the women and children.

Events that lead to mass casualties often bring with the media interest. If someone prominent is hurt that interest may be even more intense. The media will seek to obtain information about the injured including details of their injuries.

Every patient has a right to confidentiality, regardless of the public interest in them. Patients should never be exposed to the media unless they have given consent to being interviewed, filmed or otherwise identified. While families are often pleased to see media interest as it gives them an opportunity to express their outrage to a wide audience, this should not occur within the health care setting if it exposes patients to a loss of their right to privacy.

Occasionally after mass casualty incidents prominent persons will visit the institution - including politicians - often bringing media with them. Again, the rights of patients must not be ignored, and they should be able to refuse such a visit or to refuse being filmed or recorded during such a visit. Families and others close to patients should also be made aware of the right of the patient to privacy.

In most countries, the law supports medical confidentiality and recognises that the patient must decide who is told about their medical condition. This right means that families will only be told the essentials when a patient cannot consent (or refuse) to sharing information. Similarly the family will only be told full information about a competent patient with his/her agreement. Families may find this difficult to accept and expect to be kept completely aware. It is essential that health care workers explain the concept of confidentiality and encourage patients to share information with their close family.

The media frequently ignore concepts of confidentiality and assume that the broader public has a right to know everything that has occurred; TV filming in hospital emergency rooms is

commonplace. Every institution should have someone nominated and trained to deal with the media, keeping them out of patient treatment areas unless privacy can be maintained. While those working at the institution may wish to bring local conditions to international attention, as a means of seeking some help or a resolution, they cannot do so without full regard to the right of every individual to confidentiality.

3. The local militia makes an armed entry into the clinic to search for rebel soldiers and their supporters. They state they are prepared to use force against you and the clinic staff if you do not let them search for, and remove, any enemy combatants.

Hospitals, dispensaries and clinics should be exempt from intrusion by local or national militia, police or other agents of the state and of non-state actors. Such incursions at the very least might disrupt the functioning of the institution and the delivery care to those in medical need of such care. Sadly it is becoming increasingly common for such incursions to put the life and safety of staff and patients alike at risk. This is a major theme of the ICRC project Health Care in Danger.

There are circumstances in which it is legitimate for armed entries to occur. The key points here are that these circumstances are limited and should take place in a manner that limits the adverse impact on the delivery of care to patients.

There are times when such incursions are a sign of significantly higher than usual tensions; prevention, or clarity about the circumstances in which they are acceptable are better achieved in negotiation beforehand.

It is essential that those responsible for managing the health care facility attempt to link with people who are likely to have the type of power and responsibility that make them key decision makers in terms of such incursions. The nature of the discussions should be about how to handle security concerns about activities within the health care institution and, where possible, how to reduce the likelihood of incursions.

Those working in Health Care Institutions should understand that recognition of the institutions neutrality and immunity from becoming part of any armed conflict actions, under IHL, require that the Institution itself, and its staff, maintain proper neutrality. While neutrality is legally different from coping with security issues, those working in the institution should understand that it might appear to show the institution as being part of the security problem, and make discussions aimed at avoiding security crises more difficult.

While it might appear attractive to enhance the security of patients and staff by providing security services within the institution, including armed guards or systems to limit access, these seriously may distort attitudes to and confidence in the institution and may also significantly obstruct access by those in need of health care.

Doctors, nurses and other health staff are as likely as any other member of society to hold political views. It is essential that these are not expressed to the broad public from the platform of the institution as this threatens its neutrality.

Advance discussions with local political and military leaders should be based around understandings of neutrality coupled with the requirement of health care professionals, and thus the institutions in which they work, to treat all those in need of care regardless of their political views, race, religion, gender or other potential areas of discrimination.

Where those in positions of power seek to stop medical or other health care help from being delivered to those from opposition groups, they must be made aware that this damages the neutrality of the institution and could eventually affect the ability to offer care in difficult situations to their supporters.

