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FROM THE EDITOR

Bioethics in Conflict Zones

Thalia Arawi, PhD and Ghassan S. Abu-Sittah, MBChB

Wars defined as a temporal event with a start and a finish are a thing of the past. Instead, they have become chapters in prolonged and protracted conflicts that ebb and flow yet trap the hostage populations for decades, consuming the lives of generations and shaping their health needs and the provision of health care. What started as the Soviet invasion of Afghanistan in 1979 is now a mere chapter in a conflict that has lasted for over 4 decades. The Iran-Iraq War of the 1980s was followed by the First Gulf War, sanctions against Iran and Iraq in the 1990s, the second Gulf War, and a litany of different levels of ongoing violence. Even in Central America, the civil wars of the 1980s and 1990s were followed by gang wars in El Salvador and Guatemala that claim lives and similarly lead to forced migration.

Health professionals working in these conflict zones—as clinicians, humanitarian actors, or policymakers—are faced with making ethically challenging decisions as they negotiate with different political actors and navigate competing yet equally pressing health needs. "Chronic emergencies" in places like the Gaza Strip or Yemen are no longer a contradiction in terms but a fair description of recurring wars that force health professionals to continuously divert limited resources from long-term capacity building to meeting immediate needs created by the latest military onslaught—to the long-term detriment of any health system infrastructure.

In this issue of the *AMA Journal of Ethics*, ethics and health policy experts and clinicians working in protracted conflict zones share their experiences of battling to offer health care in ethical, humanitarian ways.

Thalia Arawi, PhD is the founding director of the Salim El-Hoss Bioethics and Professionalism Program at the American University of Beirut Faculty of Medicine and Medical Center in Lebanon. Her research includes clinical ethics, biomedical ethics, philosophy of medicine, humanitarian medicine, ethics in conflict zones, mental health ethics, and medical education.

Ghassan S. Abu-Sittah, MBChB heads the Division of Plastic and Reconstructive Surgery at the American University of Beirut Medical Center in Lebanon and founded the Conflict Medicine Program of the Global Health Institute at the American University of Beirut.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Relief Organizations Fund Care of Patient-Asylees Who Have Cancer?

Farrah J. Mateen, MD, PhD and Paul B. Spiegel, MD, MPH

Abstract

Several clinical and ethical dilemmas arise when caring for refugees with complex, costly, and chronic conditions in low- and middle-income countries where they often first seek asylum. This commentary responds to a case involving a patient asylee with a malignant brain tumor and considers these questions: (1) Should refugee care costs be allocated as a specific amount per refugee or designated to fund only specific interventions? (2) Should interventions not available to host population members with low incomes be available to refugees? (3) Should refugee cancer care focus on cure, rehabilitation, and palliation or on just one or two of these areas? This commentary responds to these questions by considering how to approach trade-offs between numbers of patients treated and per patient expenditures.

Case

MQ is a 63-year-old man of Syrian origin who fled the town of Daraa and sought asylum in Beirut, Lebanon, in 2015. That year, he registered for and received official refugee status with the government of Lebanon and the United Nations High Commissioner for Refugees (UNHCR) in Lebanon. MQ was unable to find work in Beirut, but he still had money in his possession from his life in Syria.

In early 2016, MQ experienced his first tonic-clonic seizure, in which he fell to the floor, his body stiffening and jerking. No factors were recognized as provoking this seizure. MQ previously smoked cigarettes (30 pack-years), but he had no history of prior malignancy. He had no symptoms of weight loss, fevers, or night sweats. At first, he did not seek medical advice for his seizure. In fact, he had not visited a clinic since he sought asylum in Lebanon. But when MQ experienced a second seizure several weeks later, family members took him to a hospital in Beirut.

MQ's blood test results were normal. Computed tomography (CT) imaging of his head, however, demonstrated a single 5 x 7 x 2 cm space-occupying lesion within the right frontal lobe of his brain, extending into the corpus callosum. The mass lesion had hemorrhagic components (blood) and surrounding edema (swelling). To further investigate and treat MQ's mass lesion, physicians recommended that he be admitted

to the hospital for urgent steroid treatment; CT imaging of his chest, abdomen, and pelvis; and magnetic resonance imaging (MRI) of his brain. The UNHCR, through its partners, paid the hospital for MQ's CT imaging but could not cover the costs of his brain MRI. Realizing he urgently needed the MRI, MQ paid with some of his own and borrowed money.

MQ's images suggested his disease was limited to his brain. MQ's care team recommended biopsy and excision of the mass lesion with adjuvant chemotherapy. The surgery alone cost the equivalent of about 6500 US dollars. Aware of MQ's (and most patients') inability to pay or even borrow such an amount, his care team helped him request funds from the Exceptional Care Committee (ECC) of the UNHCR in Lebanon.

The ECC is a group of physicians and others convened by the UNHCR to adjudicate payment amounts for medical cases that exceed a prespecified amount of money and that a refugee cannot pay. ECC reviewers agreed to pay 90% of the cost of MQ's surgery, which occurred 2 months after his first seizure. In Lebanon, the UNHCR's ECC does not pay for chemotherapy, as it is deemed too expensive. MQ saw no other option than to forego chemotherapy, given that he was already indebted to family and friends and barely able to finance his 10% of the surgery cost.

MQ's tumor was partially resected during his surgery. He recovered and was discharged from the hospital. Nine months later, MQ had another generalized seizure, and his family members brought him back to the hospital, where tumor extension was noted on imaging. Dr T attends MQ, who was visibly distressed, crying while he explained what he has been through and despairing about his illness, symptoms, and poverty. Dr T evaluated him and expects that, without adjuvant chemotherapy, MQ will probably die within the year. Dr T and members of MQ's care team wonder how to respond.

Commentary

MQ's situation as a refugee in a country of middle-income status (based on World Bank designation[1]) illustrates several dilemmas in the care of refugee patients with complex, chronic, costly, and life-threatening disorders. There were an estimated 26.4 million refugees and 4.1 million asylum seekers worldwide by the end of 2020, according to the UNHCR.[2] Most refugees, asylum seekers, and internally displaced persons are in countries that are designated by the World Bank as low or middle income.[3] The traditional framework of refugee health care has recently expanded from infectious diseases among camp-based refugees in low-income countries to include noncommunicable diseases in both low- and middle-income countries like Syria and Jordan, respectively, with the latter receiving a high proportion of older refugees, including people with multiple chronic disease risk factors.[4,5,6]

Cancer, as in the above case, can be costly to diagnose and manage and has a range of therapeutic options. Some treatments are inexpensive and easy to offer, but newer treatments tend to be expensive, less available, and less feasible to offer, despite having several advantages (eg, reduced drug toxicity, improved tolerability, life extension).[7,8] Personalized approaches based on targeted drug therapies, for example, are often possible in high-income settings[7] but extremely difficult to offer in refugee care settings due to higher costs and the need for a full range of sophisticated tests and experts. As in the case, in higher income care settings, tumor types (eg, genetic mutations) inform therapy decisions that can include a range of new or experimental interventions unavailable in lower income settings. Since intervention timing matters to

patients' outcomes, factors that inform care of refugees with cancer must be explicit and transparent. We suggest using a justice and equity lens to consider 3 fundamental questions about cases like this one: (1) Should refugee care costs be allocated as a specific amount per refugee or designated to fund only specific interventions? (2) Should interventions not available to host population members with low incomes be available to refugees? (3) Should refugee cancer care focus on cure, rehabilitation, and palliation or on just one or two of these areas?

Three Approaches to Covering Costs of Care

Costs of caring for refugees and other forcibly displaced persons are largely determined by context. Whose treatment is paid for, in what amounts, and by whom differ by asylum location.[9,10] Some governments and organizations working with refugees approach asylee care by specifying a maximum coverage amount per patient. Covering refugee cancer care costs up to a specified level (eg, dollar amount or health status) leaves some patients partially or fully treated and others untreated. If the goal is to treat as many people as possible at lowest possible cost, medications with serious side effects (eg, toxicity, secondary morbidity) might make financial sense but pose risk to individual patients. A second approach might be to partially or fully pay for therapies intended to cure patients' cancer. However, prioritizing cure (eg, access to a full course of intervention) in smaller numbers of patients leaves other patients with rehabilitation or palliative needs with less, if any, financial support. Costs not covered by a host population or government must be covered by underresourced patients, families, or communities.[11] A third approach, from a justice standpoint, prioritizes improving the health status of those in most need: rather than specifying a maximum amount per refugee or fully funding curative interventions, the goal is to offer minimum financial support for care of all patient asylees in need, where the definition of an acceptable minimum varies according to patient asylees' needs and the capabilities of the host population or governing body. In what follows, we consider merits and drawbacks of implementing the third approach.

Balancing Care of Refugees and Members of Host Populations

Concerns about equity[12] also require us to consider access to these same potentially lifesaving interventions in the host country population (ie, the nationals living in the country where the refugees are residing). Host country populations can be just as poor and underresourced as some refugee populations. In some circumstances, refugees may have more opportunities for funding through international agencies and donors, resulting in their better access to medical care than the poorer segments of the host population. This inequity creates moral dilemmas for clinicians and policymakers, since the number of patients who need advanced and state-of-the-art medical care—in both host and refugee populations—can exceed available resources and funds. Furthermore, a differential level of medical care favoring the refugees over the host country population might lead to resentment and anger in the latter. Since cancer care can be costly, treating people differently, based on their status or country of origin, can have significant implications for who can access health care.

Goals of Treatment, Prevention, Rehabilitation, and Palliation

Chronic care. Services for refugee health care are mostly reactive, as more money is spent on treatment than prevention or palliation.[9,10,13] For instance, access to smoking cessation programs, nutrition and exercise programs, and screening, in addition to access to primary health care, are cornerstones of cancer prevention in well-functioning health systems. In MQ's case, access to these services was not optimized. Similar

arguments could be made for expanding refugees' access to blood pressure management, diabetes screening, and mammograms to prevent disorders or to diagnose them early. Given the aging of refugee populations, especially in the Middle East, and the protracted nature of the conflicts in that region, disorders of older adults will continue to pressure health systems. Whether funding to focus on chronic disease and geriatric care is as readily available as funding for pediatric care and infectious disease, which are often prioritized, seems uncertain.

The roles of nongovernmental organizations (NGOs) are vital in chronic, noncommunicable disease prevention, as NGOs have flexibility, international networks, and expertise in humanitarian care. Delivery of health-focused messages, education on screening, and wellness approaches are necessary for refugees as well as host country populations.[14] Moreover, cancer prevention and rehabilitation programs are needed in many locations. Patient and family support programs for refugees and host country members with cancer would also be valuable.

Palliative care. Palliative care—encompassing the management of pain and suffering—has traditionally not been part of the UNCHR and NGOs' funding schemes for refugee health care, nor does it often exist in many of the low- and middle-income countries that host the majority of refugees. However, the traditional refugee health care agenda is dynamic and requires constant reevaluation over time. Palliative care can be effective and improve the quality of life for people with cancer near the end of life,[15] in addition to being low cost and providing aspects of care that promote the dignity of persons with cancer. For instance, pain management, patient comfort, decision-making support, addressing compounded trauma, and establishing goals of care are all integral to this approach.[16] Training for palliative care in refugee settings is, however, almost absent in lower income settings but could be integrated with other types of training in both host and refugee populations.

Conclusion

Cancer care for refugees will continue to be challenging, as the pace of science leads to many options for care for those with resources. Thus, refugees and host populations in low- and middle-income countries with limited resources have fewer specialized care options. Although we do not answer each of the questions we posed about coverage of care costs in refugee and host populations, we emphasize key resource allocation decisions. In so doing, we present the gravity of choices that refugees, their families, clinicians, host governments, NGOs, and international agencies face as they attempt to meet the needs of patients like MQ.

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Farrah J. Mateen, MD, PhD is an associate professor at Harvard Medical School in Boston, where she is affiliated with Massachusetts General Hospital. A neurologist with a PhD in international health epidemiology, she focuses on vulnerable populations, including forcibly displaced persons, in her work.

Paul B. Spiegel, MD, MPH is the director of the Johns Hopkins Center for Humanitarian Health and a professor in the Department of International Health at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland.

Editor's Note

The case to which this commentary is a response was developed by the editorial staff.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Children Be Enrolled in Clinical Research in Conflict Zones?

Dónal O'Mathúna, PhD and Nawaraj Upadhaya, PhD

Abstract

This commentary examines 4 ethical issues in a case of clinicians considering conducting research on children in conflict zones: (1) whether any time or resources should be taken away from treating acute injuries in order to conduct research; (2) obtaining consent for children to participate in research, which is particularly challenging given that children can be separated from parents or guardians; (3) whether the research is feasible at the moment, since starting research that stands little chance of being completed is ethically questionable; and (4) maintaining neutrality, impartiality, and humanity. Research that puts participants and researchers at risk of additional harm must be considered carefully. Here, we propose that both research and clinical care might occur simultaneously when researchers engage humbly with involved communities as the research is being designed, conducted, and reported in order to understand and resolve ethical issues involved.

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Case

Dr P is a physician and researcher from an East African country that has been immersed in violence and civil conflict for years. He and his colleagues work in the region with an international nonprofit organization that both provides health care services and aims to strengthen the evidence available to guide practitioners during humanitarian crises. Dr P and colleagues care for many adults and children injured by violence and are concerned about availability of interventions for diseases endemic to the region. Many children hospitalized for war injuries also have infectious diseases, such as HIV/AIDS, malaria, and tuberculosis. Dr P and colleagues consider researching these diseases' prevalence among children in the region and whether and to what extent current policies address their needs. Some enthusiastically support these research ideas, but others question whether clinical research during conflict would be the best use of clinicians' time and skills.

Dr P and colleagues form a team to collectively consider practical and ethical issues they could face when conducting research. One plan that emerges during their meetings

includes enrolling children arriving at the hospital and sampling their blood, monitoring children who test positive for an infectious disease, and evaluating how well current policies support clinicians' capacity to offer evidence-based interventions and psychosocial care. Since children often arrive at the hospital accompanied not by their parents but by other relatives or adults, parental informed consent might not be possible. Although consent from an adult relative accompanying a child is standard for medical interventions in the region, some team members wonder whether a child's assent to participate in research or an adult relative's consent to enroll a child in research would be ethically sufficient. Assuming consent can somehow be appropriately secured, some team members worry that it's not ethical to even attempt research that might not even be feasible because participants' blood samples can deteriorate and expire while being transported to the capital city for analysis. Long transportation delays are not easily averted in the region due to security incidents, roadblocks, and ambushes. Even assuming good blood sample preservation and analysis, test results (normally available 14 days after collection) will need to be conveyed to children's parents by research team members who travel to their villages. If the children's parents have been killed and no guardian is present, it's unclear whether keeping newly orphaned children in a research protocol is ethically appropriate.

Dr P and colleagues remain neutral about the region's conflict, but the government has authority over the hospital, and nearby villages are controlled by antigovernment rebel forces. Rebel groups have not objected to villagers seeking care at the hospital, but if researchers are viewed as government collaborators or agents reporting on rebel activities, everyone in the hospital could be at risk of violence. Another complexity is that the government's Ministry of Health, which would have to approve a research protocol, might oppose any project it sees as beneficial to the interests of people living in rebel-held regions.

Although convinced that children with infectious diseases are not adequately cared for under existing policies, Dr P and colleagues believe that the capacity to respond to need can't be improved without a good evidence base that research would likely establish. They are also convinced that it is ethically problematic to wait until conflict ends to conduct research that could lead to improvements, and so Dr P and colleagues continue to deliberate about what they should do.

Commentary

Conducting research in a conflict zone raises many practical and ethical challenges. Conflict varies in its nature and scale, ranging from open military warfare to other forms of armed conflict and communal violence. The 2021 Council for International Organizations of Medical Sciences consensus statement on clinical research in low-resource settings addresses concerns of working among armed populations and during riots in its comments on conflict.[1] The challenges include concerns for safety and security, lack of scientific capacity or ethical oversight, practical limitations that might compromise study quality, and political pressures and barriers.[2] However, research during conflict can be beneficial when conducted appropriately and ethically.[3] The difficulty is finding the balance between challenges and benefits, which requires careful and humble reflection on each situation's details and application of research ethics frameworks.[1,4,5] With this particular case, we will comment on 4 ethical issues, although more could be considered.

Treating Injuries vs Conducting Research

Dr P and his colleagues are trying to decide how to allocate their limited time, energy, and resources between treating acute, conflict-related injuries and addressing unmet needs of children with acute and chronic infectious diseases through research. Some of the clinicians believe evidence from research is needed to determine whether existing policies and interventions address the needs of infected children. As the Active Learning Network for Accountability and Performance in Humanitarian Action notes: "The failure to generate and use evidence in policy and response makes humanitarian action less effective, less ethical and less accountable."[6] Research in conflict zones might be needed to determine if interventions effective in other settings remain effective in conflict settings and, if not, what adaptations are necessary for conflict zones. However, some could argue that research is of low priority since it might provide little direct benefit to the children living in the conflict zone. At best, it might show that disease prevalence is higher than previously documented, that current policies are not working well, or that changes are needed that might benefit other children. When the needs of conflict-injured children are compared to those of other children who might benefit in the future from research, the urgency of their situation might seem to outweigh the long-term needs of children in the region. Others might argue that only treating the children's injuries is an overly short-sighted approach. If the clinicians focus exclusively on conflict injuries, children might afterwards get sick and die from communicable diseases and thus have little overall benefit from the clinical resources they received.

Ethical dilemmas often are portrayed as one option vs another, especially when both options are ethical but prioritize different ethical principles. Rather than pitting one option against the other, clinicians creatively considering other options might identify an alternative that satisfies both ethical commitments, although perhaps not completely. Instead of viewing this case as an "either-or" dilemma in which the clinicians should *either* care for patients *or* do research, a "both-and" approach would allow the clinicians to strive *both* to care for patients *and* to do research. Whether this approach is practically feasible will depend on resources and context. Perhaps Dr P and his colleagues could split their time between clinical care and research, or perhaps one clinician could be freed up to focus on research while others cover that clinician's patient responsibilities.

