

Medico-Legal Issues Surrounding Medical Countermeasures Used in The Gulf War - Part 1

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SUMMARY: When the multinational force deployed to the Gulf after Iraq's invasion of Kuwait in 1990, military intelligence assessed the Iraqi's as possessing and being capable of using weapons of mass destruction. There was judged to be a real threat that chemical weapons, especially nerve agents, and certain biological weapons would be used. Coalition countries attempted to reduce the effects by the use of medical countermeasures. Since the Gulf conflict a series of medico legal problems from this policy have arisen; some of which have formed the basis of claims against MOD. In this paper I shall review how consent to treatment may have been modified in the military operational context and by the interface with military law. I shall look at the issues of clinical negligence and how duty of care may be affected. In the next article I shall look at relevant employment law; briefly review how medicines regulatory provision applies to medical countermeasures, whether they were properly licensed and whether in any case this applied to the Ministry of Defence in the context of deployment to the Gulf War.

Consent To Preventive Health Measures in Military Operational Context

Respect for the ethical principle of self determination is expressed in law through the principle of consent to treatment. The law protects and preserves the right of the patient to decide what happens to him. Case law is clear and was reiterated by Lord Donaldson in *Re T* (1), the case of a Jehovah's witness who refused consent to a blood transfusion 'prima facie every adult has the right and capacity to decide whether or not he will accept medical treatment, even if a refusal may risk permanent injury to his health or even risk premature death'. The doctor who carries out a treatment without any consent or with consent obtained by fraud or duress commits a battery. *Chatterton* (2) clarified that once the patient is made aware in the very broadest of terms the nature of the procedure, provided that he has not been coerced and has capacity to consent, then any action would have to be in negligence. In order to succeed the individual would have to show not only the three pillars for negligence (duty of care owed; failure of duty of care; harm resulted) but also that had he been given more information he would have withheld consent.

In military context, the action of one person in refusing consent may have considerable implications for others. Consider the scenario in which an individual serviceman refuses consent to administration of a preventive health measure such as an anti BW (biological warfare) vaccine. If this serviceman renders himself unfit for combat by his actions he may jeopardise not only the efficiency of the military operation to hand, but also the lives of his colleagues. In this situation should the desires of the individual be subordinated to the well-being of the majority?

The Army Act 1955 and subsequent legislation (3) provide the framework of military law that is a statutory legislative structure in addition to statute and common law which applies to other citizens of the United Kingdom. There is provision within the Army Act to discipline any soldier who 'with intent to render or keep himself unfit for service...does or fails to do anything...whereby he produces, or prolongs or aggravates, any sickness or disability...' (4). Technically this section could be used to discipline a soldier who refused consent to be vaccinated or take his NAPS. However, it would have to be shown that this refusal had kept him unfit for service. The spirit of this section is to discipline soldiers who render themselves unfit by self harm. It has not been used to coerce servicemen to undergo particular treatments they do not wish to partake in without their consent. If it were, the Ministry of Defence could risk action in battery.

It has been the case during living memory that servicemen's

right to refuse vaccination, if they so wish, has been recognised. Many years prior to the Gulf conflict this very area was raised in a Parliamentary debate (5), servicemen in France and Germany were allegedly stopped from going on leave by their Commanding Officers, on the grounds that they had refused routine vaccinations. The Secretary of State for War made it clear that 'existing instructions emphasise that vaccination and inoculation are voluntary...' and that soldiers should not be coerced into receiving them. Prior to the Gulf anti BW vaccines were entirely voluntary. If individuals expressed worries about particular aspects of the vaccination programme they were not coerced to have the vaccine (6). One could argue that immunisation against BW agents by voluntary informed consent would not meet the military imperative to be able to continue operations under a biological warfare threat, especially if the take up rate was significantly less than 100%. In this situation there is a conflict between an individual serviceman's rights and the well being of the group as a whole. The courts may well decide that the more threatening the military situation the less justified individual soldiers have in standing on their rights.

Does Case Law Provide Clarification?