There is global concern about the lack of understanding of this aspect of medical neutrality and more examples of threats to its recognition are welcome as part of the on-going campaign to increase understanding and compliance at national and local levels.

Patients have a right to expect that the place in which they are offered treatment will be as safe as possible. This does not mean that the institution must arm or fortify itself, but that it will seek in the first instance to ensure that its neutral position will be understood and recognised by key power brokers in the locality. Arming and fortification should not be the first preference in terms of protection, although they may be the last resort.

Patients must also be able to expect that health care staff will not put them at risk, either by willfully breaching neutrality or by readily complying with demands from outside agencies for access to patients, or even just to patient names.

If there is an armed incursion into the institution, staff have rights, as do patients, that their safety will be considered by those running the institution. Again this requires the institutions leaders to make local connections in advance of a crisis to reduce the likelihood of such risks arising. If the institution is unable to obtain reasonable security undertakings they should consider withdrawing from the area, to protect their staff that have a legitimate expectation of working in a place that is reasonably safe.

It is understood that during periods of armed conflict, political and military unrest and other emergencies, the safety of different places may change quite quickly. Institutions should ensure that they are able to respond, and again early discussions with emerging leaders are essential.

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4. A civilian is brought in from a riot. He has sustained a head injury, probably from blunt force trauma sustained during the riot. He is wearing the colours of the supporters of the uprising. You have no training in neurosurgery, but the nearest neurosurgeon cannot reach you because of the on going riots. Do things change if the patient is 13 years old?

It is a clear principle of health care ethics that health care workers should not exceed their levels of competence. It follows from this that when managing a patient with a head injury only a clinician trained in neurosurgery should operate. Medical regulators often express this as not overstepping the boundaries linked to your training and expertise; in all ethical guidance

physicians are required to explain to patients, within the process of gaining consent for any intervention, their own level of expertise and experience linked to the likely outcome for this patient. In normal civilian practice the lack of experience and expertise by one clinician rarely causes a problem as well established systems exist for referral on to a relevant specialist.

Non-intervention by the non-expert is a counsel of excellence. In some real clinical circumstances this would leave patients with no recourse to necessary treatment. In every clinical circumstance health care workers, and especially doctors are those with the highest level of training and the broadest ability to make diagnoses, and indeed assessing the impact of choosing not to treat because of the absence of a suitably qualified expert.

The ethical requirement is to assess the impact of either not treating, or of waiting for access to an expert from elsewhere (which might mean transferring the patient). Against this, the doctor should weigh the alternative of a treatment attempt by the non-expert. There may well be circumstances where such an intervention is the least- worst option for the patient. It should also be clear that the intervention should be limited to what is essential, and planned in such a manner as to limit the potential for iatrogenic damage or risk.

Consent to treatment is a requirement for each and every treatment offered to every patient. There are circumstances where a patient is unable to consent because of their medical condition; this is likely to be the case after a serious head injury requiring emergency surgical intervention. While most legislations do not recognise consent given by those other than the patient, it is good practice for health care workers to discuss options and their intentions with those close to the patient, where that is possible. In some legislatures there may be alternative systems for gaining agreement to a clinical procedure on an incompetent patient - they should be followed. Where there is no such procedure or where the use of it is impossible (and not just inconvenient) it is ethically appropriate for life-preserving treatment to be offered provided there is no competent advance refusal of such treatment.

Consent describes the concept within which individuals make decisions about the treatment they will receive. That decision is based upon the information they are provided by health care workers including doctors and nurses, and will be influenced by their own understanding of that information, including on the risks and benefits of different treatment options.

It is a fundamental ethical principle that individuals are autonomous, that is they determine for themselves what should happen to them, and that nothing can be done to them without their understanding and agreement. It follows from this that individuals have the right, and must be given the opportunity to make such decisions, and that these decisions will be respected even where the decision made is not one that would be made by others in the same clinical circumstances. This is sometimes explained as recognising and respecting the right of individuals to make decisions, including bad decisions, about their future health care.