However the team allocates resources, good reasons are needed to justify conducting research during conflict. Addressing research in humanitarian emergencies, the United Nations' Inter-Agency Standing Committee stated: "If the research question could be answered in a nonemergency setting, then it should not be answered in an emergency setting."[7] Yet to simply "export" health interventions shown to be effective in "stable"—typically high-income—countries to conflict settings without evaluating their effectiveness is also problematic.[8] Doing so would only continue the regrettable status quo of using public health interventions in humanitarian crises that have little—and low-quality—evidence to support them.[9] Sometimes medical interventions or procedures are tried in humanitarian settings that in reality are experimental and should instead be used in research protocols, complete with ethical review. Conducting research in conflict zones raises many challenges, but if care is being provided, research to evaluate its effectiveness and safety might be feasible and ethical.

Children as Subjects

Informed consent is internationally accepted as an ethical requirement to participate in research.[1,4,5] Since participating in research is voluntary, informed consent is a way to

respect people's right to decide for themselves if they wish to be involved. Children's participation in research requires additional ethical scrutiny, especially in humanitarian and conflict settings.[10,11] Policies typically state that parents or guardians may give consent for a child to participate in research on the assumption that they know the child's best interests. The age at which children may give consent varies depending on the age of majority in a country. Below the age of majority, even when parents or guardians give consent, a child's assent or agreement might be sought, although some cultures do not believe assent is necessary or appropriate.[12] In some cultures, parents or guardians might not like researchers obtaining assent from a child if they believe children cannot understand research. Others might be offended by researchers' obtaining assent from children if doing so suggests that the parents' consent was insufficient. However, if children are not consulted, they might feel coerced into participating and not engage fully with the researchers.

The case of Dr P is further complicated by the fact that children often are separated from their parents during conflicts. Excluding them from research until they are old enough to consent might deny them the benefits that such research might generate.[13] It could be argued that children separated from their parents should not participate in research, as they might have been traumatized by the conflict and be unable to give authentic consent if no adult can give consent for them. However, people who have experienced traumatic events can understand the purpose of research and truly consent to participate.[14] The difficult circumstances that the children have been through—perhaps forced to leave their homes, knowing their parents have died, becoming their siblings' caretaker—might have accelerated their maturation and left them more capable of consenting than other children of similar ages.

Given these considerations, innovative adaptations of ethics guidelines—such as allowing relatives to give consent for children's participation in research—might be reasonable, especially if accepted in the region. Some cultures are highly individualized and insist on individuals deciding for themselves. Other cultures value wider family and community interactions and decision making.[12] Children going to medical facilities are sometimes accompanied by elders or community leaders, who may be called "uncle" out of respect for their position. Such practices further complicate obtaining consent. In such situations, those beyond the nuclear family could be assumed to know the children well and to be able to make decisions based on the children's best interests. These issues remain challenging and far from clear-cut, with local context and level of risk being important to consider.

To address issues of consent for orphaned children and those unaccompanied by parents, the researchers should spend time getting to know the participant community.[13] Community engagement helps researchers avoid pursuing methods that turn out to be unacceptable or impractical in the community. In particular, participatory research methods are increasingly seen as important ways to ensure community values and culture are understood and respected.[15] During researchers' interactions with the community, challenges and concerns can be raised and potential problems mitigated or avoided. Such discussions will reveal what method of seeking consent or assent is acceptable in that community. This approach can also help children feel comfortable, as they know the approach has been agreed upon by the community and the researchers.

Research Feasibility

Even if ethical issues can be resolved satisfactorily, the feasibility of the research must be investigated carefully. Humanitarian organizations and individuals working in conflict zones might be overstretched and underresourced to the extent that conducting research might not be feasible.[8] The case of Dr P described challenges of transporting samples, poor infrastructure, and security issues. Without practical solutions to such problems, the research might have to be adapted or abandoned.

Before conducting clinical research in conflict zones, researchers should assess the opportunities and the challenges (including methodological, logistical, political, and ethical challenges) to help them decide whether it is feasible to conduct ethical research in that place at that time. A thorough situation analysis should also include assessment of stakeholders' attitudes and beliefs about conducting research in conflict zones, the availability of research assistants from within the community affected by the conflict (who could collect data using their social networks), and assessment of the risk-benefit ratio of the proposed research by maintaining risk registers and conducting regular risk assessment during service delivery. Various tools and checklists are also available to help with assessments and planning, such as the guidelines of the International Institute of Social Studies.[16]

To justify the risk of harm and use of resources, especially in a conflict zone, the research should be able to make a meaningful contribution to practice. Conducting unfeasible research has ethical implications, since starting an unfeasible study would waste resources.[16] Furthermore, conducting an unfeasible study might leave communities distrustful of researchers or even clinicians, which could impede realization of the benefits being sought. However, such challenges should not lead to research being immediately abandoned, as alternative means and additional resources could be pursued to address the difficulties.

Researchers should also consider that the needs and research questions arising in resource-limited environments might be more amenable to study using different research methodologies, such as observational studies or adaptive trial designs.[17] Snowball sampling methodology, for example, increases the likelihood of addressing distrust and suspicion when stakeholders in conflict zones are introduced by a trusted social network.[18] Conducting research ethically in conflict settings requires significant effort and flexibility, as well as sufficient resources and expertise, and is urgently needed in many areas. Research teams should ensure that their project is feasible and their team is well prepared before starting research projects.

Interacting With Authorities

The final ethical issue to be considered here is the role of authorities. Humanitarian organizations working in conflict settings find themselves walking a tightrope between various authorities. Getting the balance wrong can have fatal consequences for those working for humanitarian organizations and those they seek to help. Providing medical care to the injured can be seen as much more beneficial than conducting research. The collection of information or biological samples might be viewed with suspicion unless the researchers and participating communities have a clear understanding of the study. Researchers have been killed due to misunderstandings or malicious rumors about the goals of their study.[19] Much can be learned about the ethics of conducting research from past experiences, an example being research carried out during the 2014 to 2016 Ebola epidemic.[17,20]

The risks for researchers working in conflict settings have been studied.[21,22] In addition to the researchers themselves, others associated with them can be put at heightened risk. In the case of Dr P, the hospital could be attacked if it is viewed as collaborating with one side or the other in the conflict. The attacks on health care facilities reported in Syria are a terrible reminder that those who seek to care for the sick and injured are no longer viewed as entitled to protection in the eyes of some combatants.[23] Instead, they might become direct targets of violence or threatened with violence if they treat certain people or don't treat others. Such risks must be considered when decisions are being made about research in conflict settings.

This case study also points to the multiple conflicts of interest that can arise in research conducted in conflict settings. Countries affected by internal conflict and violence might require all research studies to be approved or licensed by a government agency. That same government might have a vested interest in certain issues not being researched or, if they are, in ensuring that the findings are not reported in ways that criticize the government, its policies, or its allies.[24] In some cases, these constraints might prevent studies from getting the necessary approvals. Researchers might have to consider the risk of conducting such studies without the required approvals (with the result that their studies might be shut down before they are completed), of their organization being forced to leave the country after reporting the results, or of the research team experiencing violence or imprisonment.[24]

Conclusion

The ethical and practical challenges of conducting research in conflict settings should not lead to it being abandoned; creative approaches should be explored to manage time, find resources, and adapt protocols as needed. Before designing studies, it is essential for researchers to engage involved communities, even those in conflict, to understand their needs and relevant cultural practices and concerns. Such engagement must be undertaken with humility.

Research with children is an important way to address their needs (understood holistically) with evidence-based interventions and policies. Viewing them as too vulnerable to participate in research might further marginalize them and leave their treatment without supportive evidence. Although including children raises additional ethical challenges, such as informed consent, these can be addressed through meaningful engagement with the community, parents, and other authorities.

Significant efforts might be required to establish researchers' independence from the conflict. Some living in conflict zones might not accept that neutrality is possible, and hence research in these settings has inherent dangers. So, too, does providing health care.[25] Both health care and research have the potential to benefit the community greatly. Ensuring research is conducted ethically is one way to minimize the risks for everyone involved.

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Dónal O'Mathúna, PhD is an associate professor in the College of Nursing and the Center for Bioethics and Medical Humanities at Ohio State University in Columbus. His research interests include ethics and evidence-based practice in health care, with a specific focus on humanitarian crises and disaster research ethics. He was the principal investigator for the Post-Research Ethics Analysis Research Project, which investigated ethical issues in health research conducted in humanitarian crises.

Nawaraj Upadhaya, PhD is a medical anthropologist and public health researcher who has worked in conflict and other natural disaster settings in Afghanistan, Burundi, Nepal, and South Sudan. He works with HealthNet TPO, Burundi, and has coordinated the implementation of the Post-Research Ethics Analysis Research Project in Afghanistan, Nepal, and South Sudan. He has also conducted research on strengthening mental health systems in low- and middle-income countries.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Access to Military Health Care Facilities Be Controlled in Conflict?

Martin Bricknell, PhD, David Whetham, PhD, Richard Sullivan, PhD, and Peter Mahoney, PhD

Abstract

This commentary on a case analysis examines the principles that govern decisions about which patients might be admitted to an international military hospital during humanitarian or combat operations. It explores the balance between duties under the Geneva Conventions and other international humanitarian laws, the requirement to be able to provide medical support to the military mission, and the obligation of clinicians to coordinate with other health care practitioners (local civilian, local military, and nongovernment organizations). Finally, this commentary considers the practical aspects of implementing these arrangements.

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Case

MM commands a military field hospital, physically based on a semi-trailer truck convoy that follows combat troops into disputed territory as part of a United Nations (UN) peacekeeping and security mission to implement and maintain a fragile truce between local government forces and opposition forces. In the disputed territory, the humanitarian crisis is escalating; the number of casualties from armed conflict and the number of displaced persons from affected ethnic groups are increasing. When the convoy arrives and the field hospital setup is complete, MM expects large numbers of injured and ill patients to arrive and seeks resources to meet their basic needs for food, water, shelter, medicines, and other kinds of clinical intervention.

Guards will protect the field hospital's perimeter and determine who will be allowed to enter the hospital. MM is asked to provide guidance to these guards about admission criteria and whether patients' ethnic or village origins will be included among those criteria. MM considers how to respond.

Commentary

This case scenario might seem to present a simple question about the procedures to be adopted by the guard force controlling the checkpoint at the entrance to the hospital site. However, these procedures will need to comply with policies for the peacekeeping force on the use of military resources for humanitarian relief, the duties of medical personnel to provide health care free from discrimination and without distinction, and the usage of medical capacity within the whole military field medical system so that health care to the sick or injured is not compromised. The discussion that follows does not cover the arrangements for the treatment of civilians by local military medical services, which can be subject to national laws and procedures.

General Duties

Military field hospitals are normally designed, staffed, and equipped to provide health care for military personnel and other specifically designated groups termed the *population at risk* (PAR). In a UN peacekeeping mission, the PAR might include other UN personnel, such as police and civilian workers. However, it is inevitable that military medical units (eg, ambulances, field hospitals) will be presented with civilian casualties, both those caused directly by conflict and those attributable to natural causes. In Iraq and Afghanistan, United Kingdom field hospitals received a significant number of civilian casualties and casualties from the local security forces.[1] This pattern has been replicated in the US military experience in Iraq[2] and Afghanistan,[3] the German experience in Afghanistan,[4] and the Chinese experience in a UN peacekeeping mission in Mali.[5]

Parties in armed conflict have a general duty to ensure that the wounded and sick receive the medical care that they require with minimum delay and without distinction, except on medical grounds. This provision is made in all of the Geneva Conventions and Associated Protocols and covers wounded enemy combatants, prisoners, civilians, and the shipwrecked.[6] These international treaties and protocols ensure unrestricted access to care, although the obligation of state parties is to ensure that care—not necessarily all clinical services—is provided. Therefore, the military policy on admission to hospital for patients other than the designated PAR will need to consider the capabilities and capacities of the whole health system, including local private and public facilities and nongovernment organizations (eg, the Red Cross or Red Crescent).[7] This assessment might include plotting all medical facilities with contact details on a map.

Even if health care workers in the armed forces act in a humanitarian manner, they are part of a designated military force. While they can uphold the principles of humanity and impartiality, they cannot be neutral (unaligned to any security actor) or operationally independent of political actors.[8] Based on guidance from the Global Health Cluster of the Inter-Agency Standing Committee of the UN Office for the Coordination of Humanitarian Affairs, military medical units should only provide direct or indirect health assistance to civilians in emergencies and as a last resort if there are no other clinically suitable alternatives.[9] Therefore, patients with nonurgent clinical conditions (often defined as not threatening life, limb, or eyesight) should be refused entry and should be encouraged to use civilian health services.

Once an emergency patient has been accepted, in accordance with the International Committee of the Red Cross' Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies, military medical units and personnel "are required to render immediate attention and requisite care to the best of their ability. No distinction is made

between patients, except in respect of decisions based upon clinical need and available resources."[10] Military field hospitals are designed to stabilize and rapidly evacuate military patients as part of a care pathway.[11] They are neither staffed nor equipped for the long-term care of patients. Therefore, any decision to accept non-eligible patients should be seen as part of a care pathway from prehospital care through discharge from medical care, with a presumption of transferring these patients to the local medical system at every step unless clinically impossible (eg, cases requiring respiratory ventilation that is not available in the local health system).[12] Exceptionally, it might be possible for nonurgent civilian patients to be treated in the military hospital if there is both the capacity and the capability to meet the patient's needs and the local health system cannot provide suitable clinical care.

Beyond these generic principles, specific guidance is likely to be issued by the UN peacekeeping mission alongside instructions issued by the national medical authorities of the military medical units. These protocols are likely to include defined medical rules of eligibility (MRoE) that designate the PAR and the circumstances whereby civilians may receive medical care in an emergency, usually in circumstances in which their life, limb, or eyesight is at risk.[13] The application of these MRoE balances the utility of ensuring that beds are empty and available for the PAR with the humanity of meeting the nondiscriminatory emergency needs of patients.[14]

Specific Responsibilities

Although a military hospital is responsible for its own local security, it might be situated within a wider military compound that is guarded by combatants. To ensure safety, there needs to be a system at the main entrance for the clinical assessment of patients seeking care to confirm their status under the MRoE. Unfortunately, ambulances and sick patients have been used as cover to attack military installations.[15] Therefore, a full security check will need to be undertaken before the clinical assessment can be made.

In the case, MM and the leadership team of the field hospital should ensure that they understand the context of the specific crisis, including the existing local health system and humanitarian response. This contextual knowledge should include the UN policies and procedures for medical support.[16] Coordination links should be established through the World Health Organization-sponsored humanitarian Health Cluster or the national Ministry of Health so that referral and transfer arrangements can be made for any local patients that are admitted. MM should determine the probability of civilians needing emergency medical care (including for nonconflict medical emergencies, such as obstructed labor) and ensure that sufficient staff and equipment are provided. This preparation should be clinically pragmatic, based on an understanding of the nature and quality of clinical care available in the local health system, and include educating military medical personnel on the cultural aspects of caring for patients who speak a different language and have different values. This education should be included in predeployment training and also cover the clinical management of predictable scenarios, such as severe burns, significant head injury, obstetric and other nontrauma emergencies, neglected conflict wounds, cancer, and congenital disease. The management of such cases is likely to be challenging if there is a substantial disparity between the capability of the local health system and that of the international military field hospital and its evacuation pathway. Clinical personnel need to consider the circumstances in which they might have to refuse treatment or give care that differs from their national practice. It is also important to consider how to share clinical

information on patients with local civilian health authorities without compromising their security, especially if local combatants are treated.

Finally, MM and the team will need to consider the potential impact of the media and news interest in their response to any perceived humanitarian crisis. They will need to consider how to handle requests from journalists for interviews, photographs, and video recordings of the medical unit and their patients. It will be vitally important to ensure a legal and ethical approach to consent for engagement with the media and to ensure patient confidentiality.

Conclusion

Conflict and other humanitarian crises might require health care workers to make very difficult decisions that have substantial ethical implications. Many issues, such as the care of nonmilitary patients with predictable health emergencies (eg, severe trauma, obstetric crises, severe burns), can be anticipated and mitigated by policy, procedures, and training. It is important that clinical health care workers are able to fulfill their legal and ethical duty to provide individual health care solely on the basis of clinical need. However, it is also important to provide guidance on balancing the utility of maintaining the medical system's capacity to meet the potential needs of the designated PAR and the humanity of meeting the needs of all those affected by conflict.

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Martin Bricknell, PhD is a professor of conflict, health, and military medicine in the Conflict and Health Research Group at King's College London. He completed a full military career in the UK Defence Medical Services, culminating in his appointment as Surgeon General. He has extensive medical leadership experience on military operations.

David Whetham, PhD is a professor of ethics and the military profession and the director of the Centre for Military Ethics at King's College London. He also delivers or coordinates the military ethics component of courses for British and international officers at the Joint Services Command and Staff College in England.

Richard Sullivan, PhD is a professor of cancer and global health, the director of the Institute of Cancer Policy, and the co-director of the Conflict and Health Research Group at King's College London. He is a noncommunicable diseases advisor to the World Health Organization, a civil-military advisor to Save the Children, and a member of the National Cancer Grid of India. His research focuses on global cancer policy and planning as well as health systems strengthening, particularly conflict ecosystems.

Peter Mahoney, PhD is a visiting professor at the Centre for Military Ethics at King's College London. Professionally, he is a consultant in anaesthesia and prehospital emergency medicine. He previously served in the British Army—22 years in the Army Reserve and 18 years in the Regular Army. His roles included deployed medical director of the hospital in Camp Bastion, Afghanistan, and as a member of the helicopter-delivered Medical Emergency Response Team.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Military Health Care Workers Respond When Conflict Reaches the Hospital?

Hunter Jackson Smith, MD, MPH, MBE, Joseph Procaccino, JD, MFS, and Megan Applewhite, MD, MA

Abstract

Military clinicians face unique ethical challenges in conflict zones, particularly if conflict reaches a health care setting. Although the ethical challenges of rationing and triaging while fulfilling obligations to individual patients are not dissimilar to those civilian clinicians encountered during the COVID-19 pandemic, military clinicians must also meet national security and mission requirements. Conflicting clinical care, mission, and individual conscience obligations can cause moral distress, a deeply troubling internal conflict also experienced by civilian clinicians. Crisis settings imposed in conflict or during pandemic surges demonstrate the need for all clinicians to be prepared to modify practice priorities during extreme circumstances.

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Case

Dr M is an active-duty internist in a military medical center in Eastern Europe. The hospital treats active-duty and retired military service members and their families. The hospital also treats civilians in the emergency department and transfers them once they are stable. Recently, her country's military has been in conflict with an aggressive militant group.

