



# Ethical decision-making for doctors in the armed forces: a tool kit

Guidance from the BMA Medical  
Ethics Committee and Armed  
Forces Committee

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## Introduction

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.

Useful parallels can be drawn between the extreme demands of combat and some medical emergencies in civilian life, for example providing impromptu treatment at the site of a major disaster. In these circumstances, professional ethics require that robust priorities are set and that attention is given to the most serious urgent need. Military doctors may, in certain contexts, be required to fulfil their duty of care to the injured by, for example, securing the immediate area from further attack, or preventing a struck vessel from sinking, rather than attending directly to the medical needs of the injured. Only when it is safe to do so, will doctors turn their attention to delivering treatment.

In a small number of high profile cases involving serious abuse by non-medical military personnel, medical staff may have had difficulty understanding and/or fulfilling their key ethical obligations to the individuals in their care. In 2011, the report of the public inquiry into the death of Iraqi civilian Baha Mousa, in British military custody in 2003, found that military guidance on ethical duties to avoid involvement in interrogation or on practical procedures for the medical treatment of detainees, including medical examination and the identification and reporting of abuse,

was not provided to regimental medical officers at that time. Such cases highlight the importance of supporting military doctors in understanding and fulfilling their ethical obligations.

In the BMA's view, a sound grasp of basic ethical principles can bring clarity to doctors' decision-making when under pressure. In this tool kit we outline these key principles and give advice on how they can be interpreted in practice. Although this tool kit is designed primarily to support doctors, it will also provide useful guidance to other health professionals, and those with health-related or management roles, in the armed forces.

This resource is not intended to be a comprehensive guide to ethical questions arising for military doctors. It signposts the kinds of ethical factors doctors need to take into consideration when making decisions. The final section lists more detailed guidance, including from the Ministry of Defence, and further sources of information and support. When facing specific ethical dilemmas, doctors are strongly recommended to refer to this more comprehensive guidance, or to seek further advice from the BMA, GMC or their personal medical legal defence organisation.

For advice on legal issues, doctors should refer to an appropriate local Ministry of Defence legal adviser. When on operations, doctors should refer to the medical chain of command for ethics advice.

We hope that you find this tool kit useful and welcome your feedback. If you have any comments, please direct them to:

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# 1. Guiding principles

**'The health of my patient will be my first consideration.'**

World Medical Association, Declaration of Geneva

Doctors in the armed forces work in closed and hierarchical command structures. As members of the military, they are likely to identify closely with, and experience strong loyalty towards, the unit or service of which they are a part. At the same time, doctors' professional obligations require them to prioritise their ethical duties to their patients over and above their responsibilities and loyalties to the military.

These factors can result in conflicts of interest for military doctors. It is vital that doctors remain alert to the ways in which such conflicts can impact on their ability to meet their binding ethical obligations.

The following core principles form the basis of the guidance throughout this tool kit.

- The actions of all military personnel, including medical personnel, should at all times be both proportionate and just.

- The conduct of military doctors should accord with the ethical standards of civilian practitioners.
- Medical care should be delivered according to clinical need, impartially and without discrimination.
- Doctors should not be involved in or cooperate with torture, or cruel, inhuman and degrading treatment or punishment, which is illegal in all circumstances.
- Doctors should report violations of ethics and applicable laws, or practices that interfere with their ability to meet their ethical duties, to the appropriate chain of command.
- Doctors must be able to justify any departure from accepted ethical principles or guidelines.

## 2. Managing dual loyalties

**'In practice... health professionals often have obligations to other parties besides their patients... that may conflict with undivided devotion to the patient.'**

International Dual Loyalty Working Group

### **What are dual loyalties?**

'Dual loyalties', or 'dual obligations', refer to the conflicting demands placed on doctors who have direct obligations to their patients as well as to a third party. Doctors in the armed forces can at times be required to balance conflicting, and sometimes irreconcilable, obligations or loyalties.

Doctors' professional and ethical duties require them to preserve life, care for the sick and wounded, and reduce suffering. As military personnel, part of their role is to support those non-medical military colleagues whose function involves attacking and inflicting harm on the enemy. Circumstances can therefore arise where doctors come under pressure to prioritise their obligations or loyalties to the military over their ethical duties.

## Examples of dual loyalties in practice

### *Triaging enemy, civilian, coalition and UK casualties*

At the British field hospital in Afghanistan, casualties are treated solely on the basis of their clinical need. Injured suspected insurgents are, for example, treated ahead of British casualties if their condition is more urgent. The principles of triage are clear. Doctors may nevertheless find themselves under moral pressure from colleagues, or their own sense of loyalty, to prioritise the treatment of their friends and colleagues over civilians and the enemy. These feelings are of course entirely natural but, if allowed to prevail, they could lead to objectively unethical decisions. Only by recognising and acknowledging such feelings can doctors hope to set them aside where it becomes necessary to do so.