There are no directly analogous cases to date. There are, of course, only ten years of tort cases against the MOD as until section 10 of **Crown Proceedings Act 1947** was repealed on 15 May 1987 there was no option at all for a serviceman to bring such an action against the Crown. The most relevant case, which alleged both trespass and negligence, is that of *Freeman* (7), a prisoner given an anti psychotic injection with alleged force, his counsel claimed that no hold capacity to consent or withhold it was impossible within the prison context since he was not in a position to choose freely. The Court of Appeal rejected the proposition that by virtue of the 'institutional setting' Freeman could not exercise a free choice. Stephen Brown LJ commented that the 'institutional setting' should make doctors especially careful to satisfy themselves that consent was freely given. The problem of being 'especially careful' pre Gulf was the need to vaccinate 50,000 British troops in a very short time span in a time of threat. The courts may, if challenged on this point, modify the law of consent in the context of 'a mad dictator' known to hold B & CW agents and a country doing its best to protect its troops.

What In Practice Happened in the Gulf?

In practice vaccinations were entirely voluntary. To attend the vaccination parade was not. If individuals expressed worries about particular aspects of the vaccination programme they were

not in fact coerced to have the vaccines (8). The medical officer running the programme would discuss the risk benefit equation. At the time there was a very real perceived threat and the average soldier's mind was focussed on surviving the impending conflict.

Nerve Agent Pre Treatment Set (NAPS) (9) were not under medical control within the military medical command chain but were issued together with other NBC measures provided for soldiers such as gas masks and charcoal impregnated suits. The order to commence ingestion of NAPS was made on an operational basis on threat assessment. Tablets were held by individual soldiers and ingestion was entirely without supervision; it is accepted that if an individual had stated quite publicly to his commanders that he was not going to take them he might well have been charged under Section 34 of the **Army Act 1955** (10). There were no such cases. Some veterans have alleged that they were, in effect, forced (11) to take the tablets and as a result have suffered long term physical problems. To succeed in any claim they would have to show causation on the balance of probabilities for which there is no such evidence at present. Even if the individual could establish that he was not warned of side effects, and he could show that harm had resulted, he would also have to show that he would have refused consent had he been warned.

Alleged Medical Negligence and Preventive Health Measures Used in The Gulf Conflict.

In order to establish liability in medical negligence, with regard to the prescription and administration of vaccines and NAPS, the aggrieved soldier would have to establish that there was a duty of care by his military medical advisers and that there was a failure in duty of care. Any such failure would be governed by the medical professional standard test and *Bolam* (12). Should these obstacles be overcome then causation would have to be proved; research to date has produced no clear evidence. In particular, a study looking at mortality of all 700,000 American veterans (13) found a slight increase in mortality compared with servicemen who had not served in the Gulf War; interestingly, this excess was wholly accounted for by death through accidents. A survey of all US veterans both deployed and not deployed found an increase in self reported health problems (14). The main increases in reporting rates were for cognitive dysfunction, fibromyalgia, depression, anxiety, alcohol problems and chronic fatigue. There was no increase noted in more specific conditions such as malignancies. We await the publication of MRC funded studies with interest (15).

Historical Background: The Repeal of Section 10

Until 1947 any action against the Crown in tort was inhibited by two principles of ancient origin. The first was that his own courts could not implead the King. The second was that the King could do no wrong (16). In 1947 the **Crown Proceedings Act 1947** became law. This changed forever the position of the Crown in tort. Section 2 made the Crown liable in tort effectively under the same rules as a private individual. However, Section 10 of the Act made provision to exclude proceedings brought in respect of death, or personal injury, to a member of the armed forces caused by the negligence of another. This, in effect, prevented legal action in tort by members of the services who were killed or injured either by employer or medical negligence against either an individual employed by the Crown or the Crown itself. This was the case provided the Secretary of State issued a certificate indicating that the death or injury was attributable to services for the purposes of entitlement to a War Pension (17).

Legal challenges as to the validity of Section 10 started to be brought. The case of *Bell* (18) concerned alleged medical

negligence. On the preliminary issue of whether the provisions of Section 10 gave immunity to the defendant against vicarious liability to the negligence of the army's medical staff it was held that as a certificate accepting attributability had been issued Section 10 immunity held.

In 1987 Section 10 was repealed by the Crown Proceedings (Armed Forces) Act 1987. In the situation of 'imminent national danger or of any great emergency' (19); or if there are 'warlike operations in any part of the world outside the UK; or if any other operations which are or are to be carried out in connection with the warlike activity of any persons in any such part of the world...' (20) the Secretary of State is empowered to revive Section 10. The scope for such re-instatement is broad. There is even greater flexibility in the legislation in that he can make the order to make 'different provision for different cases, circumstances or persons' (21). For whatever reason an order was not made under Section 2 of the 1987 Act; there is no provision for it to be made retrospectively. Hence there is no legal bar to a serviceman pursuing legal action against MOD either for medical negligence or employer negligence.