Today, the cell phones of the staff and patients buzz with a text alert sent from the country's emergency warning system, stating there are ballistic missiles coming toward their area and to seek shelter immediately. Dr M notices several of her colleagues rushing out of the hospital in attempts to reach their loved ones. She instead works to rally her floor staff to keep their focus trained on their patients to keep them stable and protect them from any impending blasts.

Meanwhile, the hospital responds in different ways simultaneously. There is a sturdy basement level where many of the laboring mothers, neonatal intensive care unit (ICU) babies, and pediatric ICU children are being transported. Arguments erupt in the

emergency department regarding the prioritization of active-duty personnel over families and civilians. Becoming increasingly agitated, the patients on Dr M's floor question the decision that leaves them on the upper floors. One hour passes, and nothing happens. Authorities later clarify that the text alert was a false alarm and was never meant to be sent. Dr M feels guilty for not trying to reach her husband and children.

Commentary

Military medical professionals face unique ethical challenges in conflict zones. Many are trained to treat service members and civilians according to certain priorities and rules of engagement (ie, orders governing service member actions), but these guidelines cannot cover the full spectrum of ethically difficult scenarios. One such challenge is when conflict zones reach the hospital. The described case is reminiscent of an actual incident in January 2018 in Hawaii when an alert was sent to residents' cellphones directing them to seek immediate shelter from an imminent ballistic missile attack.[1] The alert forced both civilian and military hospitals on the islands to take the alert seriously and respond. It raised an important question: What if this alert had been real?

Similarly, the COVID-19 pandemic has created traumatic circumstances in health care facilities, resulting in part from the necessity to transition to a crisis standard of care in many civilian hospitals. For example, these facilities experienced difficulties triaging patients due to overfilled ICUs, pediatricians and subspecialists being forced into staffing ICUs, and challenging decisions about distributions of scarce resources (eg, ventilators, medications). What these facilities faced resembles what military clinicians must consider, particularly in conflict zones, where difficult triaging decisions and resource shortages are common. These parallel circumstances of hospital conflict zones and COVID-19 pandemic surges demand that both military and civilian health care professionals be trained to address crises and moral distress resulting from decision making that may defy typical practice or ideal care contexts. However, whereas military physicians receive training for events such as these, most civilian clinicians do not, leaving them relatively unprepared for the ethical challenges the COVID-19 pandemic has presented. This article explores ethical challenges that military health care workers face during conflict and compares conflict contexts in military health facilities with how COVID-19 challenged civilian hospitals and clinicians.

Conflicting Obligations During Crises

Physicians have a duty to care for their patients and to serve their best interests. This professional responsibility derives from the specialized knowledge physicians possess, trust in the physician-patient relationship, vulnerability conferred by illness, and the power imbalance between physicians and patients.[2] After assuming the role of providing doctor and taking a patient into their care, the physician will presumably put the welfare of the patient first.[3] This is done in small ways all the time. For example, when a surgeon is in the operating room, the surgical case is the only event that matters. If the operation takes longer than expected, there is no other consideration but to carry on uninterrupted, as if there were no life outside the operating room.

In the hospital missile case, the physicians' commitment to prioritize the care of patients above their own interests is pushed to an extreme. The duty to care prevents Dr M from seeing her family in what might have been a catastrophic event. Dr M is no longer only missing dinner with her family because a particular patient is critically ill and requires additional time; she is being asked to put her profession and patients over her family. Health care professionals like Dr M in the scenario described, who are compelled by

their duty to care for and manage patients, give themselves in exchange for the "greater good." The challenges raised here echo those faced by the countless health care professionals who worked in hospitals during the height of the COVID-19 pandemic, particularly early on when little was known about the virus' transmission, there were no definitive preventive or treatment pharmaceuticals, and the mortality rate was accelerating. However, military medical professionals have, in addition to their medical obligations, a duty to fulfill their oaths to their country. They feel not only an urge to pursue the greater good by caring for their patients but also a call to support their fellow service members, the country, and its citizens.

Military Clinicians' Preparation for Crises

Military clinicians may be better equipped to handle ethically challenging crisis events, such as mass casualty scenarios or COVID-19 pandemic surges, than their civilian peers. Often, military clinicians are tasked with preparing for similar contingencies: how to triage one's own service members in comparison to ally and enemy forces and how to prepare for foreign attacks, domestic terrorism, active shooters, or natural disasters. It is notable that military medical personnel and mobile care sites were deployed throughout the United States in areas that were particularly ravaged by COVID-19 to assist in pandemic response efforts.[4] Military medical clinicians receive practical training in mass casualty events and must both mentally and practically prepare for the aforementioned scenarios, in contrast to civilian clinicians, who are often forced to respond reactively. Preparedness for disasters also offers a lesson in building moral resilience (ie, the ability to handle ethically adverse scenarios).

Many guidelines have been produced for addressing disasters such as missile attacks.[5,6,7] It is clear from these guides that, as with COVID-19, triage of medical care during disasters emphasizes a utilitarian approach, ie, attempting to save the greatest number by focusing first on those who are most likely to survive with interventions. In the military medical environment, such prioritization assumes a broader scope in that military treatment facilities (MTFs) must, in addition to considering those in greatest need of medical care and those most likely to be saved, value the military mission's readiness and defense of its nation. This means that active-duty service members may receive special priority for care in MTFs, sometimes superseding the care of other eligible patients. For example, Department of Defense Instruction 6200.03, "Public Health Emergency Management (PHEM) Within the DoD," Section 5.2, states:

> Supporting the Mission. Under emergency conditions, the allocation of resources may not be based solely on medical necessity or risk, but also may be based on operational or other national security requirements, as directed by the President or Secretary of Defense. Some service members, for example, may receive a higher level of care due to operational requirements, independent of their immediate medical risk.[8]

In military medical environments, a utilitarian ethic is often necessary to protect the unit, maintain security, and advance the mission. Prioritizing treatment of service members in emergency and conflict scenarios is required to return them to duty quickly for maintenance of order and defense of their nation. If civilians know an MTF is nearby in a crisis scenario, they may preferentially seek emergency treatment (which can be offered for nonbeneficiaries on a space-available basis), but those patients might not understand military prioritization practices in such circumstances. Thus, after a missile attack, an MTF might place military clinicians in the difficult position of prioritizing caring for service members over civilians who may require more medically acute attention. Any prioritization that puts seriously injured patients at risk of being denied care may cause moral distress for many clinicians,[9] some of whom may be reluctant to remove a patient

from needed lifesaving equipment to instead turn their attention to another, less injured patient only because they wear a uniform. Since it is impossible to prepare for every scenario that might occur, it is important to instead focus on developing the individual and team tools needed to address such morally distressing situations before a crisis occurs. These tools include leadership and ethical training, communication with and between staff, and contingencies for disasters so that clinicians are better prepared when confronted by such challenging situations. Developing and strengthening moral resilience is one such method that might benefit both military and civilian health care professionals in this capacity.[10]

Conclusions

These and other ethical quandaries in times of acute mass disaster, such as a missile attack, deserve consideration. It is critical that military medical and civilian clinicians alike be equipped to handle ethically strenuous situations such as these. Conflict-based scenarios also offer important practical and ethical lessons for civilian hospitals and health care workers regarding emergency preparedness and building moral resilience.

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Hunter Jackson Smith, MD, MPH, MBE is chief of preventive medicine for the US Army Medical Research Directorate–Africa, stationed in Kisumu, Kenya and an adjunct assistant professor in the Department of Preventive Medicine and Biostatistics at the Uniformed Services University in Bethesda, Maryland. He also serves as a subject matter expert for the Department of Defense Medical Ethics Center. CPT Smith is board-certified in general preventive medicine and public health.

Joseph Procaccino, JD, MFS is the legal advisor to the Department of Defense Medical Ethics Center and an adjunct assistant professor in the Department of Preventive Medicine and Biostatistics at the Uniformed Services University in Bethesda, Maryland. He previously served as the legal advisor to the Air Force surgeon general and has taught health law and ethics at Georgetown University and the University of Maryland.

Megan Applewhite, MD, MA is a consulting bioethicist to the Department of Defense Medical Ethics Center and board-certified, with general surgeon fellowship training, in endocrine surgery. She is an associate professor of surgery at Albany Medical College, where she also holds the John A. Balint, MD Chair of Bioethics Education and Research.

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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Health Systems Help Clinicians Manage Bias Against Ex-combatants?

Christopher W. Reynolds and Camilo Sánchez Meertens, MPP

Abstract

Clinicians in postconflict health care settings can be tasked with caring for patients who are ex-combatants. This commentary responds to a case of a health worker with duties to care for ex-Revolutionary Armed Forces of Colombia combatants. Specifically, this article considers clinical, ethical, and legal demands of reincorporating ex-combatants in compliance with a peace agreement on systems and individual health workers.

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Case

CH is a health worker who has long served rural community members of Vista Hermosa, Colombia. CH travels to *veredas* (remote, limited-resource clinical settings) as an employee of a local health organization's outreach program, without which, hundreds of people—including ex-Revolutionary Armed Forces of Colombia (*Fuerzas Armadas Revolucionarias de Colombia*, or FARC) combatants—would lack access to clinical evaluations and health services. CH is haunted by having been kidnapped by FARC members years before. "It was horrible," CH relates. "They kidnapped and held us for 3 days without food or water. We had no idea when we would be released. They are overtaking our hospitals and have more rights than their victims." Despite a peace agreement, CH and other health workers traumatized by years of conflict struggle to maintain clinical neutrality and execute professional duties to care for all patients their hospital serves.

Commentary

Until 6 years ago, FARC was a guerrilla group that had operated in Colombia since the 1960s and had been known to kidnap health care workers for ransom or medical assistance.[1] In 2016, Colombia and FARC signed the *Acuerdo Final para la Terminación del Conflicto y la Construcción de una Paz Estable y Duradera* (peace agreement),[2] ending the longest conflict in the Western hemisphere and reincorporating 13 000 ex-combatants into society. With the agreement, FARC ex-combatants were guaranteed access to services, including health care.[3] However, as ex-FARC members began

accessing health care, CH and others felt that victims of FARC actions and members of marginalized communities were left behind, while ex-FARC patients received care. CH seems to feel burdened by an obligation to care for ex-FARC patients, whom CH still remembers as violent perpetrators.

Although the peace agreement was a revolutionary approach to peace building, ethical questions that arose during its implementation are common in postconflict clinical encounters. Two key issues were (1) resource allocation equity among perpetrators and victims and (2) supporting health workers with duties to care for members of both groups, despite their own personal trauma experiences. This article describes the Colombian approach to health care reincorporation, focusing on the ethical values of restorative justice and subsidiarity in resource allocation decision making, and considers strategies for supporting health workers struggling with how to cultivate and maintain clinical neutrality, especially when caring for ex-combatants.

Peace and Public Health

The Colombian peace agreement guaranteed ex-combatants access to health services, including government-subsidized insurance, and immediate attention in encampment zones where FARC disarmed.[2,3,4] In health care, the ethical values of restorative justice (ie, engaging each actor of conflict to repair and build relationships)[5] and subsidiarity (ie, decentralizing and sharing governance responsibilities with local organizations) can be expressed in inclusion, forgiveness, making amends, mutual healing, reintegration, and equity and can be implemented in processes of reconciliation. Restorative justice has proven effective in improving health outcomes among participants in other conflict-affected populations.[6,7,8,9] Subsidiarity was implemented by Colombia's Ministry of Health insofar as it relied on municipal-level public hospitals to provide health care for ex-combatants in reincorporation camps and for all Colombians in surrounding communities. This strategy aimed to strengthen long-term investment in local public health capacity.[10]

Caring for All Colombians

Implementing government-subsidized health care in encampment zones risked the perception that ex-FARC patients were being favored. Although most FARC ex-combatants lacked clinical records, they needed to be integrated into health service provision streams. Via decree, the Colombian government integrated 10 836 ex-FARC combatants into the Colombian universal health insurance system in 2017.[10,11] The opportunity for ex-FARC members to access the same health benefits as other Colombians helped avoid conflicts stemming from perceived favoritism. Gradual integration of encampment zone-based health service provision streams into those of the general Colombian health system also facilitated ex-FARC members' access to services available to all Colombians.

Subsidiarity also empowered hospitals to allocate resources, manage decisions, and implement nondiscrimination policies locally. The Colombian Ministry of Health's 2018 peace agreement accountability report documented 11 827 consultations, 63% of which were for Colombians who were not FARC ex-combatants,[12] and this number increased to 70% in 2020.[13] In other words, what started as a strategy to reincorporate FARC ex-combatants into Colombian society became a vision to benefit all Colombians in well-integrated, locally administered rural health programs.

Peace Requires Clinical Neutrality

While the peace agreement addressed the need for local resource allocation and management of risk of perceived favoritism, it lacked guidance for health workers with duties to care for all patients, including FARC ex-combatants. One study found that 22.6% of Colombian physicians were affected by the FARC conflict and, like other clinicians, seemed to share experiences like CH's.[14] The Geneva Conventions and Colombian law affirm a universal right to health care,[15,16] so helping clinicians manage affective negative bias that could undermine what they think a patient deserves from them is ethically, clinically, and legally important and could determine whether and to what extent the health provisions of a peace agreement will succeed.

Health workers like CH share accountability for equitable national health care provision.[17] Human rights law specifies that all "persons deprived of their liberty" deserve to be treated humanely due to their status as a "human person" with "inherent dignity," and the Geneva Conventions include clear provisions about the care of persons in enemy hands.[18] Although less has been written about health rights of ex-combatants in postconflict settings specifically, it seems reasonable to interpret both Colombian and international law as protecting them. Therefore, it is of utmost importance to understand the nature and scope of a national health system's obligations to traumatized health workers struggling to care for all patients in postconflict settings.

Peace requires health workers like CH to be agents of peace in practice by expressing ongoing, steadfast commitment to collaborative, communal healing. Official policy tasked the Colombian Ministry of Health to develop guidelines for health workers caring for FARC ex-combatants.[19] We suggest that such guidelines continue to be implemented with a focus on restorative justice, which can promote healing through ownership of one's roles in past atrocities, ownership of one's own responses to past atrocities (eg, feelings like those experienced by CH that could undermine clinicians' neutrality), and participation in exchanges and discussions that motivate reconciliation and build trust.[20] For example, because engaging with ex-FARC patients could be harmful to patients or to health workers,[18] CH needs and deserves support from the Ministry of Health in navigating trauma from CH's past in order to be positioned, now and in the future, as someone who can operationalize clinical neutrality in practice. With proper support, health workers caring for FARC ex-combatants can address their tendencies toward negative bias and discrimination against ex-FARC patients so that these patients have access to the equitable care the peace agreement promises.[21]

Onward

Restorative justice centers relationships and trust building. The Colombian peace agreement was innovative in its reliance on health workers to express and implement restorative justice values and to promote health-system level attempts to make equitable health care key to postconflict life in urban and rural communities. To increase the rural health care workforce, in particular, hundreds of ex-FARC members with combat nursing experience became certified as auxiliary nurses through capacitation programs.[22] Hiring has been regionally dependent, but organizations working with ex-FARC nurses could reduce turnover, since ex-FARC health workers tend to remain in rural areas and have unique knowledge of the regions and communities they serve. Colombia's approach offers lessons and strategies that other countries can draw upon to reintegrate ex-combatants into postconflict health care schemes and to help health workers address the ethical dilemmas they face in such scenarios.

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Christopher W. Reynolds is a third-year student at the University of Michigan Medical School in Ann Arbor. He received a Fulbright US Student Program grant in 2019 to study the health care access barriers and experiences of FARC ex-combatants in Colombia. His research interests include health care access in humanitarian settings.

Camilo Sánchez Meertens, MPP is a political scientist who earned his undergraduate degree from the Universidad de los Andes in Bogotá, Colombia, and a master of public policy degree from the Hertie School in Germany. He has worked for Colombian independent research institutes, the United Nations, and the Colombian government, including the Ministry of Health and Social Protection and the Office of the High Commissioner for Peace, and has been directly involved in the 2016 peace agreement implementation.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Everyone Is Harmed When Clinicians Aren't Prepared

Thalia Arawi, PhD, Ghassan S. Abu-Sittah, MBChB, and Bashar Hassan

Abstract

War and conflict are now common, lingering like an endemic disease in most countries of the Global South. Population displacement, infectious disease outbreaks, food and water shortages, damage to infrastructure, anxiety, and posttraumatic stress are among the phenomena to which clinicians are expected to respond as professionals. Yet curricula in health professions do not prepare trainees to cultivate the skills needed to develop intervention pathways to meet the needs of populations in conflict zones. This article argues that decolonization of curricula in health professions is key to preparing clinicians to respond with care and competence to vulnerabilities and disease burden exacerbated by conflict.

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Colonialism and Conquest Permeate Medicine and Science

War and conflict are now spread among countries of the Global South like an endemic disease, resulting in population displacement, infection outbreaks, food and water shortages, and mental illness. Proper clinical management during and after conflict cessation is lacking, as curricula in health professions do not prepare students and trainees to respond to local population needs and disease burden, particularly in areas of protracted conflict.

In a stirring work of postcolonial science fiction, *The Calcutta Chromosome*, Amitav Ghosh illuminates the colonial roots of health professions education by unraveling the secret history behind one British physician character's discovery that mosquitos transmit malaria.[1] Another character, Murugan, was almost certain this physician was part of a larger plan to control lands targeted for British conquest (and the people in them) by using mosquitos to transfer human chromosomes. Writing against the hegemony of scientific discourse from the borders of his postcolonial position, Ghosh explains what we refer to as *colonial education* by showing how settlers manipulated Western allopathic concepts of medicine, science, and technology to promote British conquest.[1] This article draws on this idea to argue for decolonization of health professions curricula to train clinicians in the practice of conflict medicine.