### *Duty of care under fire*

The principle of care under fire may require medical military personnel to use their weapons alongside non-medical colleagues, in order to meet their responsibility to protect their patients. Ministry of Defence doctrine, in line with

the Geneva Conventions, states that medical personnel may be armed with light individual weapons for use in their own defence or in defence of the wounded and sick in their charge. Medical personnel must never use weapons offensively. Once a doctor has used a weapon in defence, it is possible that he or she will be required to treat the individuals against whom the defensive action was taken. Considerable moral pressure is likely to emerge out of such situations and, as with the triage scenario above, doctors should be alert to the potential effects of such pressure on their clinical decision-making.

### **How can conflicting loyalties be managed?**

In the BMA's view, adherence to the principles listed in section one, above, is vital if doctors are to address the conflicting obligations they are likely to face while serving in the armed forces. The medical role is further protected by international humanitarian law, which reinforces the ethical obligations of doctors practising in the military context during active conflict. Outside of armed conflict, human rights law and elements of domestic law apply.

## Key provisions under international humanitarian law

The Geneva Conventions are founded on the idea of respect for the individual and his or her dignity. People who are not directly involved in hostilities and those put out of action through sickness, injury, captivity or any other cause must be respected and protected against the effects of war. Those who suffer must be aided and cared for without discrimination. In particular:

- the wounded and sick must be respected and protected in all circumstances
- they must be treated humanely and must receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition
- there must be no distinction in the treatment of the wounded and sick on anything other than clinical grounds
- forces must care for the wounded and sick of enemy forces taken prisoner as they would care for their own; and
- no one shall be compelled to perform acts contrary to the rules of medical ethics or to refrain from action which is required by those rules.

Doctors are never absolved of their overriding responsibilities but they may at times feel pressure to subordinate or reinterpret their ethical duties where these duties appear to conflict with their broader loyalties to the military, their colleagues or friends. Military commanders are required to support doctors in the fulfilment of their ethical duties, and will expect doctors to act in accordance with their professional obligations. However, circumstances, such as those outlined on pages 8 and 9, can place doctors under huge pressure. Guidance on how doctors in the armed forces can manage their dual loyalties in response to particular ethical dilemmas is given throughout this tool kit. Recognising where such tensions arise, and how they may influence decision-making, are important steps in ensuring that the doctor's own principles are not eroded.

### **Key messages**

- Doctors in the armed forces have direct obligations to their patients as well as to the military.
- Doctors are never absolved of their overriding medical ethical responsibilities.
- Human rights law, domestic law and, in the context of active conflict, international humanitarian law reinforce and protect the

ethical obligations of doctors practising in the armed forces.

- Adherence to core ethical principles can help doctors to address the conflicting obligations and loyalties they are likely to face while serving in the armed forces.

### 3. Consent and capacity

**'... it is unlawful... to administer medical treatment to an adult, who is conscious and of sound mind, without his consent... Such a person is completely at liberty to decline to undergo treatment, even if the result of his doing so will be that he will die.'**

Lord Keith in the case of *Airedale NHS Trust v Bland*

#### **When is it necessary to seek patient consent?**

It is well-established in medical ethics and law that patient consent is required whenever a doctor wishes to examine or treat a patient. For consent to be valid the patient must have capacity, be informed and be consenting voluntarily.

#### **Is consent required where a patient lacks capacity?**

As in civilian practice, where a patient lacks capacity, treatment should be provided on the basis of what is in his or her best interests. Doctors should presume a patient has capacity to consent to treatment unless there is evidence to the contrary. An unconscious patient will clearly lack capacity to consent,

whereas a severely wounded but conscious patient is likely to retain a degree of capacity and this capacity may fluctuate.

### **Does consent need to be sought for emergency treatment?**

The nature of some emergencies means that the priority will be the swift provision of treatment in the patient's best interests, rather than delaying vital treatment in order to obtain consent. While every effort should be made to obtain consent from patients who have capacity, as in civilian practice, there will be circumstances when it is not possible and the need to save life or avoid significant deterioration in the patient's condition is paramount.

#### **Obtaining valid consent to emergency treatment**

In providing trauma care to a conscious civilian war wounded patient at a basic front line medical facility, you have no interpreter to facilitate your communication with the patient, who speaks no English and is frightened. The idea of valid, informed consent as an exchange of information between doctor and patient is of little or no help to you

or the patient. Obtaining consent is a secondary consideration to doing whatever is necessary to stabilise the patient. Does this mean that ethical considerations are irrelevant here?