Medical Duty of Care

In ordinary military situations including operational deployment a duty of care is owed in the normal way and the standard remains that of the ordinary skilled doctor within that particular art, that is: *Bolam* and the medical professional standard test. The interface between what are 'generally accepted medical standards' referred to in article 11(1) additional protocol 1 of the Geneva Convention 1949 and the practical exigencies of battlefield medicine turns ultimately on the question of 'necessity' or more accurately 'impossibility'. It would be absurd to demand the resources of a modern teaching hospital in an advanced country upon the battlefield (22). The 1977 Additional protocol 1, article 10(2) makes it clear that patients 'shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. What is in fact practicable? In the case of wounded soldiers, if resources are limited triage principles apply (23). This is not really analogous to the case of soldiers receiving vaccinations. However, it illustrates that even in the case of preventive health measures in a country preparing itself for war a pragmatic approach as to what is reasonable may have to apply.

In the war situation: is there still a duty of care?

It was generally accepted that there is no direct English authority to support the proposition that one soldier owes no duty of care in tort to another when engaging the enemy in battle conditions until the case of *Mulcahy* (24). There were however, Commonwealth precedents (25). In *Mulcahy* the MOD appealed against an order in the County Court refusing their application to strike out the plaintiff's claim. The plaintiff, still serving, was part of a team manning a howitzer gun; the SNCO in charge was the only person who could give the order to fire.

The plaintiff claimed that at the time the gun was fired he was ordered to go to the front of the gun to collect something and as a result he suffered hearing loss. His lawyers argued that the case was fundamentally different from hand to hand conflict and that, although they were in Iraq in the course of battle and rounds were being fired against the enemy, there had been no return fire. Initially counsel for the plaintiff argued that the gun was being fired as part of a training exercise but he quickly dropped this argument. Although the County Court Judge referred to '...degrees of involvement in war like activity...' at appeal Neil LJ refused to consider the concept of distance from the battlefield in general. He held that the plaintiff was in a war zone carrying

out warlike activity. It was held that a serviceman owed no duty of care in his conduct towards a fellow soldier when engaging the enemy during hostilities, even if proximity and foreseeability of damage were proved.

How is the judgement in Mulcahy likely to affect a Gulf War Illness sufferer bringing a medical negligence action?

Mulcahy looks at the issue of a common law modification of the duty of care one soldier owes another in a battle situation; that is in the general sense rather than specifically in medical negligence. It could well apply if a soldier tried to sue a medical officer, or vicariously the MOD, for treatment in a battle situation. In this situation Mulcahy would no doubt hold, it would be politically unacceptable for a soldier to have to worry about being sued by his fellows for actions in the heat of battle.

What about the situation for preventive health measures? It is highly unlikely that a Mulcahy defence could be used in alleged negligence in the provision of vaccinations as by their nature they were not used in 'battle conditions'. Some follow up doses of anti-BW vaccinations inevitably were given during the air war which preceded the land battle; it might prove difficult for the ministry to allege no duty of care was owed in these conditions.

Failure in duty of care a realistic proposition?

I have already established that when a duty of care is owed, there is likely to be a modification of the level of care, which could be realistically offered, in certain operational situations. It may be possible for the plaintiff to argue that he received inadequate care after the conflict, and indeed many Gulf veterans have done just that. It would be much more difficult for the plaintiff to successfully argue that he received inadequate treatment after the conflict. One possible area of weakness is in the regulation and licensing of medicines which I shall review in the next article.

Causation: a Medical Issue to be resolved

Establishing cause and effect in cases alleging medical negligence will depend on what is shown by the ongoing research into the health of veterans. Equally, claims of employer negligence (e.g. Alleged failure to provide adequate protection when pesticide spraying) will depend on some evidence to show that ill effects have been so caused. The plaintiff will have to show, on balance of probabilities, that his health problem was caused by a negligent act of MOD; bearing in mind the state of knowledge at the time. He will have to establish that there was not a more likely cause of his problems as per Wilsher (26). Gulf War litigation cases (with the exception of a small sub group of PTSD Gulf cases) are currently on hold awaiting outcome of the two MRC funded research programmes.