Conflict as Endemic Disease

Over the last 3 decades, the majority of implacable wars have transpired in the Middle East and North Africa (MENA) region and been perpetrated under the guise of democratization, a mantra used by wealthy nations that have stakes in these countries' oil reserves or their strategic geographical locations. War and conflict are now defining characteristics of most countries of the Global South; armed conflict has continued in the MENA region since World War I.[2] As one of the authors (G.A.S) said elsewhere: "This perspective contrasts with the humanitarian discourse of emergency and temporality."[2] He added: "During the civil war in Syria, humanitarian agencies came in with the language of emergency service and temporary conflicts. But we were witnessing patients who had, in the case of Palestine, repeated injury and re-injury within the same body of the same patient. In Iraq, injury was a social phenomenon."[2]

Injured people and their injuries taught war surgeons that there is no such thing as a *temporary crisis*, a term still used in error by humanitarian agencies. Instead, war in these regions should be likened to endemic disease. Ceaseless conflicts in disaster areas give birth to other conflicts. When war becomes accepted and is incorporated into the lives of people living in conflict regions, conflict is indeed endemic and omnipresent. Yet characterizing conflict in this way can also be acknowledged as a product of colonialism, since endemic disease is a concept derived from colonial tropical medicine that is rooted in colonizers' perceived need to make a region safe for occupation.[3]

The health consequences of conflict are numerous and can be immediate or delayed and direct or indirect. While population displacement, infection outbreaks, food and water shortages, compromised access to health services, and damage to infrastructure are immediate effects of war,[4] anxiety, posttraumatic stress, and other mental illnesses can linger much longer than predicted,[5] neither killing patients nor letting them live. In addition to health care system collapse, infrastructure decimation (eg, impaired sewage systems, clean water supply disruption) increases the number of displaced persons seeking asylum, and congregation of people in areas with poor sanitation and congested living conditions contributes to environments in which waterborne diseases thrive.[4] A study conducted in Syria revealed that the DNA of microbes in areas of war has mutated, resulting in high rates of multidrug resistance among Syrian refugees compared to members of local populations, and that conflict hinders safeguards against antimicrobial resistance.[6]

If war and conflict were understood as endemic disease, health care in conflict zones would not be able to ignore the unique nature of what we refer to in the rest of this article as *wound narratives*: stories of why and where war and conflict occur and by whom or upon whom it is perpetrated. Wound narratives should be key parts of health professions education because they are inscribed on war- and conflict-wounded bodies at the times those bodies and persons are harmed and remain throughout a lifetime.[7] Recent unconventional use of forbidden weapons in the Middle East (ie, Syria, Iraq, Yemen, and Palestine) is allowing for the emergence of not only new wound narratives but also new wounds and embodied experiences of those wounds that will linger and require healing.

In the MENA region, education of health professions tends to conform with Western, allopathic values without incorporating curricular content to build trainees' skills to respond to needs of conflict-affected populations burdened not only by illness and injury from conflict in the region, but also by psychosocial and political factors that exacerbate

their experiences of illness and injury. The same British physician fictionalized in Ghosh's novel gave an address in 1899 in which he stated: "In the coming century the success of imperialism would depend largely upon success with the microscope."[8] This vision of prowess of the biomedical model, symbolized by the microscope, would guide the medical education, pharmaceutical, and scientific enterprises. Arts and humanities, however, are deemed less worthy than science, particularly in the Global South, and are "gradually losing status and influence."[9] At a time when we need to extend the influence of arts and humanities in health care, we instead see universities "learning from the business and commercial world today … how to develop a customer perspective,"[10] a curricular approach that must be transformed in order for trainees to be prepared to meet the needs of those living in areas of endemic conflict.

Decolonizing Curricula

Decades after many countries of the Global South gained autonomy, postcolonial thinking still governs their health professions schools' curricula. A contemporary example of how these countries' medical education has fallen under the spell of colonial education is that medical schools continue to measure their success by the number of physicians who practice in the Global North and West and by their subspecializations (eg, in robotics or artificial intelligence). An obstacle to developing health care in the Arab world, for example, is that, concomitant with rise in the nature and number of injuries over the past 2 decades, clinicians have emigrated to wealthier, more profitable regions of the world. International educators and organizations in health professions might, in response, consider drawing upon the example of Paulo Freire to encourage early-career clinicians to practice in areas of great need, such as those with endemic conflict.

When he was secretary of education for São Paulo, Freire declined support from the World Bank to carry out educational reforms—and told the mayor that he would quit if the loans were approved[11]—to avoid assuming a personal role in exacerbating "increased inequality, decreased democracy, and ecological degradation"[12] on an international scale. Conflict medicine training, especially in the Global South, needs to be deterritorialized and reterritorialized because, as noted in Shaull's preface to Freire's *Pedagogy of the Oppressed*, there is no such thing as a neutral educational system.[13] Freire's work stipulates that critical education must break from a historically entrenched, colonial master narrative to focus on local needs, cultures, and ecologies and help the oppressed recover their sense of humanity. Freire operates on the premise that politics cannot be divorced from education; curricula (overt and hidden), pedagogy, and assessment serve political agendas.[13] What we suggest here is that educators in health professions must cultivate awareness of whose agendas those are and how they are being asked to motivate them.

Local Determinants of Health and Healing

In the Global South, wounds are political, and so is education. Curricula that delete anticolonial content, for example, deserve attention here. Neglect of international contributions to medicine and its origins expresses an impoverished conception of knowledge that Freire problematizes. Freire questions knowledge transfer practices that position one person as a knower and another as knowing nothing, suggesting that knowledge itself is "a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing."[13] Education must go beyond mere transmission of information, and health professions education, specifically, should be

enriched via what Freire calls a "dialogical process" that centers community concerns, generates dialogue, and seeks to awaken critical consciousness.

Such a reorientation of health professions education would also likely trigger educational imagination, particularly needed in times of protracted conflict and in war zones. Decolonizing curricula in health professions to reflect local needs and vulnerabilities is vital to teaching healing as service. Freire's views of education allow room for service-learning curricula that illuminate needs of people in regions affected by conflict. Clinicians should be sensitized, experientially and dialogically, to psycho-socio-political determinants of health. Clinicians must also appreciate that endemic conflict needs eradication through decolonization of science and medicine. Educators in health professions should develop conflict medicine programs that do not replicate International Red Cross and Red Crescent Movement[14] or World Health Organization Academy[15] teachings but rather privilege the lived experiences of people in conflict zones with close attention to their wound narratives.

Education is what William Walters and Barbara Lüthi call a "cramped space" that registers "degrees of deprivation, constriction, and obstruction, but always and simultaneously a concern for the ways in which such limits operate to stimulate and incite movements of becoming and remaking."[16] In order for experiential learning and curricular imagination to flourish, 4 hurdles need to be overcome: (1) failure to appreciate that conflict is endemic to many regions of the world, (2) lack of will to reform colonial practice and pedagogy, (3) lack of adequate curricula, and (4) lack of funding. These obstacles, which prominent in the Global South, can perhaps be summarized by what Atul Gawande noted in *Complications: A Surgeon's Note on Imperfect Science*: "We want perfection without practice. Yet everyone is harmed if no one is trained for the future."[17]

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Thalia Arawi, PhD is the founding director of the Salim El-Hoss Bioethics and Professionalism Program at the American University of Beirut Faculty of Medicine and Medical Center in Lebanon. Her research includes clinical ethics, biomedical ethics, philosophy of medicine, humanitarian medicine, ethics in conflict zones, mental health ethics, and medical education.

Ghassan S. Abu-Sittah, MBChB heads the Division of Plastic and Reconstructive Surgery at the American University of Beirut Medical Center in Lebanon and founded the Conflict Medicine Program of the Global Health Institute at the American University of Beirut.

Bashar Hassan is a fourth-year medical student at the American University of Beirut Faculty of Medicine in Lebanon. He plans to pursue his research fellowship in plastic and reconstructive surgery during the next 2 years before applying for residency in the United States.

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Survivor-Centered Approaches to Conflict-Related Sexual Violence in International Humanitarian and Human Rights Law

Klearchos A. Kyriakides, PhD, MPhil and Andreas K. Demetriades, MBBChir, MPhil

Abstract

This article outlines the history of international humanitarian law *vis-à-vis* conflict-related sexual violence (CRSV) from the promulgation of the Lieber Code in 1863 until the adoption in 2019 of United Nations Security Council Resolution 2467. This article considers how a survivor-centered approach to CRSV has emerged, particularly since 2008. The authors identify 3 significant clinical, ethical, and legal lessons: (1) international humanitarian law, as articulated in the Geneva Conventions and other legal instruments, requires clinicians to adopt a holistic approach to care; (2) during or after any conflict in which CRSV has allegedly been inflicted, a clinician may be required to provide evidence to an official investigatory body or court; and (3) infliction of rape in any conflict may equate to commission of torture and possibly genocide, a reality which obliges every clinician to appreciate that a patient may simultaneously be a victim of human rights violations and of crimes.

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Conflict-Related Sexual Violence Law Before 1948

It was a sign of the far-sightedness of President Abraham Lincoln, a lawyer by profession, that on April 24, 1863, he issued what is commonly known as the Lieber Code.[1] This groundbreaking legal manual and by-product of the US Civil War is indelibly associated with the Berlin-born Francis Lieber, a naturalized US citizen and academic.[2,3] For all of its defects and deficiencies when viewed from the standpoint of the 21st century, Articles 44 and 47 of the Lieber Code were ahead of their time in that each was drafted in a way that embodied an express reference to rape. Under Article 44, "All wanton violence committed against persons in the invaded country" and *inter alia* "all rape" are "prohibited under the penalty of death, or such other severe punishment as may seem adequate for the gravity of the offense."[1] Under Article 47 of the Lieber Code, "Crimes punishable by all penal codes, such as arson, murder, maiming, assaults,

highway robbery, theft, burglary, fraud, forgery, and rape, if committed by an American soldier in a hostile country against its inhabitants, are not only punishable as at home, but in all cases in which death is not inflicted, the severer punishment shall be preferred."[1] Not surprisingly, the Lieber Code forms an integral part of the background of modern legal manuals devoted to the conflict-focused area of international law now known as international humanitarian law (IHL), otherwise known as the law of war or law of armed conflict. Such manuals include the US Department of Defense *Law of War Manual*. Its preface, signed by Stephen W. Preston, general counsel of the Department of Defense, openly acknowledges the debt owed to the Lieber Code:

> This manual has many distinguished antecedents that have provided important guidance to the US Armed Forces. For example, General Order No. 100, the Instructions for the Government of Armies of the United States in the Field, commonly known as the Lieber Code, was prepared by Professor Francis Lieber and approved by President Abraham Lincoln during the Civil War in 1863.[4]

Notwithstanding the express references to rape in Articles 44 and 47 of the Lieber Code and the implicit prohibitions against rape in the Hague Conventions of 1899 and 1907,[5,6] IHL and its counterpart, international criminal law (ICL),[7,8] were slow to acquire effective mechanisms for punishing international crimes. This was demonstrated by the mass inhumanities, including rapes, unquestionably committed during the First World War[9,10] and by the widespread impunity that followed.[11]

Even after the Second World War, IHL and ICL were likewise slow to recognize rape as a weapon of war that needed to be treated as a priority to be confronted. Thus, despite compelling rape-related evidence incriminating the armed forces of Germany[12,13,14] and, indeed, some of her enemies,[15] rape was not expressly mentioned in either the agreement relating to the International Military Tribunal at Nuremberg or the Charter of the Tribunal, as adopted by France, the United Kingdom (UK), the United States, and the Union of Soviet Socialist Republics (USSR) on August 8, 1945.[16] Nor was rape expressly mentioned in the indictment issued before the start of the historic first postwar trial held in Nuremberg.[16] In consequence, it is hardly surprising that there is no express reference to rape in the judgment handed down by the four judges—from France, the UK, the US, and the USSR respectively—at the close of this breakthrough in international criminal justice that unfolded from November 14, 1945 until October 1, 1946.[16]

By contrast, rape was expressly cited in the indictment of the International Military Tribunal for the Far East[17] (despite not being expressly mentioned in the charter, dated January 19, 1946[18]). Furthermore, in the context of crimes against humanity, rape was expressly discussed in the judgment of the International Military Tribunal for the Far East, as handed down in 1948. Nevertheless, the victims of rape were not invited to present evidence before the tribunal in Tokyo and, accordingly, their voices were not heard.[19]

By 21st century standards, it is astounding that rape was omitted from the indictment prepared by the American, British, French, Soviet prosecutors for the first postwar trial at Nuremberg, although French and Soviet prosecutors went on to adduce evidence of rape before the tribunal there.[19] It is equally astounding that, although the postwar tribunal in Tokyo considered the issue of rape to a far greater extent, it overlooked the pressing of thousands of "comfort women" into enforced prostitution in "Japanese military brothels."[19] These omissions, however, may have reflected a transnational culture that was uncomfortable with the crime of rape and, in a sense, treated it as a taboo. The transcript of an address, published on August 24, 1953, by US Supreme

Court Associate Justice Robert H. Jackson, who had previously served as the chief US prosecutor in Nuremberg, is illustrative of this culture. In the context of what he depicted as the "large gap between the number of estimated crimes and the number of reported crimes," Jackson turned his attention to a question of eternal importance which he articulated as follows: "Why do people not report crimes?" In response, he said something characteristically honest that offers a glimpse into one of the brains behind the indictment and related prosecutions at Nuremberg: "Sometime ago I read of a lawyer who advised his daughter not to appear as complaining witness in a rape case. I had a lot of sympathy with him. I am not sure, with the modern methods of publicity, that I would report a rape in my family. We need every possible incentive to disclose, not to cover up, crime."[20]

Without in any way wishing to undermine the lasting legacy of a legal heavyweight whose place in history is secure, the authors of this article cannot imagine any judge, let alone any member of the US Supreme Court, venturing such thoughts in public in the 21st century. Yet Jackson evidently had no qualms about venturing them in 1953.

Conflict-Related Sexual Violence Law Since 1948

Since 1948, the year in which the tribunal in Tokyo handed down its judgment, a sea change has occurred in IHL and its approach to rape as well as forms of conflict-related sexual violence (CRSV). In turn, this sea change has had deep implications, not least of all for members of the legal profession,[21,22] the medical profession,[23,24,25,26] and other related professions. The sea change began to crystallize upon the adoption, on August 12, 1949, of the Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War (to which the US is a state party).

Under Section 1, Article 27 of the convention, "Women shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault."[26] Article 27 plugged the conspicuous gap in IHL that existed in view of the shortcomings of the 1945 charter and subsequent judgment of the International Military Tribunal at Nuremberg. To quote from the Commentary to the Fourth Geneva Convention, published in 1958 by the International Committee of the Red Cross (ICRC), the guardian of the 4 Geneva Conventions:

> Paragraph 2 [Article 27.2] denounces certain practices which occurred, for example, during the last World War, when innumerable women of all ages, and even children, were subjected to outrages of the worst kind: rape committed in occupied territories, brutal treatment of every sort, mutilations etc. In areas where troops were stationed, or through which they passed, thousands of women were made to enter brothels against their will or were contaminated with venereal diseases, the incidence of which often increased on an alarming scale.
>
> These facts revolt the conscience of all mankind and recall the worst memories of the great barbarian invasions. They underline the necessity of proclaiming that women must be treated with special consideration. That is the object of this paragraph, which is based on a provision introduced into the Prisoners of War Convention in 1929, and on a proposal submitted to the International Committee [of the Red Cross] by the International Women's Congress and the International Federation of Abolitionists.[27]

Although Article 146 of the Fourth Geneva Convention imposed an obligation on every state party "to provide effective penal sanctions" for any "grave breaches" of the same convention,[26] none of the four Geneva Conventions of 1949 created any international criminal court with prosecutorial and judicial arms. Thus, for decades after 1949, the fine words in these 4 conventions could not be effectively enforced unless a state subject to them either voluntarily chose to abide by their terms or, in the event of a

breach by military personnel or civilians under their jurisdiction, voluntarily opted to enforce them via the domestic military or criminal justice systems. Against this unsatisfactory background, rape and other forms of CRSV remained an odious feature of various conflicts, such as the one in which US forces were immersed in Vietnam until the US withdrawal in 1975[28] and the one in Afghanistan in the years after the Soviet invasion in 1979.[29]

On May 25, 1993, the post-1946 sea change in IHL was given international teeth, albeit in a limited geographical context, when the UN Security Council (UNSC) established the International Criminal Tribunal for the former Yugoslavia (ICTY).[30] When the US endorsed this move, its ambassador to the UN, Madeleine Albright, proclaimed: "We must ensure that the voices of the groups most victimized are heard by the Tribunal. I refer particularly to the detention and systematic rape of women and girls, often followed by cold-blooded murder."[31]

On a global basis, more international teeth were added to IHL after the opening of the International Criminal Court (ICC) on July 1, 2002, upon the coming into force of the Rome Statute on the International Criminal Court of 1998 (to which the US is a signatory but not a state party).[32] Article 7.1(g) of the Rome Statute defines a crime against humanity in a way that encompasses "Rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization, or any other form of sexual violence of comparable gravity" provided any such "form of sexual violence" is "committed as part of a widespread or systematic attack directed against any civilian population, with knowledge of the attack." Meanwhile, under Article 8 (2)(a)(xiii) and other provisions of the Rome Statute, "sexual violence" of lesser gravity is capable of being a war crime.[33] Since 1993, cases involving alleged CRSV have been brought before the ICTY and ICC in addition to other international criminal courts, notably the International Criminal Tribunal for Rwanda (ICTR) and Special Court for Sierra Leone (SCSL).

For clinicians, the impact of these developments was illustrated by the pivotal role of Dr Idriz Merdžanić in the ICTY case of *Prosecutor v Milomir Stakić*.[34,35] In the words of a profile published by the ICTY, Dr Merdžanić was "a Bosnian doctor who treated victims of the Trnopolje Camp" and who "testified on 10 and 11 September 2002 in the case against Milomir Stakić."[36] In a judgment handed down on July 31, 2003, the ICTY found Stakić guilty of various crimes, including persecution committed by acts such as rape and sexual assault. To quote from the ICTY profile:

> In the months that Dr. Merdžanić was at the [Trnopolje] camp, he treated women who had been raped. From the clinic window, Dr, Merdžanić and his colleagues could see men go into the women's sleeping quarters at night, flash their lights at the women they liked and take them out. Some of the women later came to the clinic to ask for help. Dr. Merdžanić succeeded in having a number of them sent to the gynaecological ward in Prijedor to investigate their allegations. He later found out that they had indeed been raped.[36]

In its judgment, the ICTY repeatedly cited the evidence presented by Dr Merdžanić, which it evidently regarded as credible.[34,35,36]

What can clinicians learn from the case of *Stakić*? Perhaps the most obvious moral of the case is that, in exceptional conflict-related circumstances, a clinician may face incidents of CRSV as harrowing as those witnessed by Dr Merdžanić. Despite the stresses these incidents will unavoidably create, clinicians must maintain their professionalism, exercise moral courage, and reach rational decisions. In parallel, as explained in more detail below, clinicians must appreciate that any episode of CRSV

unfolding before their eyes may one day be the subject of an official investigation or court case in which their actions or omissions are scrutinized.