It also follows that for individuals to make such decisions there is a strong requirement on health care workers to communicate effectively with the patient. Unless there is good quality communication it is unlikely that the patient will have the best information, which is needed to make an informed (and therefore legally valid) decision.

There are many blocks to good communication between patient and health care worker. In situations of armed conflict, this will include time, and often language. Give the importance of consent to all and any treatment, systems to deal with communication between health worker and patient should be established including managing language differences, by employing translators and producing basic information in local languages. This should include all forms which patients might be expected to sign. Ideally simply written leaflets in local languages that enable patients to read about the decisions they are being asked to make should be available, especially in relation to the most commonly performed procedures.

In most legislations the ability to make decisions on medical treatment is linked to the age of majority or legal competence as well as to other elements of competence to make decisions. One alternative is described in law in England to allow young people below the age of legal majority to make decisions provided they understand the concepts they need to understand to make that decision. The health care professional assesses the competence of the young person, informally "testing" their understanding of relevant issues such as risk before considering their belief on what treatment should be offered. The age of the patient then becomes relevant only in that adults are, in most legislations, regarded as a default position to be competent to make decisions for themselves, but that young people not yet legally adults, have to be tested for competence.

In the case described above, such a discussion would give the opportunity to express concerns over the lack of access to a fully trained and expert neurosurgeon, and to obtain the views of the patient or others making decisions on behalf of the patient. At the very least it offers an opportunity to explore the relative risks of non-treatment and of treatment by a non-expert.

It is likely that in some cases decisions will have to be made without any discussion with those considering matters from the point of view of the patient. It is strongly advised that the clinician should if possible discuss his/her intent to treat with other clinician colleagues to ensure that his/her decision is one that would be supported by others. This will also give an opportunity to share concerns with other clinicians, and to take into account their views about what treatment should be offered, and where the treatment limits should lie.

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5. A man arrives at your ICRC clinic for war wounded. He has been in a motor bike accident just down the street and is a local police officer.

Many health care institutions will treat all or any patient presenting to them. There are, however, some that are set up with a specific remit. When institutions are established by charities or other non- state and often non- national groups, they may have to register a very specific remit and group of patients, who are all they are entitled or allowed to treat. Breaching that duty would potentially open them to criminal charges and threaten their ability to continue to provide care to their specific group of patients.

Against this is the ethical requirement on health care professionals to that all those needing treatment without favouritism. In this case doing so might risk the ability of the ICRC to continue to treat other patients.

If the patient will suffer untreatable harm, or where there is a risk of death than the limits that would otherwise apply cannot be followed; again there is a key issue of institution managers ensuring that local leaders and other major stakeholders are aware that these are exceptional cases and do not reflect a widening of the remit of the institution.

Where it becomes clear to those managing the institution that they are the only facility capable of offering care to a group of patients, and that their current remit prohibits them from making that offering then they must enter into discussion about how either they can extend their role or that they can encourage and support the provision of an alternative facility.

6. You are admitting many patients with severe diarrheal disease, and suspect an outbreak of Cholera. Most of the patients have just crossed the border to where your clinic is, from a place in the middle of a conflict. Many refugees are gathering on that border and want to cross into the safer areas near your clinic, and then to move deeper into the country to stay with relatives and friends, but the local government is asking for your advice in terms of the outbreak. There are few local facilities, and you know that the refugee camps have no secure water supply or sewerage systems. Does it make a difference if those wanting to move are IDPs¹? Does it make any difference if the epidemic is transmissible?

Many of the facilities provided by humanitarian organisations and other non-state agencies and providers in failing States or in states undergoing armed conflict are likely to have good or excellent abilities to collect and analyse data. This may well mean that they are the first with the ability to spot an emerging trend such as an emerging epidemic. They must have a process in place for handling the information, including liaison with local public health authorities and possibly also with WHO or other global or intergovernmental agencies.

In the situation set out in the case study there are a number of complicating factors including the place on a national border and the possible infectious/contagious nature of the outbreak. It should also be remembered that such outbreaks can cause more loss of life than the conflict itself.