*Where it is not possible to wait for an interpreter in order to obtain consent without risking serious harm to the patient, the priority should be providing treatment to prevent such harm. In cases of genuine uncertainty, it is reasonable to assume that injured people will want to receive appropriate care and treatment. Depending on the particular situation, doctors will need to consider and balance their duty to respect the individual's right to consent and their duty to protect patients from harm. Patient consent involves treating patients as individuals and respecting their right to decide what is done to their body. These underlying ethical principles remain key, even where it is not possible or appropriate to obtain consent from a patient in an emergency situation.*

## **How can doctors ensure that they respect an individual's right to consent where there are language barriers or where patients may feel under duress to consent?**

Effective communication is essential to the consent process, both in terms of providing patients with sufficient information to ensure that consent is valid, and making sure that patients are not coerced into consenting to treatment. Significant practical difficulties can arise where an interpreter is not available but is required to communicate information between the doctor and patient.

In some circumstances, it will not be possible to wait for an interpreter without risking serious harm to the patient and the priority will be providing treatment to prevent such harm. Depending on the particular situation, doctors will need to consider and balance their duty to respect the individual's right to consent and their duty to protect patients from harm. As outlined in the box above, in cases of genuine uncertainty, it is reasonable to assume that injured people will want to receive appropriate care and treatment.

Patients may anticipate aggression or ill-treatment from foreign military personnel and as a result refuse medical treatment, or alternatively consent to it because they fear

the consequences of non-cooperation. Doctors should be sensitive to such anxieties, for example by ensuring that consent procedures are not delegated to non-medical military personnel and explaining to patients that the doctor's duty is to his or her patients. Language difficulties can exacerbate the suspicion and anxiety of patients and make the process of explanation particularly challenging. In these circumstances, doctors and other medical staff can, however, become expert at providing non-verbal clues and reassurance when communicating with patients.

Where an interpreter is from a different cultural or religious background to the patient, this can have an adverse impact on the consent process. For example, the cultural bias of an interpreter may influence the way in which information is relayed between doctor and patient, or a patient may be uncomfortable with the use of an interpreter from a particular region or background. Patients should, where possible, be asked in private, using non-verbal communication, if they accept a proposed interpreter. Doctors should be alert to the fact that enemy combatants often view interpreters as collaborators. This can place any discussion, and interpreter, at risk, and such situations must be handled sensitively.

## What form should consent take?

Consent can be express or implied. Generally there is no legal requirement to obtain written consent, but local protocols may require consent forms to be used in certain circumstances and doctors should ensure that they are familiar with such requirements. Consent forms can be evidence of a consent process, but are not the process itself. The quality and clarity of the information given to the patient should be the principal consideration.

### English language consent forms

You notice that civilian casualties undergoing an initial medical assessment, on arrival at the medical facility where you are based, are given a consent form written in English immediately before being seen by the duty doctor and are told to sign. The vast majority of patients being seen at the facility do not read or speak English and no translation or interpretation services are offered. Can a signature on the form be taken as valid consent for the initial examination and any treatment that is subsequently given?

*The process described here will not result in valid patient consent. It is important to*

*remember that a signature on a consent form does not in itself constitute valid consent, even though local protocols may require the use of such forms. Although a signed form can provide evidence that a discussion between a doctor and patient has taken place, where the patient cannot understand what they are consenting to, either because of language barriers or because they are simply not given an explanation, consent will not be valid. Where urgent treatment or examination is required, it may not be feasible to wait for an interpreter. Non-verbal communication and medical language cards can be used to convey information about what an examination will involve. In the case of non-urgent treatment or examination, it may be possible to wait for an interpreter. Patients should, where possible, be asked in private if they accept the proposed interpreter. It is inappropriate to use other patients, who can speak or read English, as interpreters. This is likely to undermine medical confidentiality and may expose patients to security risks. Patients being asked to interpret may not feel they can decline if they perceive their own care may be adversely affected.*

## Can a patient refuse treatment?

Adult patients with capacity are entitled to refuse treatment. This right must be respected, even when doing so may result in permanent physical injury or death.

Patients may refuse treatment through anxiety. Fear of what might be done to hurt or harm them may be the main reason for refusing treatment. It is important, wherever possible, for doctors to communicate sensitively to the patient, with appropriate interpretation, the medical consequences of refusing treatment, and that treatment is being recommended for his or her benefit. Effective communication can help to build trust between the doctor and patient and ensure that the distinction between military and medical intervention is clear.