Accordingly, however difficult it might be under the intensely pressurized conditions and climate of coercion that any conflict is inclined to generate,[37] a clinician must comply with the law and the principles of medical ethics, such as those adopted by the UN General Assembly in 1982.[38] To these ends, some professional bodies have published guidance aimed at clinicians serving within or beyond the armed forces. An example of the former is "Ethical Decision-Making for Doctors in the Armed Forces: A Tool Kit," a joint publication of the British Medical Association and its Armed Forces Committee.[39] The opening 2 paragraphs and the "key messages" constituting the final paragraphs encapsulate the legal and ethical challenges facing physicians in the regular armed forces of a democratic state subject to the rule of law:

> Doctors working in the armed forces owe the same moral obligations to their patients, whether comrades, enemy combatants or civilians, and are subject to the same ethical standards as civilian doctors. The extremity of the circumstances in which military doctors operate can make it difficult at times to understand how best to fulfil these obligations.
>
> Unlike the majority of civilian doctors, military doctors can also be subject to significant competing or dual loyalties. Ethical obligations to individual patients may come into conflict with the demands of military necessity or with perceived obligations to the operational unit. For example, a doctor's duty of confidentiality will potentially come into tension with his or her obligation to keep commanders informed of an individual patient's fitness for active service. Of course these simultaneous duties do not inevitably create a conflict, and neither are they unique to military medicine. Occupational health physicians and prison doctors have similar dual obligations, which must be carefully managed…
>
> Key messages
> - Abusive situations rarely emerge suddenly.
> - Perpetrating, being present at, being aware of, or being suspicious of abuse, and doing nothing about it, are all unacceptable and unjustifiable.
> - Physicians should be aware of the factors which can influence the likelihood that they will recognise or report unethical or abusive practices.
> - Physicians should keep their own record of all action they take in respect of reporting abuse.[39]

Clinicians can learn at least one other thing from the successful prosecution of Stakić and his conviction in 2003. The case of *Stakić* belongs to a wider pattern of prosecutions in which CRSV has been given the prominence it deserves; in turn, that pattern underlines the linkage between CRSV, the essentiality of post-violence health care, and the delivery of criminal justice. In the words of the UN publication on the ICTY, ICTR, and SCSL:

> Sexual violence form part of convictions of genocide, crimes against humanity and war crimes. Sexual violence against civilians also takes various forms and constitutes or is part of different crimes at the three courts. For example, rape and other forms of sexual violence constitute or form part of the crimes of torture, enslavement, sexual slavery and persecution as crimes against humanity; of torture and outrages upon personal dignity as war crimes; and of serious bodily or mental harm as genocide.[40]

Centering Survivors

Since 2008, a new phenomenon has emerged—the UN-backed "survivor-centered approach" to CRSV.[41] This approach is a by-product of a string of CRSV-focused resolutions of the UNSC.[42] The first was Resolution 1820, adopted by the UNSC, with US support, on June 19, 2008. Among its provisions is the following:

> [Urging] all parties concerned, including Member States, United Nations entities and financial institutions, to support the development and strengthening of the capacities of national institutions, in particular of judicial

and health systems, and of local civil society networks in order to provide sustainable assistance to victims of sexual violence in armed conflict and post-conflict situations.[43]

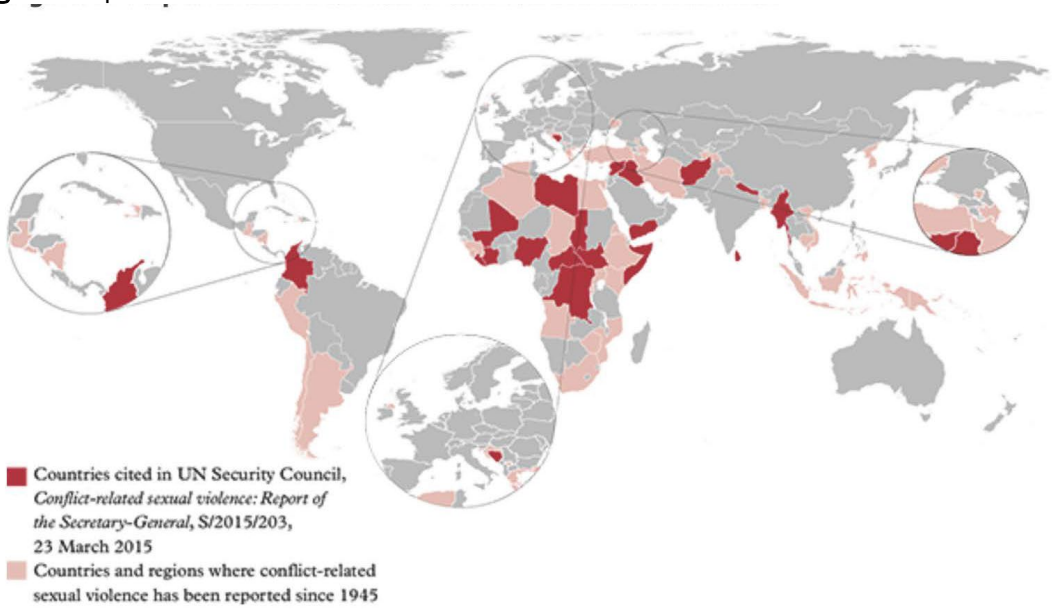
More recently, on April 23, 2019, the UNSC adopted Resolution 2467 on CRSV, with eventual US support.[44] Tellingly, its preamble not only acknowledges "the responsibilities of States to end impunity and to prosecute those responsible for crimes of genocide, crimes against humanity, and war crimes, perpetrated against civilians,"[44] but also recognizes "the need for a survivor-centered approach in preventing and responding to sexual violence in conflict and post-conflict situations,"[44] the parallel "need for survivors of sexual violence to receive non-discriminatory access to services such as medical and psychosocial care to the fullest extent practicable," and the related "need to be free from torture and cruel, inhuman or degrading treatment."[44] The operative paragraphs of Resolution 2467 include one reiterating a previous "demand" of the UNSC "for the complete cessation with immediate effect by all parties to armed conflict of all acts of sexual violence and its call for these parties to make and implement specific time-bound commitments to combat sexual violence."[44] Another calls on "all Member States to ensure that survivors of sexual and gender-based violence in conflict in the respective countries receive the care required by their specific needs and without any discrimination."[44] Resolution 2467 goes on to affirm "that victims of sexual violence, committed by certain parties to armed conflict, including non-state armed groups designated as terrorist groups, should have access to national relief and reparations programmes, as well as health care, psychosocial care, safe shelter, livelihood support and legal aid."[44]

All in all, as the UN emphasizes, Resolution 2467 is "a powerful new instrument in our fight to eradicate this heinous crime, significantly strengthening prevention through justice and accountability and affirming, for the first time, that a survivor-centered approach must guide every aspect of the response of affected countries and the international community."[45]

Three Lessons

As CRSV remains a global problem (see Figure), clinicians must understand its medico-legal implications[46,47,48] in light of relevant ethical, clinical, and legal lessons of history. Three are identified below.

Figure. Map of Sexual Violence in Conflict-Affected Countries



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Lesson 1. The first lesson is that, in common with other clinicians, physicians are integral to IHL.[50,51,52] To quote Jean Pictet, a towering figure in the history of the ICRC and co-drafter of the Geneva Conventions of 1949: "International humanitarian law, whose purpose is to attenuate the evils of war, has been intimately bound from its earliest days to physicians and all others whose mission in life is to heal—the noblest of all professions."[53]

During any conflict or subsequent occupation, it is all but inevitable that clinicians will be affected by IHL. In such circumstances, clinicians serving in uniform in regular armed forces will be subject to protections accorded by IHL, such as those in Chapter III (entitled "Medical Units and Establishments") of the First Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of 1949. They will additionally be subject to the prohibitions recognized by IHL, such as the prohibitions in each of the 4 Geneva Conventions of 1949 against "wilful killing, torture or inhuman treatment, including biological experiments, wilfully causing great suffering or serious injury to body or health" (Article 50 of the First Geneva Convention of 1949, Article 51 of the Second Geneva Convention of 1949, Article 130 of the Third Geneva Convention of 1949 and Article 147 of the Fourth Geneva Convention of 1949).[26] At the same time, clinicians will remain subject to the domestic law of the country they are serving, the service law applicable to the armed forces to which they are attached, and the overall military justice system connected to that service law.[54] To cap it all, every clinician will remain subject to the regulatory and disciplinary systems of their specific branch of their specific profession.

With respect to whether a clinician is a combatant or noncombatant during any conflict, the relevant rules of IHL are complex and not easy to summarize in a relatively short article such as this. It suffices to quote from *The Joint Service Manual of the Law of Armed Conflict*, a publication of the Ministry of Defence of the UK:

> Some members of the armed forces of a state (medical personnel and chaplains) are classed as non-combatants and do not have the right to take a direct part in hostilities.... The expression "medical personnel" is not confined to doctors and nurses but also embraces a wide range of specialists, technicians, maintenance staff, drivers, cooks, and administrators provided that they are exclusively assigned to the medical staff. Non-combatant members of armed forces who participate directly in hostilities may expect to forfeit that noncombatant status. They also render themselves liable to trial and punishment. Non-combatant members of the armed forces are, however, legally permitted to defend themselves against acts of violence which are directed against them and, for this purpose, the use of firearms may be justified. Medical personnel do not forfeit their protection under Geneva Convention I 1949 [ie, the First Geneva Convention of 1949] by being armed and by using those arms in their own defence or in the defence of the wounded and sick in their charge.[55]

Other clinicians may not be in uniform, but they may work within the health care system of the country where a conflict is unfolding or where an occupation has ensued. As such, clinicians, irrespective of whether they are members of the armed forces, must be protected by—and must respect—the prohibitions imposed by IHL; these include those recognized by each of the 4 Geneva Conventions mentioned above. Accordingly, if a clinician falls afoul of IHL, this may trigger professional disciplinary proceedings (eg, for allegedly infringing an ethical principle or regulatory rule), domestic civil proceedings (eg, for alleged negligence), criminal court or court martial proceedings (eg, for allegedly aiding and abetting a rapist) or, in exceptional circumstances, international criminal proceedings (eg, for alleged complicity in a crime against humanity or a war crime).

In this context, all clinicians should be familiar with the *Doctors Trial*, which formed part of the second wave of trials instituted at Nuremberg during the late 1940s. Clinicians should likewise be familiar with the lessons to be derived from the case[56] and with the Nuremberg Code on Medical Experimentation, which has become synonymous with it.[57] In the *Doctors Trial*, 23 defendants, 20 of whom were physicians, were put on trial before the US Military Tribunal. On August 20, 1947, 16 of the defendants were found guilty, with 7 of these sentenced to death.[58,59] The following extract from the judgment encapsulates the essence of the case against the doctors who were found guilty:

> Judged by any standard of proof the record clearly shows the commission of war crimes and crimes against humanity substantially as alleged in counts two and three of the indictment. Beginning with the outbreak of World War II criminal medical experiments on non-German nationals, both prisoners of war and civilians, including Jews and "asocial" persons, were carried out on a large scale in Germany and the occupied countries. These experiments were not the isolated and casual acts of individual doctors and scientists working solely on their own responsibility, but were the product of coordinated policy-making and planning at high governmental, military, and Nazi Party levels, conducted as an integral part of the total war effort. They were ordered, sanctioned, permitted, or approved by persons in positions of authority who under all principles of law were under the duty to know about these things and to take steps to terminate or prevent them.[60]

The *Doctors Trial*, together with more recent cases involving clinicians accused of international crimes, such as *Prosecutor v Elizaphan and Gérard Ntakirutimana*,[61] have been discussed elsewhere,[62] and ought to be familiar to every clinician.

In the light of the legal history sketched out above, each case involving an allegation of CRSV against a clinician or any other person will turn on its facts, the applicable laws, the available evidence, and the critical issue of whether—and, if so, how—the wheels of justice are activated. If the wheels of domestic justice are activated in a fair manner via the criminal or military justice system of, say, the state responsible for a soldier alleged to have engaged in CRSV, the case is unlikely to reach an international criminal court. However, since its establishment in 1998, the ICC has, in theory, served as a

prosecutorial and judicial backstop which can field cases where impunity is alleged to have prevailed.

In practice, but subject to the caveats mentioned elsewhere in this article, the first lesson requires every clinician to comply with the applicable laws and to adhere to medical ethics[63,64,65] while staying safe[66] and ensuring that an alleged victim of CRSV benefits from a holistic survivor-centered approach.[67,68] As the UN warns: "Individuals must be given appropriate information to enable them to take informed decisions regarding their medical, sexual, reproductive, psychosocial, psychological, legal, and security needs, as well as their participation in justice and accountability processes."[69] To these ends, in addition to treating an alleged victim of CRSV, it is ethically appropriate for clinicians to go further by, for example, reminding the patient that they may seek—and may be entitled to—other forms of advice and support. These will invariably include independent legal advice from a suitable lawyer in addition to any available legal aid.[70,71]

Lesson 2. The second lesson is that during or after any conflict in which CRSV has allegedly been inflicted, a clinician may be invited or required to provide evidence to a police investigation, an official inquiry or other investigatory body, or a court. In such circumstances, the precise nature of each clinician's involvement will be determined by the answers to various questions. Such questions include the following:

- Is the clinician a victim of CRSV, an alleged perpetrator of CRSV, an accomplice or accessory of the alleged perpetrator, a witness to an alleged act of CRSV (ie, a fact witness), an expert witness, or otherwise involved in the case?

- What is the status of the clinician—a member of a medical unit or other unit of the regular armed forces of a sovereign state, a clinician in a civilian hospital or other nonmilitary medical setting, an alleged *de facto* member of irregular forces or proscribed terrorist organisation, or a member of another category?

- Does the case involve an alleged crime, such as rape; an alleged civil wrong, such as an alleged act of medical negligence during the treatment of the patient; an alleged act of professional misconduct, such as a breach of patient confidentiality; or an alleged violation of constitutional or human rights for which a public body, a government or the state itself is allegedly responsible?

- In a criminal case, is the applicable law domestic criminal law, service law, domestic civil law, domestic or international human rights law, or IHL and, through that, ICL? If the case involves domestic criminal law but within a transnational setting (eg, because the alleged perpetrator is a member of the armed forces on deployment overseas), which country's domestic criminal law applies?

- What is the identity of the state whose law enforcement authorities have acted upon an allegation of CRSV? What is the precise nature of the allegation itself? Which are the applicable rules of evidence? And, if the case is litigated, which are the relevant court procedures? Indeed, if the case does reach court and if the clinician is required to participate as, say, a fact witness, other questions will arise, not least on account of the requirements of the specific professional code

> of conduct binding upon the clinician and of any pertinent guidance issued by the professional or regulatory body under whose ambit the clinician falls.[72,73]

In turn, the second lesson underlines the indispensability of accurate, comprehensive, and contemporaneous medical records.[74] It likewise highlights the ethical dilemma that may arise if a clinician is caught between, on the one hand, the duty to maintain patient confidentiality, private information, and personal data and, on the other hand, a parallel duty to comply with any court order or law requiring the release of patient details.[75,76]

The second lesson is not only illustrated by the testimony of the aforementioned Dr Merdžanić in the case of *Stakić*. It is also illustrated by the historic 2-volume report of the then European Commission on Human Rights, adopted on July 10, 1976, in the case of *Cyprus v Turkey*.[77] In an investigation prompted by grave allegations that Turkey was responsible for, among other things, "Wholesale and repeated rapes" after Turkey had invaded the Republic of Cyprus in 1974, the commission paid particular attention to the evidence presented by two medical witnesses—Dr Kostas Hadjikakou, a doctor in the field of orthopaedic medicine, and Dr Xanthos Charalambides, a gynaecologist. In its evaluation of the evidence, the Commission was particularly impressed by the written and oral evidence that each doctor gave:

> The Delegation noted that the two medical witnesses, Drs. Hadjikakou and Charalambides, endeavoured to be precise and to avoid any exaggeration. Their statements were corroborated by the other witnesses … and by the great number of written statements submitted. The Commission is therefore satisfied that the oral evidence obtained on this item is correct.[77]

In the Commission's assessment, "The evidence shows that rapes were committed by Turkish soldiers and at least in two cases even by Turkish officers, and this not only in some isolated cases of indiscipline."[77] Thus, the Commission found, "by 12 votes against one," that "the incidents of rape [identified in the Report] … and regarded as established constitute 'inhuman treatment' in the sense of Art. 3 of the [European] Convention [on Human Rights], which is imputable to Turkey"[77,78]; under Article 3 of the Convention, "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."[79] There was a clear correlation between the Commission's conclusion and the credible evidence presented by the 2 aforementioned physicians.

Lesson 3. The third lesson is that, given developments in international human rights law (IHRL)[80] and IHL[81,82] since the late 1990s, the infliction of rape in any domestic or international conflict is considered not only inhuman but also capable of being equated to the commission of torture and even genocide. Accordingly, international law on rape has broadened since 1976 when, in the aforementioned case of *Cyprus v Turkey*, the Commission only went as far as to regard rape as inhuman.