Epidemics of all sorts need immediate and comprehensive plans for management, including establishing who will be informed. It is clearly part of the expertise of those establishing management plans to consider the nature of the epidemic, and particularly the elements that will decrease transmission. Airborne, water borne and other forms of transmissible disease need different management processes.

One element of managing the epidemic is ensuring that the institution does not itself become the major vector for increasing the number of people affected; that is that there is no avoidable transmission within the institution. It is fully understood that in many epidemics health care staff might be infected when they treat patients. While institutions have a responsibility to staff to provide as safe as possible a working environment, it is always been accepted that there can be

¹ Internally Displaced Persons

some risks in treating patients. Institutions should do all they can, including providing personal protective equipment, vaccinations and immunisations and reasonable opportunities for treatment if any is available.

In the case cited, it is essential that the institution (which may well mean you as the physician) should ensure that local civil and political leaders are involved in planning as one large element of stopping the epidemic is providing safe potable water, and good sewerage facilities as matters of urgency. There is also a clear need for leadership in providing a clinical response to help those already affected as well as a public health need to ensure planning for epidemic containment is adequate and appropriate.

The civil or political status of those affected makes no difference to you as a clinician, and one element of your role may be to persuade local authorities that political interference with their movement into a treatment facility will have serious and immediate consequences clinically and to epidemic control.

The nature of the epidemic has a significant impact on the public health planning. Managing an outbreak of, say, influenza has different requirements from managing, say, Ebola Viral Disease. Planning must be based upon an understanding of the nature of transmissibility as well as other factors. Interfering with the liberty of individuals, including their ability to leave the area, or even the health care facility, can only be ethical if it is proportionate and necessary within the epidemic response.

The Nuffield Council of Bioethics published what they call a ladder of intervention. This sets out that the more a step would limit individual freedoms the more it must be demonstrable that it is an essential step to dealing with a public health problem, that there is evidence that it will work and that it is proportionate to the harm done by not intervening.

There is an ethical duty on local authorities to ensure that the public they serve are protected from avoidable harm – so they also have a requirement to put systems in place that will reduce the likelihood of epidemics. But a culture of blame does not help resolve the problem when an epidemic occurs. If as a physician you see no epidemic but conditions deteriorating to those that are likely to hasten an epidemic, then you have a duty to bring the attention of authorities to the problem. Using medical evidence can help to persuade authorities; dealing with the consequences of an epidemic usually costs more than basic steps to prevent it from occurring,

Refugees and IDPs have little political power and with some other groups in society may have little traction in seeking help or support from governments, nationally and locally. The role of doctors is to advocate that all people have the same basic rights, and that public health requires protection of everyone regardless of whether they have political power or not. Those who are not citizens are also the responsibility of the state within whose borders they find themselves, at the very least for safe environmental conditions in which to live while decisions about their right to stay are being made.

Finally

Throughout this guidance it should have been clear that many of the cases are most easily dealt with when a relationship of trust has been established with the local community including the political and social leaders. This allows tensions to be defused and may reduce the risk of issues such as hospital searches for “the enemy” far less likely.

It is the duty of health care workers to ensure that such dialogues have been opened up, and to be part of the dialogue process if they can add anything constructive to it. It is also clearly the duty of the employers of those HCWs is to ensure that they are suitably protected, and such dialogues are a practical means of achieving this.

These dialogues also give an opportunity to consider other important issues, many of which will have a major ethical component. These will include the responsibility that the health care institution has to the local health care infrastructure – not to undermine it, to remove its trained staff, or to override local cultural norms. At the same time imported health care workers should not be expected to ignore matters where local cultural norms conflict significantly with ethical norms – such as assisting with Sharia’a punishments, or with practices such as Female Genital Cutting. In these circumstances the Institution must be clear that it will not take part in these practices, and in the latter case it may choose to try to remove the potential for harm by working with local activists seeking to end this practice.

Further reading

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