Conclusion

I have established that although there is provision in military law to force individual servicemen to receive preventive health measures; in practice the concept of the autonomous adult having the right to consent or refuse consent to treatment was not interfered with. The situation pre Gulf of a deployment to war was of an employer trying to provide protection against BW and CW agents as well as it was able. It is arguable, applying the analogy to Freeman (27), that the individual, although holding capacity to consent, could not really be in a position to choose freely. There is undoubtedly a conflict of interests between the rights of the individual and the well-being of the group. The courts may modify the law of consent in the context of a 'mad dictator' known to hold B and CW agents and a country doing its best to protect its troops.

I have established that during battle conditions themselves it would be exceedingly difficult for a soldier to succeed in a medical negligence case against MOD, as the Mulcahy precedent is clear on the point that there is no duty of care in battle conditions. In preparation for the deployment, both in medical countermeasures and in the assessment of the individuals mental and physical health, there is a duty of care; the standard required is modified in common law from that expected in normal peacetime conditions. It may be that the courts would consider, in view of the real threat from C and BW agents that there is less justification of the individual soldier's rights.

REFERENCES

1. ReT [1992] 4 All ER 649.
2. Chatterton v Gerson [1981] QB 432; [1981] 1 All ER 257.
3. Army and Air Force Act 1961; Armed Forces Act 1966; Armed Forces Act 1971; Armed Forces Act 1976; Armed Forces Act 1981; Armed Forces Act 1991. Associated regulations.
4. Army Act 1955 s42(1)d; (2).
5. Parliamentary Debates (Official Reports) 1954-55 537 Feb 14 to Mar 4 w67.
6. Parliamentary Debates (Official Reports) 10 Dec 96 pl32 Mr N Soames referring to a question regarding a particular Gulf Veteran 'he would have only been injected on the basis of informed consent'.
7. Freeman v Home office. [1984] 1 All ER 1036 (CA).
8. Parliamentary Debates (Official Reports) 10 Dec 96 pl32 Mr N Soames referring to a question regarding a particular Gulf Veteran 'he would have only been injected on the basis of informed consent'.
9. Pyridostigmine Bromide 30mg.
10. Army Act 1955 s34 makes provision for a person subject to military law who '...whether wilfully or through neglect ...disobeys any lawful command'.
11. MONTAGU-SMITH N., 'Surviving the Desert Storm'. (1997) I.C.Lit. Feb 11-16.
12. Bolam v Friern Hospital Management Committee. [1957] 2 All ER 118.
13. KANG H, BULLMAN T. 'Mortality among US veterans of the Persian Gulf War'. *N Engl J Med* 1996; **335**: 1498-504.
14. The Iowa Persian Gulf Study Group. 'Self reported illness and health status among Gulf War Veterans'. *JAMA* 1977; **277**: 238-245.
15. MRC is funding two major research programmes. One at Manchester University led by Prof N Cherry looking at Gulf veteran morbidity; and one at the London School of Hygiene led by Dr P Doyle looking at reproductive health outcomes.
16. Lord Canterbury v R (1843) 12LJ Ch281.
17. Crown Proceedings Act 1947 S10 'Nothing done or omitted to be done by a member of the armed forces of the Crown while on duty as such shall subject either him or the Crown to liability in tort for causing the death of another person, or for causing personal injury to another person, in so far as the death or personal injury is due to anything suffered by that other person while he is a member of the armed forces of the Crown if: a.[he is] on duty as a member of the armed forces... b.The Minister of Pensions certifies that his suffering [is]...attributable to service for the purposes of entitlement to an award: provided that this subsection shall not exempt a member of the said forces from liability in tort in any case in which the court is satisfied that the action or omission was not connected with the execution of his duties as a member of those forces. S2(2)makes similar provision preventing proceedings against the Crown.

18. Bell v Secretary of State for Defence [1968] 1QB (CA) 323.
19. S2(a) Crown Proceedings (Armed Forces) Act 1987.
20. S2(b) supra.
21. S2(2)(3) supra.
22. H Mc Coubrey Centre for International Defence Law Studies University of Nottingham 'Medical Ethics, Negligence and the Battlefield' conference paper presented 3 December 1994 United Kingdom Group of the International Society for military law and law of war.
23. 'Field Surgical Pocket Book'. HMSO 1981 Ch2 p25; Ch26 p290.
24. Mulcahy v MOD. [1996] 2 All ER 756.
25. Shaw Savil and Albion Co. Ltd v The Commonwealth. (1940) 66 CLR 113.
26. Wilsher v Essex Area Health Authority. [1988] 1All ER 891.
27. Freeman v Home Office. [1984] 1 All ER 1036.