In IHRL, the potential nexus between rape and torture was established in 1997 in *Aydin v Turkey*.[83] This landmark case arose from the long-standing internal conflict in southeast Turkey. As confirmed by the European Court of Human Rights (ECtHR), the case arose after "a Turkish citizen of Kurdish origin" alleged that, when aged 17, she had been raped and otherwise physically and mentally mistreated while "in detention" in Turkey at the hands of "security forces."[83] In its judgment, the ECtHR held that "the accumulation of acts of physical and mental violence inflicted on the applicant and the especially cruel act of rape to which she was subjected amounted to torture in breach of Article 3 of the Convention [prohibiting *inter alia* torture]." Thus, the ECtHR concluded that there had been a "violation" of Article 3 for which Turkey was responsible.[83]

In 1998, in the case of *Prosecutor v Zejnil Delalic*, the ICTY held that, for the purposes of IHL, rape could likewise amount to torture if certain specific conditions were satisfied.[84,85] In another case that same year, *Prosecutor v Jean-Paul Akayesu*, the ICTR reached a similar conclusion[86] while going even further by holding that, given the facts in that case, "rape and sexual violence … constitute genocide."[86] In the same case, the ICTR defined rape as "a physical invasion of a sexual nature, committed on a person under circumstances which are coercive."[86] The use of the word *person* indicates that males and females are capable of being victims of rape for the purposes of IHL. This word choice is consistent with the principle of equality before the law, which is widely considered to be a cornerstone of the rule of law.[87,88,89]

For the clinician, these legal realities raise at least one awkward ethical issue. On the one hand, a clinician must appreciate that the patient may simultaneously be a victim of torture and possibly even genocide.[90] The patient may thus be the survivor of crimes and human rights violations, if not other illegal acts.[91] Given the traumatic ordeal potentially experienced by the patient, the clinician must therefore have justice in mind while maintaining patient confidentiality and treating the patient with particular care, sensitivity, and respect for human dignity.[92,93] At the same time, as already indicated above, the clinician should maintain accurate, comprehensive, and contemporaneous medical records. Subject to certain conditions being met, those notes may have to be produced as evidence before a domestic court[94,95] or, in exceptional circumstances, an international court of law.[96,97,98] The clinician may thereby help justice to be served. On the other hand, a clinician must approach any alleged victim of rape with a nonjudgmental open mind[99] and without stepping into the shoes of a police investigator, lawyer, or judge. To that extent, the UN's promotion of the term *survivor* is somewhat problematic. After all, at first sight, it appears to rest on an inappropriate assumption—that an alleged survivor of CRSV (ie, a person claiming to be a survivor) is a survivor. That is not necessarily so. Nor is it necessarily the case that an alleged perpetrator of CRSV is a perpetrator. An alleged perpetrator remains such while benefiting from the presumption of innocence until either a guilty plea or conviction following a fair process.

Albeit in a non-CRSV context, the conviction in England in 2019 of the fantasist, Carl Beech, serves as a salutary reminder that an alleged victim of a sexual crime may not necessarily be telling the truth. Before being unmasked, Beech made a string of sensational allegations about the alleged wrongdoing of prominent personalities. In turn, these allegations were widely reported by the media, echoed by parliamentarians, and, in circumstances that became intensely controversial, investigated by the police. Eventually, after evidence emerged that Beech was a fantasist, he was prosecuted and convicted of 12 counts of perverting the course of justice.[100] Beech was also exposed for other reasons "after indecent images were found on his electronic devices."[100] The scale of the criminality of Beech is clear from the Sentencing Remarks issued by the judge in Newcastle Crown Court upon handing the convicted Beech a total sentence of 18 years of imprisonment.[101] For the purposes of this article, it suffices to quote just the opening 2 sentences:

> Between December 2012 and March 2016 you [ie, Carl Beech] deliberately, repeatedly and maliciously told lies to the police and the Criminal Injuries Compensation Authority falsely claiming that, as a child between the ages of 7 and 15, you had been a victim of appalling sexual and physical abuse, had witnessed other children being similarly abused and seen three children being murdered. You falsely accused a number of well-known public figures including politicians, very senior military figures and the heads of the intelligence services, many of whom had since died but some were still alive, of having been members of paedophile groups and the perpetrators.[101]

For clinicians, what makes the case of *R v Carl Beech* particularly instructive are at least 2 factors. Firstly, the case reminds us that there may be bad apples among the ranks of ethical, honest, and otherwise professional clinicians. In the words of the judge in his Sentencing Remarks, Beech was "a trained paediatric nurse" as well as "a nursing manager before becoming a Care Quality Commission inspector,"[101] the Care Quality Commission being the independent statutory regulator of health and audit social care in England. Yet, despite this professional background, which should have instilled Beech with a sense of professionalism infused with ethics, his "actions," in the words of the Sentencing Remarks, "traduced reputations by maliciously making lurid and the most serious false allegations" that caused "distress, anger and loss … to the individuals … accused and their families, some of whom died during the process."[101] Secondly, the case of *R v Carl Beech* reminds us that, although an allegation of rape or sexual crime must be taken seriously and investigated effectively by the police, the allegation remains an allegation pending any lawful plea of guilt or conviction. This reminder flows from the oft-quoted observations of Mr Justice Megarry in a much earlier English case reported in 1970:

> As everybody who has anything to do with the law well knows, the path of the law is strewn with examples of open and shut cases which, somehow, were not; of unanswerable charges which, in the event, were completely answered; of inexplicable conduct which was fully explained; of fixed and unalterable determinations that, by discussion, suffered a change.[102]

In his independent review of the Metropolitan Police Service's handling of nonrecent sexual offence investigations alleged against persons of public prominence, Sir Richard Henriques, a retired judge of the High Court of England and Wales, was damning in his criticism of the widespread police practice of "believing" a "victim" of sexual abuse:

> I understand the strategic aim of improving the Police Service response to complaints of sexual abuse and the aim to make it easier for victims of sexual abuse to make a complaint to the police. The officers steadfastly insist that the "victim must be believed during the taking of the statement." I disagree. It is the duty of a police officer to investigate. Many decisions in the criminal justice process have to be taken on paper. The police officer taking a statement from a complainant has a unique opportunity to assess the complainant's veracity. The effect of requiring a police officer, in such a position, to believe a complainant reverses the burden of proof. It also restricts the officer's ability to test the complainant's evidence.[103]

Hence Recommendation 2 of Sir Richard Henriques states:

> The instruction to "believe a 'victim's' account" should cease. It should be the duty of an officer interviewing a complainant to investigate the facts objectively and impartially and with an open mind from the outset of the investigation. At no stage must the officer show any form of disbelief and every effort must be made to facilitate the giving of a detailed account in a non-confrontational manner.[103]

Hence also a related warning issued by Sir Richard Henriques, which states: "In fact, nobody knows, nor can ever know, the extent of false complaints. It is critical, however, that those charged with the responsibility of investigating crime, or instructing others in that process, have in mind the real, as opposed to the remote, possibility that a complaint may be false."[103]

Henriques' review is not immaterial to clinicians. Whenever a clinician encounters a patient alleging that they are the victim of CRSV or other crime and that another named or unnamed person is the perpetrator, the clinician must maintain a nonjudgmental open mind. On the one hand, the patient may be telling the truth. On the other hand, the patient may be telling a pack of lies.

Conflict-Related Sexual Violence and Abortion

In the context of CRSV, it would be remiss of the authors not to mention the sensitive issue of abortion. After all, during or in the aftermath of any conflict, a patient may seek medical advice with the aim of terminating an unplanned pregnancy caused by an alleged rape. To that end, the victim may consult a clinician who happens to have sincere conscientious objections to abortion. In such circumstances, the clinician cannot react by burying their head in the sand. At the very least, that may amount to professional misconduct. Instead, the clinician must respond in line with the law, any applicable code of professional conduct, and any relevant ethical guidance issued by the clinician's regulator. An example is the guidance published by the General Medical Council, the regulator of physicians in the UK, entitled "Personal Beliefs and Medical Practice."[104] Among its contents is a reminder of the provisions of paragraph 52 of "Good Medical Practice," the code of conduct binding upon physicians in the UK:

> 52. You must explain to patients if you have a conscientious objection to a particular procedure. You must tell them about their right to see another doctor and make sure they have enough information to exercise that right. In providing this information you must not imply or express disapproval of the patient's lifestyle, choices or beliefs. If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.[105]

There is so much more to the ethico-legal dimensions of abortion,[106] and this article has merely scratched the surface. The fact remains that, due to the nature of CRSV, the ethico-legal dimensions of abortion could suddenly come to the fore during any conflict or occupation. Accordingly, an individual clinician must know how to respond.

Conclusion

International law vis-à-vis CRSV has undergone a sea change since 1945—so much so that, as the North Atlantic Treaty Organization recognized on June 1, 2021, CRSV "can amount to a serious violation of International Law," including IHL and IHRL; CRSV can likewise "amount to a crime under international criminal law and in some jurisdictions, under domestic law."[107] The sea change has also resulted in the UNSC not only embracing a holistic survivor-centered approach to CRSV but also adopting UNSC Resolution 2467.

For all of its importance, Resolution 2467 will have no practical effect unless all states ratify the core instruments of IHL, adhere to them, and enforce them. Failing that, Resolution 2467 will likewise have no practical effect unless the UNSC, the ICC, and other appropriate international bodies exercise their powers consistently in order to give practical meaning to Resolution 2467 and its call for CRSV-related impunity to come to an end.

A survivor-centered approach has profound ethical, legal, and other implications, not least of all for any clinician who is called upon to treat an alleged victim of CRSV within or beyond a conflict zone. Such a person must respond appropriately—in line with their ethical and legal duties, in the interests of the patient, and, potentially, for the sake of justice.

Postscript

On August 15, 2021, after the first draft of this article was composed, the Taliban stormed back to power in Afghanistan. On the same day, *The Conversation* published an article with a self-explanatory title: "The world must not look away as the Taliban sexually enslaves women and girls."[108] On the following day, the UN circulated a press release[109]

that summarized the findings of a new report of the UN Secretary-General, dated July 16, 2021, and entitled "Children and Armed Conflict in Afghanistan."[110] The press release echoed a message issued by Virginia Gamba, the UN Secretary-General's special representative for children and armed conflict, who had "called for Afghanistan to uphold the criminalization of the practice of *bacha bazi*, a form of sexual abuse against boys, in line with revisions to the penal code in 2018."[111]

Thus, even before the return of the Taliban to power in Kabul on August 15, 2021, Afghanistan was already bedevilled by CRSV and the impunity that accompanied it. Since then, fresh waves of CRSV have reportedly washed over that landlocked country.[112,113] If those reports are true, the global struggle against CRSV has entered a menacing new epoch.

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Klearchos A. Kyriakides, PhD, MPhil is a senior visiting fellow in the School of Law of the Cyprus Campus of the University of Central Lancashire in the United Kingdom.

Andreas K. Demetriades, MBBChir, MPhil is a consultant neurosurgeon at the Royal Infirmary of Edinburgh, United Kingdom. Apart from his clinical research interests, he also teaches students at the University of Edinburgh Medical School as an honorary Apothecaries lecturer in the history of medicine and serves as secretary and co-vice president of the Scottish Society of the History of Medicine.

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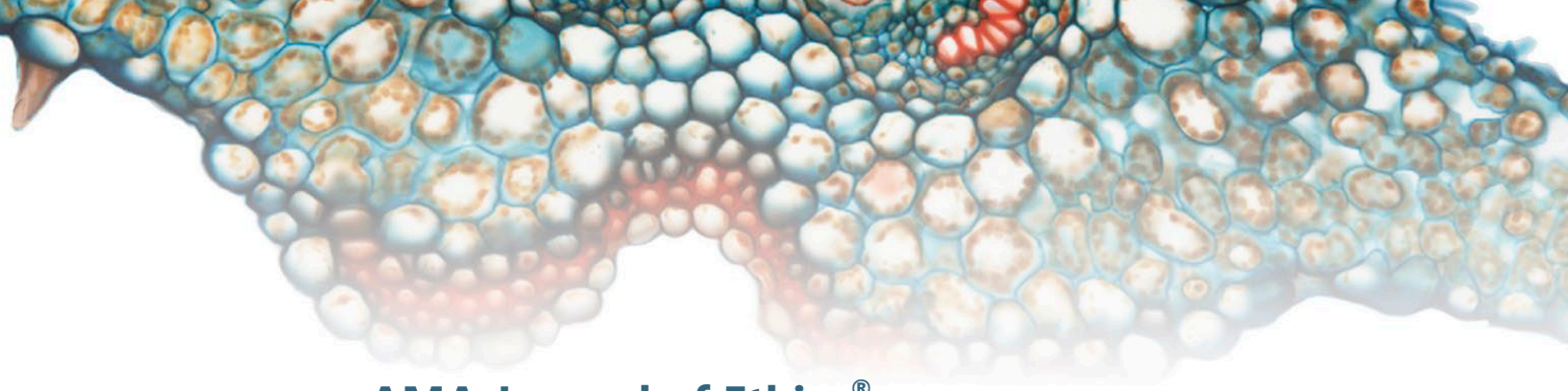

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ORIGINAL RESEARCH: PEER-REVIEWED ARTICLE

Why We Need Stricter Oversight of Research Involving Human Subjects Affected by Conflict

Anushka Ataullahjan, PhD, Samantha Lo, MSc, Mohammad Haaris Aziz, MBBCh, Nadia Amin Somani, and Zulfiqar A. Bhutta, PhD, MBBS

Abstract

Background: Despite the potential for ethical violations when research is conducted with conflict-affected populations, there is limited information on how and the extent to which ethical considerations specific to doing research with these populations are integrated into national and international ethics guidelines and, in turn, how these guidelines translate into practice. This study aims to fill this gap by systematically analyzing the existing research ethics guidance of humanitarian donor countries, conflict-affected countries, United Nations (UN) agencies, and funding agencies, as well as ethics reporting in research articles on conflict-affected populations published in peer-reviewed journals.

Methods: A review of 32 research ethics guidelines and granting regulations from UN agencies, donor agencies, and governments was conducted, and the reporting of ethics procedures and practices of 498 articles published in peer-reviewed journals was analyzed.

Results: Of the reviewed guidelines and regulations, 87.5% did not mention conflict-affected populations, and only one guideline (3.1%) catalogued any of the complexities of conducting research with conflict-affected populations. Among the reviewed published research articles on conflict-affected populations, obtaining ethics approval or a waiver was reported in only 48.2% of articles, and obtaining informed consent was reported in only 46.6% of studies. In the subset of articles that did not report receiving ethics approval, 88.5% were published in journals that required reporting of ethics approval.

Conclusions: This study highlighted a gap in current research guidelines and granting regulations on the ethical conduct of research with conflict-affected populations and illustrated the need for such guidance to be integrated into governing documents and research practices. Moreover, this study demonstrated that there is a need for stricter enforcement of

reporting requirements by journals to ensure that research with conflict-affected populations meets the required ethical standard. Partnerships among institutional ethics committees, donor agencies, and journals can ensure that the rights of conflict-affected populations are protected.

The American Medical Association designates this journal-based CME activity for a maximum of 1 AMA PRA Category 1 Credit™ *available through the* AMA Ed Hub™. *Physicians should claim only the credit commensurate with the extent of their participation in the activity.*

Unique Vulnerabilities

Individuals from conflict-affected populations have unique vulnerabilities due to a variety of different circumstances, including their personal history, citizenship status, displacement trajectory, and socioeconomic status.[1] This population includes individuals who are refugees or internally displaced persons and those living in areas of conflict. As the number of individuals affected by conflict grows to unprecedented heights,[2] research focusing on this group has also increased.[3,4,5,6,7,8,9,10] The increased risks of exploitive research practices experienced by refugees and conflict-affected populations have been described.[11] This body of literature has highlighted the complexities of obtaining informed consent and the potential for unintentional coercion, given power differentials.[1,12,13,14,15] In order to safeguard the rights of conflict-affected populations, rigorous ethics approval procedures are necessary. However, despite the potential for ethically fraught research practices (see Table 1), mechanisms to oversee research with conflict-affected populations are limited.[13] Often, institutional ethics committees do not have the capacity to monitor research practices and must rely upon insufficient scientific and technical guidance for conflict-affected populations.[1,13]

Table 1. Examples of Ethical Considerations in Research With Conflict-Affected Populations

Ethical Issue	Examples
Informed consent	A mistrust of authorities might contribute to individuals' reluctance to sign forms out of fear that they might be used to take advantage of them.[1] Individuals who are fleeing countries where governments are known to engage in coercive practices and violate human rights might not understand that they are able to refuse participation in studies.[12] The reliance on humanitarian actors to provide housing, provisions, and medical services might also unintentionally coerce individuals into participating in research.[13,14]
History of ethical violations	Instances of violations of confidentiality have generated a mistrust of foreign scholars and reluctance to participate in research.[15] At times, these breaches of trust have caused irreparable harm to participants, including instances in which research groups have disclosed the identities of women who were raped, leading to these women being shamed and scorned by the community, or disclosed the identity of a refugee and activist, placing them in immediate danger.[14]
Nonfunctional IRB	In some conflict settings, ethics review boards might not be functioning or might be entirely absent. In these cases, agencies might rely on their own ethics review policies, which might not conform to international human rights standards or law.[16]
Political pressure	Political pressure to withhold or alter data can introduce ethical dilemmas and have severe implications for the safety of researchers.[1] A recent and well-known example was the arrest of Paul Foreman, the head of Médecins Sans Frontières Holland, and Vincent Hoedt, Darfur regional coordinator in South Sudan, for publishing a report on rapes in Darfur.[17]
Tensions with impartiality	In conflict situations, being perceived as impartial might not be possible, especially when polarization in the community is so strong that if one does not favor a certain group, one is seen as the enemy.[18]

Dynamic context	In contrast to humanitarian contexts, in which the needs of populations can rapidly evolve, ethics review processes can be lengthy, slow, and create a disconnect between research design and implementation.[19]
Dual imperative	The increased vulnerabilities and risks associated with participating in research in conflict settings require that any research must be driven by the needs of the population and meet a higher standard of benefit to the population.[20]

With limited guidance on the ethical tensions that can emerge when research is conducted with conflict-affected populations, many ethics review boards struggle with reviewing applications outlining research with these populations.[14,19] Recognizing this gap, there have been increasing global efforts to codify and create guidelines for ethical research with conflict-affected populations. Among these efforts is the work of Enhancing Learning and Research for Humanitarian Assistance, a nonprofit organization that has created a research ethics tool in the form of a series of questions that allows researchers to reflect on the ethics of their work at different stages of the research process, from planning to dissemination.[21] Moreover, the Nuffield Council on Bioethics report, *Research in Global Health Emergencies: Ethical Issues*, created an ethical compass to guide research practices that highlights principles such as fairness, equal respect, and reducing suffering.[22] Similar efforts have also been initiated by independent ethics review boards, such as the one established by Médecins Sans Frontières.[1]

Despite such efforts by independent organizations, little is known about the extent to which and the ways in which national and international ethics guidelines incorporate guidance for research on conflict-affected populations. Our study aimed to fill this gap by systematically analyzing the existing ethics guidelines of humanitarian donor countries, conflict-affected countries, United Nations (UN) agencies, and funding agencies. We also aimed to understand how guidelines translate into practice by analyzing research practices in empirical articles on conflict-affected populations. Through a comprehensive review of guidance and its translation into practice, our study adds to a small but growing body of literature on research ethics for conflict-affected populations.[23]

Methods

Data sources. Using targeted Google searches and search functions on agency websites, we found national research guidelines for 17 humanitarian donor countries and unions (Australia, Belgium, Canada, Denmark, the European Union, France, Germany, Ireland, Italy, Japan, the Netherlands, Norway, Sweden, Switzerland, the United Kingdom, Spain, and the United States) that were drawn from the list of top 20 countries contributing to humanitarian assistance as identified in the 2018 Global Humanitarian Assistance Report.[24] Furthermore, using targeted Google searches and search functions on government websites, we found national guidelines from 8 conflict-affected countries (Bangladesh, Lebanon, Liberia, Nigeria, Pakistan, the Democratic Republic of Congo, Mali, Ukraine) of 20 identified. Sixteen conflict-affected countries were identified using the 2018 Harmonized List of Fragile Situations,[25] and 4 were identified by other means. Two guidelines from humanitarian donor countries (Spain, Germany) and 3 guidelines from conflict-affected countries (Democratic Republic of Congo, Mali, Ukraine) were not extracted because they were not in English. Using similar searches, research guidelines were included in the analysis from 3 UN agencies—the UN Office for the Coordination of Humanitarian Affairs, the World Health Organization (WHO), and UNICEF—of the 9 such agencies active in conflict settings that were identified from the 2018 Global Humanitarian Assistance Report,[24] and granting

regulations were included in the analysis from 9 donor agencies (the Bill and Melinda Gates Foundation, the Wellcome Trust, the Medical Research Council, the National Institutes of Health, the North American Aerospace Defense Command, the Swedish International Development Cooperation Agency, GAVI, the Global Fund, and the International Development Research Centre) (see Supplementary Appendix) from a list of 10 of the major research funding bodies and national funders (the Global Financing Facility was excluded).