### Cultural sensitivity in the consent process

A local civilian woman has arrived at the medical facility with life-threatening injuries, which need immediate intervention. She has capacity and is refusing treatment on the grounds of skin exposure. Can you begin treatment?

*The patient's right to refuse treatment must be respected, even where doing so may result in permanent physical injury or death. It can be incredibly difficult for medical staff to stand aside and not treat. In a situation like this, there are ways to allay the patient's concerns and increase the likelihood that she will consent to treatment. Simple practical interventions, such as introducing partitions into treatment areas, can ensure that patients undergoing emergency treatment feel less anxious and exposed, although this may not always be appropriate in an operational environment for reasons of security. In addition, by keeping in mind the overriding need to respect patients' dignity, doctors are more likely to recognise behaviour among their colleagues, which may compromise dignity, and to challenge such behaviour.*

### **Can members of the armed forces refuse treatment?**

Members of the armed forces have exactly the same freedom of choice as to the medical treatment they receive as all other patients. Doctors should never impose treatment where a patient with capacity refuses or consents

only under duress. Where a patient will not comply with a military requirement to receive a particular treatment, for example a vaccination, doctors should refer the matter back to the military chain of command, with the patient's consent. It is a chain of command decision, rather than a medical decision, to determine the employability of an individual who declines a particular vaccination.

### Key messages

- Patient consent is required whenever a doctor wishes to examine or treat a patient.
- Where a patient lacks capacity, treatment should be provided on the basis of his or her best interests.
- Consent procedures should not be delegated to non-medically trained personnel.
- Where there are language barriers, doctors may need to use non-verbal communication when communicating with patients.
- Adult patients with capacity are entitled to refuse treatment and this right must be respected, even when doing so may result in permanent physical injury or death.

## 4. Confidentiality

**'In almost every profession – whether it's law or journalism, finance or medicine... people rely on confidential communications to do their jobs. We count on the space of trust that confidentiality provides. When someone breaches that trust, we are all worse off for it.'**

Hillary Clinton, US Secretary of State

### **Who is owed a duty of confidentiality and what information is confidential?**

Doctors owe a duty of confidentiality to all of their patients, including after death. All information that, directly or indirectly, might identify a patient is subject to this duty. This includes information that is written, visually or audio recorded, or simply held in a doctor's memory.

Depending on the particular situation and the identity of the patient concerned, different pressures may be placed on the military doctor's duty of confidentiality. There will be circumstances where a doctor will not receive any information, such as name or date of birth, about a civilian patient treated

in an emergency, before that patient is transferred out of his or her care. In contrast, where doctors have an ongoing therapeutic relationship with members of their own unit, they will potentially hold a substantial amount of confidential information and may, on occasion, be asked by the military chain of command to disclose it.

In each scenario, the doctor's duty of confidentiality remains the same. Any identifiable information relating to a patient, whether civilian or military, should be kept confidential, unless there is a compelling reason why it should not be (see below). The duty of confidentiality applies equally to information relating to treatment given in an established healthcare facility, such as a hospital or clinic, and emergency treatment delivered elsewhere.

### **Why is the duty of confidentiality important?**

Respect for confidentiality is central to the development of trust between doctors and patients. In circumstances where patients may be more inclined to mistrust doctors, for example because they are part of a foreign military force, explaining the doctor's duty of confidentiality, and reassuring patients that

their information will be kept confidential, can help to build trust and emphasise the distinction between medical and military intervention. It is also important that fellow members of the UK armed forces know that the duty of confidentiality applies to their medical treatment.

Certain patients, for example those being detained, may be vulnerable to abuse of their medical information. Doctors should therefore be especially careful to ensure the confidentiality of all personal medical information, including any medical records, where a detainee is subject to interrogation, or could be at a later stage.

### **When can confidential information be disclosed?**

Patients must be able to expect that information about their health will be kept confidential unless there is a compelling reason that it should not be. The duty of confidentiality is not absolute. Confidential information can be disclosed where:

- the patient has capacity and consents to the disclosure; or
- it is required by law; or
- it is justified in the public interest (the GMC

gives the example of there being a potential public interest in protecting individuals or society from risks of serious harm, such as serious communicable diseases or serious crime).

There is also a presumption that information can be disclosed to fellow health professionals involved in the provision of treatment to the patient, on the basis of implied consent. Where particularly sensitive information is concerned, for example involving sexually transmitted disease or psychiatry, this presumption should be confirmed explicitly by asking the patient if he or she consents.

### **‘What’s wrong with him, doc?’**

A senior officer from the military chain of command asks you what exactly is wrong with a member of your unit who you have been treating since his admission to the medical facility the previous day. Are you able to reveal what you know about your patient?

