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

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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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