We utilized the BRANCH Consortium database to identify articles for review. The BRANCH database contains articles published between January 1, 1990, and March 31, 2018, on a range of health interventions delivered to women, children, and adolescents in conflict-affected populations in lower and middle-income countries.[3,4,5,6,7,8,9,10] The database drew on 6 searches that were conducted in MEDLINE, Embase, CINAHL, and PsychINFO using keywords and medical subject heading terms (MeSH) related to conflict, health, and women, children, and adolescents. (Final searches were run between April 2018 and July 2018 for papers published between January 1, 1990, and March 31, 2018.) Articles that were not published in English or in peer-reviewed journals, that reported on military personnel, and that were single-patient case reports were excluded. Systematic reviews, editorials, opinion pieces, guidelines, and economic or mathematical modeling studies were also excluded. The analysis included a total of 498 articles published in peer-reviewed journals.

Data extraction and analysis. Guidance from donor countries and conflict-affected countries was reviewed for mention of ethical principles and related terms, such as researcher safety, confidentiality, scientific validity, collaborative partnerships, informed consent, security risks, social value, postresearch conduct, community engagement, and harm-benefit ratio. Data were also extracted on the local ethics review process and how to proceed when in-country ethics boards are not functioning. In addition, we reviewed research ethics guidelines or granting regulations from UN agencies and funding bodies to determine if studies must consider any of the ethical principles mentioned above to be eligible for funding as a way to help disentangle the role that granting agencies play in determining ethical research practice. Single data extraction was performed by 3 of the authors (S.L., M.H.A., N.A.S.).

From the articles, we extracted data on the reporting of ethics approval, informed consent, types of informed consent, funding, and collaboration. Additional searches identified ethics requirements for publication. Descriptive statistics were used to summarize key indicators related to the reporting of ethics approval and informed consent.

Results

Review of guidelines. Conflict-specific guidance was overwhelmingly absent from research guidance issued by governments, donor agencies, and UN agencies. Of the 32 research ethics guidelines and regulations reviewed, only 4 mentioned conflict-affected populations—UNICEF, WHO, the Australian National Statement on Ethical Conduct in Human Research, and the US Agency for International Development (USAID) Scientific Research Policy. None of the research guidelines from conflict-affected countries mentioned conflict-affected populations. Three guidelines grouped conflict-affected populations and/or refugees as vulnerable groups, including the USAID Scientific Research Policy, UNICEF guideline, and WHO guideline. However, these guidelines failed to highlight any specific vulnerabilities of conflict-affected populations related to their

displacement history or experiences of violence in comparison to other vulnerable groups (see Table 1 for examples).

Even fewer guidelines explicitly described procedures for research with conflict-affected populations. Only the Australian National Statement on Ethical Conduct in Human Research noted how specific ethical principles, such as researcher and participant confidentiality, fair selection of participants, and the particularities of informed consent with refugees, should be considered. The UNICEF guideline added that any research with refugees or people in conflict or in postconflict settings requires additional review but did not specify what that would entail.

Lastly, only 3 guidelines—the Australian National Statement on Ethical Conduct in Human Research, the second edition of the Canadian Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and the Wellcome Trust's policy on research involving human participants—described how to proceed when there is a nonfunctional or absent institutional review board (IRB). However, the Canadian Tri-Council Policy and Wellcome Trust policy did not explicitly link an absent IRB to research in conflict settings or with conflict-affected populations.

Review of research practices. The majority of the 498 articles published in peer-reviewed journals focused on infectious disease (20.5%); maternal, newborn, sexual, and reproductive health (19.9%); and mental health (18.7%). The geographic regions of investigation included Sub-Saharan Africa (35.7%), Western Asia (20.3%), South Asia (16.5%), and Southeastern Asia (15.5%). Many articles focused on the health of refugees (37.6%), and the most common study type was observational (73.3%) (see Table 2).

Table 2. Analysis of 498 Articles in Peer-Reviewed Journals

Variable	No. (%)
Publication year	
1990-1994	24 (4.8)
1995-1999	51 (10.2)
2000-2004	59 (11.8)
2005-2009	87 (17.5)
2010-2014	145 (29.1)
2015-2018	132 (26.5)
Region	
Africa	
Northern Africa	18 (3.6)
Sub-Saharan Africa	178 (35.7)
Americas	
Latin America/Caribbean	6 (1.2)
Asia	
Southeastern Asia	77 (15.5)
South Asia	82 (16.5)
Western Asia	101 (20.3)
Europe	

Eastern Europe	1.0 (0.2)
Southern Europe	23 (4.6)
Oceania	
Melanesia	1 (0.2)
Multiple countries	11 (2.2)
Study type	
Mixed methods	22 (4.4)
Observational methods	365 (73.3)
Qualitative methods	23 (4.6)
Quasi-experimental/nonrandomized control trial	18 (3.6)
Randomized control trial	70 (14.1)
Research participants	
Internally displaced persons	77 (15.5)
Mixed	89 (17.9)
Nondisplaced persons	54 (10.8)
Refugees	187 (37.6)
Returning refugees	4 (0.8)
Not reported	87 (17.5)
Health area focus	
Infectious diseases	102 (20.5)
Injuries	71 (14.3)
Mental health	93 (18.7)
Noncommunicable diseases	23 (4.6)
Nutrition	31 (6.2)
Sexual reproductive and maternal newborn health	99 (19.9)
Water, sanitation and hygiene	14 (2.8)
Multiple health areas	65 (13.1)
Location of authors	
National study	31 (6.2)
International study	467 (93.8)

Reporting of ethics approval was low, with only 45.8% of articles reporting that ethics approval was received and 2.4% of articles reporting that an ethics waiver was obtained. In almost half (47.3%) of the articles, the authors did not report whether they had sought ethics approval or a waiver for their study. In an additional 2.0% of articles, the authors reported that they had not sought ethics approval or a waiver exemption for their study, and in 2.4% of articles, the authors reported that they did not seek ethics approval but did not report if they had sought a waiver. No articles reported seeking ethics approval and not receiving it.

Of the 22 studies for which the authors reported that they did not seek ethics approval or a waiver or reported that they did not seek ethics approval but did not report if they sought a waiver, the stated reasons included that the study was a monitoring and evaluation study (54.5%) or used chart or secondary data (31.8%) or that there was no

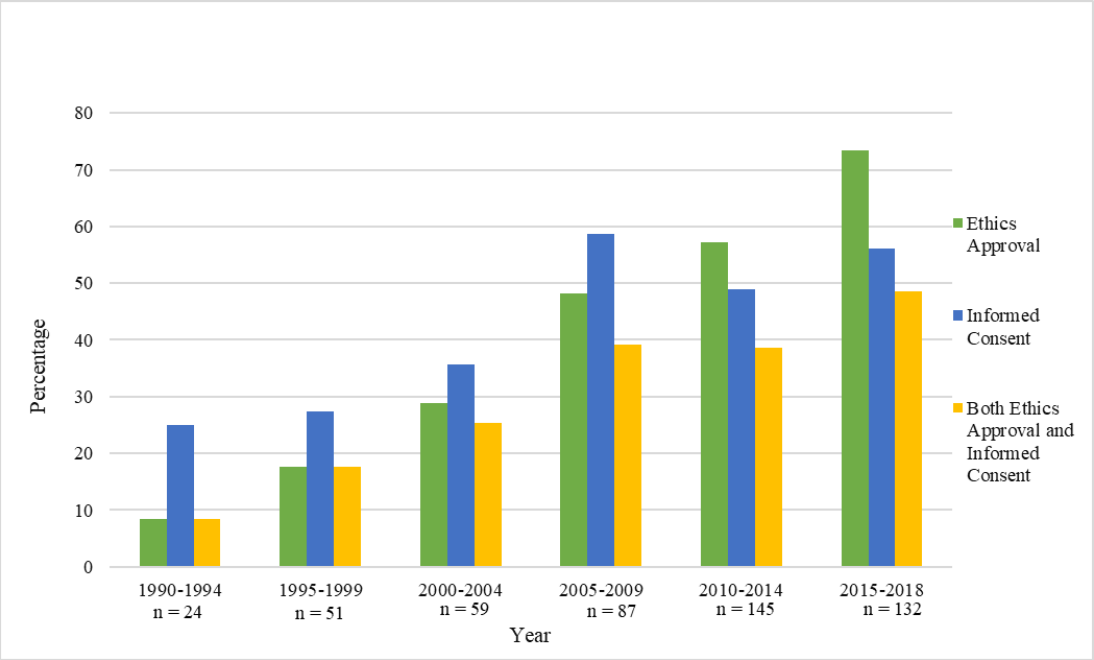
active IRB (4.5%). For the remaining 9.1% of articles, it was unclear why researchers did not seek ethics approval or a waiver.

Reporting rates of ethics approval differed greatly between international and national studies, with lower reporting of IRB approval in the subset of international studies (43.0%) than national studies (87.1%). Among international studies, in only 38.8% did the authors report receiving ethics approval from both their home institution's ethics board and the ethics board in the country of study; in 28.4%, the authors reported receiving ethics approval only from an international institution; and in 31.8%, the authors reported receiving ethics approval only from an institution in the country of study. Interestingly, 88.5% of the articles for which the authors did not report obtaining ethics approval were published in journals that required reporting of ethics approval. Of the 236 studies that did not report ethics approval, only one was published in a journal listed in the 2016 Beall's List of Predatory Publishers.[26]

Reporting of informed consent was also low, with only 46.6% of all research studies reporting that informed consent was obtained. In almost half (49.0%) of the studies, the authors did not report whether they obtained informed consent from their study participants, and in 4.4% of studies, the authors reported that they did not obtain informed consent. Of the 232 studies for which informed consent was obtained, the most common types of informed consent were written consent (34.9%) and verbal consent (33.2%), and a small proportion of the studies reported other types of consent, such as implied consent or a combination of written and verbal consent (3.0%). An additional 28.9% of studies did not report how informed consent was obtained.

Despite low overall rates of reporting ethics approval and informed consent, our findings demonstrated that reporting has increased with time (see Figure). Reporting of ethics approval and informed consent followed a linear trend with the exception of articles published between 2005 and 2009, which had the highest percentage of studies reporting informed consent. Interestingly, reporting of ethics approval and informed consent was discordant, with some studies reporting either ethics approval or informed consent.

Figure. Reporting of Obtaining Ethics Approval and Informed Consent by Year



Discussion

Overwhelmingly, our study demonstrated that ethics guidelines from national government organizations and UN agencies and grant regulations from funding agencies do not include details about the ethical conduct of research with conflict-affected populations. The majority of guidelines and granting regulations reviewed (87.5%) did not mention conflict-affected populations, and only one (3.1%) described any of the complexities related to conducting research with conflict-affected populations. These findings support critiques that many institutional ethics committees are inadequately prepared to provide ethical oversight of research that is conducted with conflict-affected populations.[13] Although it should be noted that the lack of guidance does not imply that unethical research practices are occurring, it highlights a gap that must be addressed. There is a need to integrate guidance for research with conflict-affected populations into national, UN agency, and donor guidelines.[1,21,22] We contend that such guidance should describe how to navigate ethical tensions that might arise in the conduct of research with conflict-affected populations, including how to negotiate conflicting ethical principles and how to operate in settings where there is a nonfunctional ethics review board. Further research is also needed to understand how the lack of detailed guidance is shaping research practices.

Our study also identified poor ethics reporting practices, with 47.3% of articles not reporting ethics approval or a waiver. These findings align with similar studies, including a recent scoping review by Makhoul et al on ethical research practice in studies with refugees and war-affected populations in the Arab world, which found that 52% of studies did not report receiving ethics approval.[23] Similar to Makhoul et al, our findings suggest that the reporting of ethics approval and informed consent has improved from the 1990s to the present, which might reflect changes in reporting requirements of journals.[23] Importantly, our study identified a large disparity between the subset of national studies and the subset of international studies reporting ethics approval. This

finding is particularly concerning, given the history of ethical violations by foreign scholars.[15]

Among the studies for which the authors did not report whether they received or did not receive ethics approval or a waiver, 88.5% were published in peer-reviewed journals that required the reporting of ethics approval. This inconsistency highlights the need for stricter enforcement of reporting requirements. Although poor reporting of ethics approval reflects a wider systemic issue,[27,28,29] the potential for ethical violations in research with conflict-affected populations requires greater ethical oversight of research practices.[13] Journals have a responsibility to ensure that all published articles contain details on ethical procedures, including, at a minimum, informed consent and institutional ethics approval. Some journal editors might contend that our request places additional burdens on authors and editorial staff. We agree that such requests place extra demands; however, we argue that the increased potential for ethical violations with conflict-affected populations requires stricter reporting standards. We would further argue that reporting should extend to a discussion of the ethical tensions that arose during the research process and how the researchers navigated those challenges. These discussions not only would be insightful for others working in similarly complex environments, but also would help make the research process more transparent and prevent any intentional or unintentional ethical violations.

Our study had several limitations. We relied on information that was reported by authors in the articles and were unable to do any additional follow-up. Our study was also limited to articles published in peer-reviewed journals. Moreover, given that the focus of our study was guidelines shared by decision-making bodies, such as governments, donors, and UN agencies, we did not extract guidelines from any nongovernmental or independent organizations. We were also limited to guidelines and granting regulations that were available online, and we excluded non-English literature and guidelines. We must also acknowledge that we only extracted current journal reporting requirements, which might have changed since when the article was published. Lastly, to identify articles, we used a database limited to articles on the delivery of reproductive, maternal, newborn, child, and adolescent health and nutrition interventions in conflict settings. However, we believe that using this database might actually have led to the inclusion of a wide set of studies capturing a range of health conditions and contexts.

These limitations are coupled with several strengths. To the authors' knowledge, this is the only study evaluating the reporting of ethical research practices with research on conflict-affected populations globally. Additionally, our review comprehensively looks at different stages of the research process from guidance to practice.

Overall, our work echoes the calls made by others—namely, that generating ethical research extends beyond the role of the researcher to include funders, journals, and other policy decision makers.[22,23] Partnerships between institutional ethics committees, donor agencies, and journals could ensure that guidelines are adhered to by researchers and that conflict-affected populations are protected. Through critical reflection and multidisciplinary collaboration, we can begin to shift the conversation of ethics from one of harm minimization to one of reciprocal benefit for researchers and conflict-affected populations.

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Anushka Ataullahjan, PhD is a senior research associate at the Centre for Global Child Health at the Hospital for Sick Children in Toronto, Canada. Her research aims to understand how health decisions are shaped by social, political, and religious beliefs and ideologies. She is particularly interested in health equity and understanding the regional, national, and global histories that give rise to specific inequities and health practices.

Samantha Lo, MSc is a former graduate research student at the SickKids Centre for Global Child Health in Toronto, Canada. She is interested in collaborative research and innovation to achieve health equity in local populations around the world.

Mohammad Haaris Aziz, MBBCh graduated from the Royal College of Surgeons in Ireland–Medical University of Bahrain. He has a keen interest in ethical clinical research practices and plans to become a primary care physician to work with underserved populations.

Nadia Amin Somani is a master of science student at the School of Public Health Sciences at University of Waterloo in Canada. She has many interests that she hopes to explore further, such as maternal and child health, innovation, education, and gender inequality.

Zulfiqar A. Bhutta, PhD, MBBS is the Robert Harding Inaugural Chair in Global Child Health at the Hospital for Sick Children in Toronto, Canada, and the co-director of the SickKids Centre for Global Child Health. He is also the founding director of the Institute for Global Health and Development and the Centre of Excellence in Women and Child Health at Aga Khan University. Dr Bhutta has published extensively on newborn, child, adolescent, and maternal health and nutrition with a focus on fragile settings, including conflict settings.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Traumatic Imagination in Traditional Stories of Gender-Based Violence

Ayesha Ahmad, PhD, Lida Ahmad, MA, Shazana Andrabi, MA, Lobna Ben Salem, PhD, Peter Hughes, MBBS, Jenevieve Mannell, PhD, Sharli Anne Paphitis, PhD, and Gamze Senyurek, MA

Abstract

Traumatic imagination includes creative processes in which traumatic memories are transformed into narratives of suffering. This article emphasizes the importance of storytelling in victims' mental health and offers a literary perspective on how some women's experiences of suffering can be expressed in the telling of traditional stories, which confer some protection from stigma to individual women in Turkish and Afghan societies.