*Based on the information provided here, it should be explained to the senior officer that, because of the duty of confidentiality, it is not possible to meet the request for*

*medical information unless the patient consents to it. As in occupational health settings, the doctor may specify the practical implications of the patient's condition, for example that he is not fit for active duty, but without giving clinical details. Clinical information about an individual's diagnosis or treatment is confidential. The confidentiality of all patients must be respected unless one of the exceptions applies. Although a senior officer is making the request, there is no presumption in favour of disclosing information without consent, as the individual is not a health professional involved in the provision of treatment to the patient. Further information is needed in order to determine whether disclosure is required by law or justified in the public interest. It may be that the patient has capacity and would be willing to consent to the disclosure, in which case the information can be released.*

## **When can confidential information be disclosed in the public interest?**

Confidential information can be disclosed without consent where the public interest in the disclosure is sufficiently strong. This

is where the disclosure is likely to protect individuals or society from a risk of serious harm, for example where disclosure is essential to prevent a serious and imminent threat to the life of the individual or a third party, or to national security. Doctors must be able and prepared to justify any decision to disclose information without the patient's consent.

The justification for disclosure on public interest grounds stems from the harm that may result from non-disclosure. The fact that a request or order to disclose information comes from a senior officer does not, by itself, justify disclosure.

When deciding whether to disclose information to protect the public interest, doctors must:

- consider how the benefits of making the disclosure balance against the harms associated with breaching the patient's confidentiality
- assess the urgency of the need for disclosure
- consider whether the patient can be persuaded to disclose voluntarily
- inform the patient before making the disclosure and seek his or her consent, unless doing so would increase the risk of harm or prejudice the reason for disclosure

- document the steps taken to seek or obtain consent and the reasons for disclosing without consent
- reveal only the minimum information necessary to achieve the objective
- be able to justify the disclosure; and
- document both the extent of and the grounds for disclosure.

### **Making a disclosure in the public interest**

A sergeant in your unit asks if he can talk to you in confidence. Several weeks ago his patrol came under attack. Two of his colleagues were killed and three were severely wounded. Although he did not sustain any physical injuries, he has been unable to sleep properly since the incident and is experiencing feelings of extreme panic. Two days ago he received a letter from his girlfriend back home, telling him that their relationship is over. He says he feels like he is 'cracking up' and is worried that things will just 'snap'. What is your duty of confidentiality here?

*The doctor needs to assess the risk and then communicate the minimum information necessary to prevent harm*

*to the individual and others. Wherever possible, the doctor should first seek the consent of the individual concerned before disclosing information about the conversation. The sergeant should be encouraged to take his concerns to the chain of command in order to access practical support. The principle of disclosure in the public interest may allow disclosure to a commanding officer without the consent of the patient where, for example, the health of the patient puts the health, security or safety of the unit, the patient or the wider public at risk. Again, this should involve revealing the minimum information necessary to prevent the threat of harm posed by the individual to himself and others, for example by suggesting that the sergeant be taken away from the front line and access to live arms. If appropriate, the doctor can medically 'downgrade' an individual. This lets officers know that there is a restriction on the duties that the individual may perform, without having to disclose any medical details. Whether to disclose information is a decision that has to be made on a case-by-case basis by the individual doctor concerned. Blanket rules cannot be applied in these circumstances.*

## Key messages

- Doctors owe a duty of confidentiality to all of their patients, including after death.
- The duty of confidentiality applies equally to the health information of fellow members of the UK armed forces as it does to civilian patients.
- It may be necessary for doctors to explain their duty of confidentiality to patients and offer reassurances that their information will be kept confidential.
- Any identifiable information relating to a patient should be kept confidential, unless there is a compelling legal reason why it should not be.
- Doctors must be prepared to justify any decision to disclose information without the patient's consent.

## 5. Competence

**'Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must... recognise and work within the limits of your competence.'**

The duties of a doctor registered with the General Medical Council

### **Is it unethical for doctors to act outside of their competence?**

Disregarding the GMC's requirement that doctors work within the limits of their competence, as quoted above, could leave doctors open to fitness to practise proceedings or legal action. However, the increasing specialisation of medical practice means that military doctors may routinely be required to provide care for patients across a broader range of competencies than would be required of a practitioner in ordinary civilian practice. For example, it would be impractical to deploy individuals from all surgical specialties to all field hospitals. Consequently military surgeons are routinely required to treat injuries outside the limits of competence that would normally apply to their specialty in civilian practice.

Military doctors may therefore find themselves in a position where they are required, or feel under pressure, to undertake procedures that they would not normally attempt outside of the military context. Doctors may also witness others being placed under similar pressures. It can be difficult to decline such requests, or to expose such practices, but the wellbeing of patients must be the overriding concern. (See below for guidance on exceeding competence in emergency situations.)

### **What should doctors do if they are called upon to exceed their competence?**

Where doctors are requested to undertake a procedure that they believe exceeds their competence and could harm patients, they should, where possible, request supervision from a senior or more experienced colleague to ensure that any risks to patients are minimised. If the request for supervision is declined, or there is no suitable colleague available, and the doctor believes that intervening will present a significantly greater risk of harm than waiting for a suitable colleague to become available, he or she should decline.

These circumstances can be difficult, and it may be necessary to report any such situation that remains unresolved via the medical chain of

command. Doctors themselves have a duty to mitigate such difficulties as far as practical by seeking appropriate training and experience. In addition, the chain of command should ensure that this can and does occur.

### **Is it ever acceptable for doctors to exceed their competence?**

Generally, if no other suitably qualified colleague is available, doctors should act if that would be likely to increase a patient's chances of survival or a significantly improved outcome. In certain circumstances, including combat and other emergency situations, doctors may be stretched to the very limit of their competence. Circumstances may arise where there is a stark choice between intervention from a doctor who is inexperienced in a particular procedure and a patient receiving no intervention at all. Consideration should be given to whether it would result in a better overall outcome for the patient if that doctor were to intervene, despite a lack of experience, than if there was no intervention. Decisions should be made on the basis of each individual case.

## Key messages

- The wellbeing of patients must be the doctor's overriding concern.
- Where doctors are required to undertake a procedure that exceeds their competence and could put patients at risk, they should request supervision from a senior or more experienced colleague.
- If the doctor believes that intervening will present a significantly greater risk of harm than waiting for a suitable colleague to become available, he or she should decline.
- Where there is otherwise no prospect of a patient receiving medical intervention, generally doctors should act if that would be likely to increase a patient's chances of survival or a significantly improved outcome.

## 6. Treating detainees

**'Health personnel... charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.'**

United Nations Principles of Medical Ethics in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

During operational deployment, forces are likely to have cause to detain individuals from military or civilian populations. Regardless of their specific legal status, which will vary according to the operation, all detainees will require medical assessment and support.

Where the examination and treatment of detainees is part of their regular duties, doctors should ensure that they are familiar with the extensive military doctrine covering the medical examination and treatment of detainees (see pages 49-51 for further sources of information and support). The following guidance does not attempt to repeat the

procedural detail of such doctrine, but applies the core principles outlined throughout this tool kit to those scenarios that doctors in the armed forces are likely to encounter when providing care to detainees.

### **What are doctors' responsibilities in providing medical support to detainees?**

Medical care and treatment must be provided with impartiality and without discrimination. This means that detainees must be given the same quality and standard of care as all other patients. In accordance with the principle of equivalence, the ethical standards required of doctors apply equally to the treatment of detainees as to all other patients.

A doctor's role in relation to detainees should be restricted to assessing, protecting or improving the physical and mental health of patients. As well as providing direct medical support to detainees, doctors also have responsibilities in monitoring the standards of health and hygiene within a detention facility, such as access to food and water, sanitation, heating, lighting and ventilation. Whenever a doctor considers that a detainee's physical or mental health will be harmed by continued detention, or by the conditions in detention, this should be reported to the commander

of the detention facility and to the medical authorities.

Doctors also have a duty to ensure that their patients are not being abused while in detention, and to act on any evidence of abuse. Further guidance on identifying and reporting abuse is given on pages 43-48.

### **Can doctors declare detainees fit for detention, interrogation, questioning or punishment?**

While it is clearly in detainees' interests to be medically examined on entering detention, on transfer between different detention facilities and on release, it is unacceptable for doctors to declare detainees fit for detention, interrogation, questioning or any form of punishment. Instead, doctors should identify specific medical needs resulting in advice that a detainee is not fit for detention, interrogation or questioning. Alternatively, a doctor can declare that there are no medical reasons for the doctor to intervene, or that a detainee is not fit for detention, interrogation or questioning. Similarly, doctors must not question detainees about matters unless relevant to their medical care.

Detainees may be particularly vulnerable to the abuse of their medical information. Doctors should therefore be especially careful to ensure the confidentiality of all personal medical information, including any medical records, where a detainee is subject to interrogation, or could be at a later stage.

### **Are doctors allowed to assist in the interrogation, questioning, punishment or restraint of detainees?**

Under no circumstances should doctors use their knowledge or skills, or an individual's health information, to participate, assist or advise in the interrogation, questioning or punishment of detainees. To do so would remove the crucial distinction between the medical and military roles, and as such would be a serious breach of medical ethics.