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Representing the Unrepresentable

In war, every word uttered matters. Meanings find expression in stories of suffering that align with one's worldview, perceptions of oneself, and environment. Telling such stories can become effective ways to channel trauma and create landscapes of resistance.[1] Storytelling by women in war, conflict, and hostile environments also symbolizes how "writing from outside power, resists dominant discourses that consistently refuse to include their stories."[2] Arva and Roland, in presenting magical realism as a narrative strategy for representing "unspeakable" historical traumas, state: "[E]stablishing a theoretical link between magical realist writing and trauma requires an interdisciplinary conceptual tool,"[3] which they call *traumatic imagination*.

> Traumatic imagination ... is intended to describe an empathy-driven consciousness that enables authors (and readers as co-authors of texts) to act out and/or work through trauma by the means of magical realist images..... [I]t may also be conceptualized as a consciousness of survival to which the psyche resorts when confronted with ... compulsive repetition of images of violence and loss. Through magical realist writing, the traumatic imagination transfers to narrative memory events that have been precluded from narrativization by trauma.[3]

We were drawn to this concept when a colleague in Afghanistan was, as Roland and Arva observed, "struggling to *re*-present the unpresentable"[3] after witnessing an act of

extreme violence by Taliban authorities toward a young girl wearing clothes they deemed too short. We apply traumatic imagination to this struggle and more broadly here as we describe the importance of storytelling to mental health. We offer a literary perspective on how women's individual experiences of suffering find expression in traditional stories and critique the idea that stories of trauma, particularly those related to gender violence in conflict settings, silence voices of women who have experienced trauma.

Traumatic Imagination and Traditional Storytelling

In our work in Afghanistan and Turkey, we have seen how and why traditional storytelling, expressing magical realism deeply rooted in oral storytelling and poetry recitation, is a resource for women who have experienced violence. Traumatic imagination can enable some women to give voice to their suffering borne of conflict. Traditional stories, specifically, can serve as protective cover for storytellers at risk of harm or stigma if they are personally identified. Storytelling traditions in Turkey have been shifting and express modern influences that can be helpful in illuminating violence experiences in other conflict settings (eg, familial or international).[4]

Situated in transitions from nomadic to settled lifestyles, travellers' oral tales soon became encumbered by everyday rituals, customs, taboos, and talismans. By the 20th century, the lived realities and experiences of everyday people had inspired literary eras of Turkish writing.[5] The social realist and existentialist movements, which preceded and followed the "village novel" period, respectively, expressed points of view from minority groups and represented contrasts between modernity and traditionalism or between East and West.

The literature of the latter half of the 19th century was shaped by the emergence of magical realism, which was rooted in the author or teller's realistic perceptions of their surroundings but was also infused with the mystical and supernatural. Magical realism was a way to assimilate memories, stories, and legacies that had travelled to modern Turkey from afar. But, perhaps most importantly, magical realism also allowed a writer or teller to "evade and unsettle hegemonic views"[6] and has, therefore, resonated with women who resist patriarchy by sharing yet-unheard stories.[2] Raza and Imran discuss *border space* as key in magical realism: "Existence thrives on this border space, neither being overtly on one side nor on the other. Such a liminality is all encompassing as it absorbs two contradictions. By being neither here nor there, it is everywhere, in both regions across the border. Thus, the strip of border space is magical and curtails stark realities simultaneously."[7] That is, a story connects the space bordering violence and the power of a woman storyteller, illuminating the hybridity of a voice not yet heard that speaks. A magically realistic story expresses a human perspective "expounded upon as a tool of magic in the realm of the real."[7] A woman speaking of suffering beyond the boundaries of her own voice might be interpreted as narrating within a storytelling tradition of magical realism, which commonly weaves experiences of everyday living with a greater spirituality or sense of being.

In their analysis of Elif Shafak's *The Gaze*, Raza and Imran argue that Shafak's narration "further develops the notion of hybridity by employing attributes of Self and the Other through stylistic and thematic features."[7] Magical realism offers a way to tie together individual stories of suffering and to connect them to healing via traumatic imagination, which enables this narrative transformation. That is, magical realism in traditional storytelling helps an author or teller transform an experience of trauma into a narrative that can offer meaning for both the teller and the hearer or reader of such stories.

Stories' Health Applications in Conflict and Peace

Women suffer harms of physical and psychological violence[8] in familial and public spheres of life in times of conflict and peace. Specifically, following the Taliban's takeover of Afghanistan in August 2021, violence towards women in the region has escalated, demonstrating an ongoing need for storytelling in women's collective struggle.[9] Connecting one's own story to traditional stories allows individuals and communities to tap "literacy practices supported by family networks,"[10] and participate in community-based mental-health interventions that use storytelling in trauma therapy and recovery.

Importantly, telling stories is not without risk. Women "as storytellers of suffering are the epitome for understanding the lived spaces of war,"[11] and risk to their safety stems from their being identified and from the stigma of having suffered violence. Stories in times of conflict remind us that "words and silence are weaponised in war, meaning that a woman's story is silenced because of what she has the power to reveal, but she is never silent; stories are living breathing vessels of the self and surrounding world."[11] These lessons apply in times of peace, too, as healers can facilitate patients' storytelling by allowing patients' stories to be heard as relevant and meaningful, by considering the role of imagination in violence interventions and confidence holding, and by providing spaces for storytelling as sites of healing from both individual and collective trauma.

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Ayesha Ahmad, PhD is a senior lecturer in global health at St Georges' University of London, an honorary lecturer at the Institute for Global Health of the University College London, a research associate at the University of Johannesburg, South Africa, and a member of the clinical ethics committee at Great Ormond Street Hospital for Children. She specializes in mental health in conflict settings.

Lida Ahmad, MA has a background in sociology and specializes in Afghan women's rights. She has worked extensively on gender-based violence in Afghanistan.

Shazana Andrabi, MA is a senior assistant professor at the Centre for International Relations at the Islamic University of Science and Technology in Awantipora in Jammu and Kashmir, India. Her research focus is gender and gender-based violence.

Lobna Ben Salem, PhD is an associate professor of comparative literature at the University of Manouba in Tunisia, where she chairs the Department of English. She is interested in African, North African, and Middle Eastern literature and culture, and her work has been published in *Global Health Action* and *Postcolonial Text*.

Peter Hughes, MBBS is a consultant psychiatrist in South West London and St George's Mental Health NHS Trust in the United Kingdom. Dr Hughes has extensive experience in humanitarian psychiatry and is also the consultant psychiatrist for the Storytelling for Health, Acknowledgement, Expression, and Recovery Project.

Jenevieve Mannell, PhD is an associate professor in the Institute for Global Health at University College London. She specializes in the prevention of violence in high-prevalence settings and is actively working in Afghanistan, India, Peru, Samoa, and South Africa.

Sharli Anne Paphitis, PhD is a research fellow at Kings College London who leads the South African site of the Storytelling for Health, Acknowledgement, Expression, and Recovery Project and works with the Global Health Research Groups of the National Institute for Health Research on mental health care for survivors of violence in South Asia. She earned a PhD in philosophy from Rhodes University, where she was a senior lecturer in community engagement and in philosophy from 2014 to 2019. Her work focuses on mental health care among survivors of violence in South Asia.

Gamze Senyurek, MA is a visiting fellow at Amsterdam University Medical Center in The Netherlands. Her research interests include bioethics, vulnerable groups, intimate partner violence, global health issues, and qualitative research methods.

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

What Does Ethics Demand of Health Care Practice in Conflict Zones?

Leonard Rubenstein, JD, LLM and Rohini Haar, MD, MPH

Abstract

Human rights violations in armed conflict against community members, displaced persons, and health workers include combatants' uses of threats and coercion, attacks on health facilities, and abuses against civilians. Traditional clinical and public health ethical obligations are not sufficient to guide practice in those spaces. This article describes some of the complex realities of health practice in conflict zones that challenge adherence to clinicians' ethical obligations and create severe risks to the health, well-being, and dignity of the people they serve. It also proposes some solutions to these challenges.

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Introduction

Health care in conflict settings where pervasive human rights violations occur poses unique ethical as well as clinical challenges. In addition to responding to common issues arising in humanitarian health care, such as priority setting in situations of scarcity, health workers in these environments may need to respond to pressures from combatants or others to depart from ethically mandated care, address the service and programmatic consequences of violence inflicted on health care, and decide when, to whom, and how to report human rights violations. Traditional clinical ethical responsibilities regarding independent judgment, impartiality, competence, devotion to patients, and minimizing harm apply to these problems, as do principles of humanitarian practice.[1] Conventional responses to ethical questions are often insufficient in conflict settings, however; clinicians must also have capacity to navigate complex relationships among combatants, colleagues, patients, and community leaders.

Threats of Violence and Decision Making

Consider the problem of combatants threatening to interfere with clinical decision making in violation of human rights and humanitarian law. State forces or nonstate armed groups sometimes insist on control of triage decisions by demanding treatment priority for their fighters or allies or expulsion of ethnically or religiously identified patients from a health facility, interrupting treatment, or interfering with duties executed by health workers who are women perceived as nonadherent to local dress codes or

rules about male accompaniment.[2] Additionally, counterterrorism laws can direct health workers—on pain of prosecution—to not offer care to an alleged member of a terrorist organization.[3]

Such forms of coercion do not always create ethical dilemmas, since obligations to provide care—even in the face of greater-than-usual risk to a clinician's own safety, health, or life—apply.[4,5] Yet coercion and threats constrain clinicians trying to take a right course of action. Some circumstances resemble dual loyalty problems in peacetime practice, in which authorities such as prison wardens, employers, or police pressure clinicians to act contrary to their professional ethical values or in a manner that breaches patients' human rights.[6] For example, one Syrian physician who had experienced demands to prioritize care of one group of fighters revealed to academic and humanitarian organization researchers in an interview: "We asked the wounded man [fighter] to be patient till we finish another. They got angry and threatened us with a weapon. I was very afraid, and I did not know how to work—I felt they would shoot bullets in the hospital. So, I left the patient whom I was treating, and I hid."[7]

Refusing combatants' demands risks retaliation, and clinicians can feel powerless. For this reason, clinical program managers and organizations must develop strategies for supporting clinicians—for example, by setting ground rules about triage priorities with combatant commanders or engaging community leaders as interlocutors with them. One Syrian health worker reported: "We always deal with civil local councils and they, in turn, getting along with the military and solve problems." Another said: "Once we had [*sic*] the position that one of the fighters was intent on violence with one of our cadre, but the locals in the area who worked with us stood against him."[7]

Some international groups invest in political, relationship-building, and community work to help anticipate and resolve threats and interference. The International Committee of the Red Cross (ICRC) and Médecins Sans Frontières (Doctors Without Borders, or MSF) spend considerable resources cultivating working relationships with combatants and communities to try to minimize interference in their operations, such as combatants undermining triage decisions, bringing weapons into health facilities, or violently entering a hospital to arrest a patient. As a result, these organizations often successfully obtain deference from combatants to their independent medical decision making.[2]

Clinicians can be trained to respond to demands or interference with appeals to self-interest or assertions of clinical authority. During the war in Chechnya in 1999, rebels demanded that their wounded be treated before Russian soldiers who more desperately needed care, but Dr Khassan Baiev faced down threats: "In this hospital I give the orders."[8] In other fraught circumstances, clinicians might be wise to back down, but training and skill development can often help avoid the worst outcomes. It's important to note that local health workers can be especially vulnerable to threats of violence. Their local knowledge can be a tremendous asset and contribute to handling combatants' demands, deescalating tension, and mitigating risk.

Clinical and Organizational Management

A second problem concerns how to manage clinical care and service delivery when violence is inflicted on or directly affects health care services. Violence may be inflicted for strategic or tactical reasons, out of indifference to or reckless disregard for the precautions in military operations required to avoid harm to health care facilities, or out of a belief that enemies, whether civilian or military, are not entitled to care.[2] Between

2016 and 2020, combatants perpetrated more than 4000 documented acts of violence against health workers and facilities in armed conflicts across the globe. Combatants kidnapped more than 400 health workers, killed almost 700 of them (eg, in missile attacks, bombings, shelling, shooting, or arson), and injured 1500 more.[9]

The conundrums in making care decisions in such circumstances are often emotionally and intellectually wrenching. In interviews conducted in 2017 with clinicians and administrators providing health services in Syria, clinicians reported having to decide whether to discharge a patient sooner than medically indicated to avoid the possibility of that patient being in the health facility during an attack. They also faced the question of whether to reopen a facility after an attack or to move services to safer areas.[7] In these and similar cases, articulating ethical values and creating robust and inclusive processes for decision making can help clinicians and administrators manage challenges.[7] Open discussion of the uncertainties and risks with patients and families; consultations with communities, staff, and local leaders; transparency; and good communication of reasons for the decision can all contribute to resolution. Efforts may also be made to ameliorate the potential harms to people affected by whatever decision is made.

In addressing these issues, moreover, short-term ethical and security risks may have to be taken to ensure the safety of patients. In 2018, in Batangafo, Central African Republic, an armed group loosely affiliated with one religious group attacked thousands of displaced people who were mostly from another group. Combatants destroyed homes and markets, and about 10 000 people fled to a compound operated by MSF.[10] The staff built latrines and allowed a market into the compound, as the community's own market had been destroyed. Hospitals are not designated places of refuge under international humanitarian law, however, and the influx of thousands of displaced people disrupted MSF clinical operations and increased the risk that the compound would be attacked. The risk increased when an opposing armed group arrived to defend people in the compound and blocked people affiliated with the attackers from entering the MSF hospital. Those blocked from entry accused MSF of partiality, demanded expulsion of the displaced people in the compound, and threatened violence against the compound.[10]

Allowing the compound to be a place of refuge and denying entry to certain wounded people might seem to raise concerns about MSF's favoring one group and allowing the effectiveness of the hospital's medical services to be compromised. But by refusing to expel the displaced people, MSF enhanced their protection. It also met its obligation to provide care for all in need by providing patients who were barred from entering the compound with services nearby, thus reinforcing its commitment to impartiality. Its experience and knowledge of the community, along with the help of other organizations and its offering medical care for all, led ultimately to a resolution.

Abuse Reporting in Conflict

A third problem—how to address horrific abuses health professionals may witness or learn about in the course of medical work—is complicated for both individual health workers and organizations. There is a strong case to be made that obligations of justice, beneficence, and nonmaleficence require reporting of human rights violations against patients and other members of the community. There are, however, risks in reporting. Reporting can require naming perpetrators and disclosing victims' identities and can

carry risk of retaliation, which can include violence against patients and health workers and limiting a health organization's access to populations in need.

The ICRC rarely names perpetrators of human rights violations in order to try to preserve its neutrality and avoid compromising its unique role as a confidential interlocutor with all parties to conflicts. By contrast, MSF, dating to its founding 1 year after the war in Biafra (now part of Nigeria) ended in 1970, has been dissatisfied with the ICRC's practice of only rarely naming human rights violators. MSF adheres to a concept of *témoignage*, or "witnessing":

> When Doctors Without Borders/Médecins Sans Frontières (MSF) teams witness extreme acts of violence against individuals or groups, or when access to lifesaving medical care is hindered, we may speak out publicly. Our decision to do so is always guided by our mission to alleviate suffering, protect life and health, and to restore respect for human beings and their fundamental human rights.[11]

MSF is willing to speak out, despite risk of being forced out of a country, when it believes witnessing will not pose risks to patients and communities.[2]

For individual or local health workers not affiliated with humanitarian groups, such as the ICRC and MSF, little guidance is available to help them determine whether and when to report human rights violations. The ICRC has published ethics guidance for health workers in conflict regions, which stresses the imperative not to jeopardize the safety of patients or the organization but that expresses concerns about human rights abuse reporting. It warns that unverified statements to the media about human rights violations can endanger others and generate accusation and counter-accusation in the media, which ICRC construes as serious professional misconduct by health workers.[12] When reporting constitutes an expression of health professionals' duty to prevent harm, however, it is ethically similar to their duty to report domestic violence.[13] Not doing so can be morally distressing, especially when rape, torture, and other atrocities are not exposed and could exacerbate others' vulnerability to similar abuses. Some medical groups suggest that not reporting constitutes failure to protect patients from harm and amounts to complicity.[14] A World Medical Association declaration obliges physicians to encourage authorities' adherence to international law and report torture and cruel or inhuman treatment.[15]

The Office of the United Nations (UN) High Commissioner for Human Rights and the Office of the UN High Commissioner for Refugees, in conjunction with a global humanitarian coordinating body, recognize that civilian protection requires that humanitarian organizations find appropriate ways to report major violations of human rights and humanitarian law. In addition to questions about whether and when to report violations or alleged violations, who should report (eg, at the site level, country level, or headquarters level), to whom to report (eg, UN agencies, perpetrators, others), and how advocacy should proceed to minimize risk to victims are also important ethical and procedural questions.[16] Courtland Robinson of the Johns Hopkins Center for Humanitarian Health (oral communication) notes, for example, that individuals at different levels of an organization can report in different ways: health workers in a refugee camp might be most effective at minimizing risk to victims if they report rape to camp managers while continuing to treat and counsel victims; country directors might be best positioned to raise concerns with responsible officials at the country level; and headquarters might be best positioned to publicly disclose and plan advocacy strategies. Speaking at an increasingly greater distance from perpetrators as one moves

up an organization's proverbial administrative ladder could be an effective means of protecting victims and reporters from retaliation.

Conclusion

Clinical and other professional groups, as well as donors and international agencies supporting humanitarian health responses, need to provide support to those who confront confounding, painful, high-stakes decisions.

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Leonard Rubenstein, JD, LLM is a professor of the practice at the Johns Hopkins Bloomberg School of Public Health in Baltimore, Maryland, where he is also a core faculty member at the Center for Public Health and Human Rights. He is also a core faculty member at Johns Hopkins University's Center for Humanitarian Health and Berman Institute of Bioethics. He founded and chairs the Safeguarding Health in Conflict Coalition and is the author of *Perilous Medicine: The Struggle to Protect Health Care From the Violence of War* (Columbia University Press, 2021).

Rohini Haar, MD, MPH is an adjunct professor in the School of Public Health at the University of California, Berkeley, and an emergency physician with Kaiser Medical Center in Oakland. She has engaged in extensive research on human rights and on health in armed conflict and political violence.

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