### **When is a doctor not a doctor?**

You are asked to take part in an interrogation. Members of your unit running the detention facility tell you that your involvement will be legal if you are removed from the medical chain of command. When you question this idea, you are told that all you have to do is make

it perfectly clear to the detainees that you are not their doctor. Is this correct?

*Doctors must not take part in this process. They must always act in the best interests of their patients. The military doctor's role is first and foremost as a health professional. Simply telling detainees that an interrogator is acting outside of his or her capacity as a doctor would not alleviate the ethical conflict here, or limit the damage to patients' trust in an independent, impartial medical service. Any attempts to involve doctors in interrogation, punishment, non-medical questioning or restraint should be resisted and reported immediately using the medical chain of command.*

Doctors must not participate in any procedure to restrain a detainee unless it is for the protection of the detainee's health or safety, or for the protection of fellow detainees or detention facility staff, including the doctor, and does not risk harming the patient's health. The circumstances where it will be acceptable for doctors to be involved in restraint are likely to be very unusual. Where used, the type of restraint should be the least intrusive

available and the minimum amount of restraint necessary, for the shortest period possible, to achieve the objective.

### **What happens if a detainee refuses to be medically examined?**

Those who are detained are likely to view members of the detaining authority, including medical staff, with caution. They may refuse examination through anxiety. Doctors can increase levels of trust by explaining their medical role and duty of confidentiality, the purpose of the examination, and the fact that they are not involved in the process of detention or questioning. Such explanation is likely to require time and the involvement of an interpreter.

If a detainee continues to withhold his or her consent to medical examination after being provided with all relevant information, this refusal must be respected and documented. Only an external visual inspection should be carried out. This should not extend to forcibly undressing the detainee.

Having a formal record of an individual's pre-detention health is important. Such records enable any subsequent changes to be clearly linked to conditions inside detention and

protect detainees from the increased risk of suffering injury, including self-harm, during detention. Detainees, like all adult patients with capacity, are however entitled to refuse treatment or examination and this right must be respected.

### **Key messages**

- Detainees must be given the same quality and standard of care as all other patients.
- A doctor's role in relation to detainees should be restricted to assessing, protecting or improving the physical and mental health of patients.
- It is unacceptable for doctors to declare detainees fit for detention, interrogation, questioning or any form of punishment, or to participate in such activities.
- Doctors should never use their knowledge or skills, or an individual's health information, to participate, assist or advise in the interrogation, questioning or punishment of detainees.
- Detainees, like all adult patients with capacity, are entitled to refuse treatment and this right must be respected.

## 7. Identifying and reporting unethical practices and abuse

**‘Time and again, it is the medics who find out first what is going on, and tell the outside world about it.’**

**John Simpson, BBC World Affairs Editor**

Historically, doctors have been prominent in championing the cause of those subjected to abuse at the hands of state authorities across the world.

The 2011 report of the Baha Mousa public inquiry stated that procedures to enable the detection of abuse had not been instituted at the time of Baha Mousa’s death.

While abuse is not tolerated within the UK military, British military doctors may still witness unethical practices perpetrated by other nations’ forces. A failure to act in the face of abuse could allow it to continue unhindered.

Military protocols and instruments of international humanitarian law detail the requirements and procedures for reporting

abusive practices. The following advice gives an overview of the principles that should guide doctors' actions.

### **What amounts to unethical practices and abuse?**

Abusive situations rarely emerge suddenly. The process of dehumanisation and desensitisation often begins with relatively minor disproportionate behaviour, which may go unnoticed or unremarked. Over time, this can escalate to practices that would generally be perceived as abuse, that is as breaching the core principle that military actions at all times be both proportionate and just. By this stage, those involved may be less likely to recognise the behaviour as ethically unjustifiable or illegal.

Perpetrating or being present during abuse is not the only behaviour that equates to involvement in abuse. Individuals are complicit in abuse where they are aware of it, but do nothing about it, or where they conceal the facts of abuse.

## Looking the other way

You are asked to assess a civilian patient, who has recently sustained life-threatening injuries, and to advise whether she is well enough to be transferred to a medical facility under the command of another nation's armed forces. You have reason to believe that staff within that facility have not complied with humanitarian principles in the past and that patients have been mistreated. This is something that is widely but informally acknowledged among members of your own unit. What are your responsibilities here?

*A doctor should decline to make any assessments that might contribute to the transfer of a patient in situations where the doctor has any significant concern that such transfer is to a facility in which the patient's care will be adversely affected, diminished or compromised. Transfer decisions should be based on the expectation that equivalent or better circumstances can be provided. Doctors have clear responsibilities to act on their knowledge of suspected abuse. It is unacceptable for a doctor to ignore the possibility that a patient who is currently under his or her care may be abused or*

*exposed to ill-treatment. The doctor should use existing reporting systems to highlight his or her concerns to the senior medical officer of the medical facility at which he or she is based and to the medical director for the multinational forces HQ, and to seek assurances that they are being acted upon. In addition, legal advice may be required.*

Members of the military are required to obey lawful orders. They work in closed and hierarchical command structures and identify closely with, and experience strong loyalty towards, the unit or service of which they are a part. Of course these factors do not make abuse inevitable. For example, an order which would lead to action contrary to medical ethics would be unlawful and as such must not be obeyed. It is however important that doctors in the armed forces remain aware of the way in which such features of military life can influence the likelihood that they themselves will either recognise unethical or abusive practices, or have the moral courage to report such practices, especially where this would involve exposing colleagues to disciplinary procedures or questioning the actions of seniors.

Doctors should also be alert to any deterioration in the mental health of comrades. Established links between mental ill health and the perpetration of abuse emphasise the importance of the military doctor's role in tending to the mental health problems of comrades (see pages 29-30 for guidance on reporting concerns about a colleague's deteriorating mental health).

### **What are doctors' responsibilities in responding to evidence of abuse?**

If doctors suspect practices that are harmful to the health and wellbeing of their patients, they must make immediate enquiries to verify or allay their suspicions. This can involve asking questions of colleagues, discussing concerns with other medical staff, and talking to military and medical commanders. Following such enquiries, or as soon as doctors become aware of unethical practices or abuse, they have a responsibility to report this via both the military and medical chains of command, and to ensure that any relevant medical records or reports are accurate and up to date. Doctors should keep their own record of all action they take in respect of reporting abuse.

Their responsibilities require doctors not only to seek out information but also to act upon

it. Where a doctor is unable to obtain the required information, he or she should escalate enquiries through local command structures and the medical chain of command. Doctors should also seek assurances that information they have reported is being acted upon.

### 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.
- Doctors should be aware of the factors which can influence the likelihood that they will recognise or report unethical or abusive practices.
- Doctors should keep their own record of all action they take in respect of reporting abuse.

## 8. Sources of further information and support

### **British Medical Association**

Medical Ethics Department, BMA House,  
Tavistock Square, London WC1H 9JP.

Tel: +4420 7383 6286 Fax: +4420 7383 6233

Email: [ethics@bma.org.uk](mailto:ethics@bma.org.uk)

Web: [bma.org.uk/ethics](http://bma.org.uk/ethics)

Armed Forces Committee, BMA House,  
Tavistock Square, London WC1H 9JP.

Tel: +4420 7383 6020

Email: [info.armedforces@bma.org.uk](mailto:info.armedforces@bma.org.uk)

### **General Medical Council**

Regent's Place, 350 Euston Road,  
London NW1 3JN.

Tel: +44 20 7189 5404 Fax: +44 20 7189 5401

Email: [standards@gmc-uk.org](mailto:standards@gmc-uk.org)

Web: [www.gmc-uk.org](http://www.gmc-uk.org)

### **Defence Medical Services Professional Conduct and Ethics Committee**

SO1 Medical Policy, HQ Surgeon General,  
Coltman House, DMS Whittington,  
Lichfield WS14 9PY.

Tel: +441543 434118

Email: [SGACDSStratPol-MedPolSO1@mod.uk](mailto:SGACDSStratPol-MedPolSO1@mod.uk)

## Publications

*Joint Medical Doctrine*. Joint Doctrine Publication 4-03. 3rd edition, May 2011. MOD.

*The Joint Service Manual of the Law of Armed Conflict*, Chapter 7 'The Wounded, Sick, and Dead and Medical Services' and Chapter 8 'Prisoners of War'. Joint Service Publication 383. 2004. Oxford University Press.

*Medical Support to Persons Detained by UK Forces whilst on Operations*. Joint Service Publication 950, leaflet 1-3-4. March 2011. MOD.

*Captured Persons (CPERS)*. Joint Doctrine Publication 1-10. 2nd edition, October 2011 (reviewed for amendments on a 6 monthly basis). MOD.

The Geneva Conventions of 1949 and their Additional Protocols. Available at:  
[www.icrc.org](http://www.icrc.org)

*Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies*. August 2012. ICRC.

Doctors may find the following BMA ethics guidance useful. It can be accessed at [bma.org.uk/ethics](http://bma.org.uk/ethics):

*Confidentiality and disclosure of health information tool kit (2009)*

*Consent tool kit (2009)*

*Medical Ethics Today: The BMA's handbook of ethics and law (2012)*

*Mental Capacity Act tool kit (2008)*

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