

THE ETHICAL DILEMMA OF PROVIDING INTENSIVE CARE TREATMENT TO LOCAL CIVILIANS ON OPERATIONS

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Introduction

I will apply dietetic measures for the benefit of the sick and injured according to my ability and judgement; I will keep them from harm and injustice Hippocrates 4th Century BC

The military doctor puts themselves in a position of having multiple ethical dilemmas, in addition to those of their civilian counterpart. These are not new; Ambrose Pare describes medical euthanasia during the siege of Turin in 1536, and there are multiple accounts of medical practitioners allegedly being complicit during torture. Treating civilians in the battlespace also has a long history; the Geneva Conventions over many years have formalised an obligation to do this.

However Intensive Care puts an additional dilemma on the physician. In any hospital, the Intensive Care Unit (ICU) is a limited resource and doctors are often faced with the decision as to whether to admit a patient or not, and if the unit is full how to accommodate them. This may mean moving a stable patient, with all its attendant risks, or looking after the new patient outside the unit – which has been shown to worsen outcome.

The Field Intensive Care Unit adds yet another dimension to this. They are established for the short term care of a pre screened, fit, adult population who will be evacuated in a matter of hours. Often they will have no support from nearby units for transfer in times of stress, yet must always be positioned to accept a surge of patients should the battle tempo increase. In addition there will always be ‘higher command’ demanding the scarce resource be rationed to ‘friendly forces’.

Several papers have addressed some of these issues, but there is little about the particular stressors of ICU treatment on operations. This brief paper attempts to cover some of the arguments; however it can not be relied upon as a definitive statement of law, and ethics will always be a matter for the individual practitioner to justify to themselves, the courts, but most importantly to their patients. It will concentrate on Peace Support Operations and warfighting – as clearly the dilemmas on Humanitarian / Disaster Relief Operations are different.

Military Necessity versus Clinical Need

It is often said that a military doctor is ‘an officer first, a doctor second’. If this were truly the case there would be little conflict in the care of civilians. It has been argued that casualties could be classified in terms of their ‘salvage value’, that is to say how much use they will be to the fighting force in the future [1]. If this were the case, there would be no benefit in treating civilians at all. Indeed it could be argued that treating civilians would denude the limited resource of Intensive Care and therefore deplete the fighting force. However this flies in the face of our obligations

under the Geneva Conventions, and, closer to home, the doctrine of CIMIC. It is also in direct conflict with every doctor’s desire to treat all patients as equals, only in accordance with their clinical need – an obligation not only under the Hippocratic Oath, but also from the General Medical Council (GMC) who state that a doctor must make ‘the care of your patient your first concern’ and ‘you must not refuse or delay treatment because you believe that a patient’s actions have contributed to their condition’ [2].

It can be seen that the military Intensive care doctor therefore has 2 loyalties – to the fighting force (with its attendant higher command) and to the sick patient presented to him. From this the concept of ‘Dual Loyalty’ has been developed, which has been the subject of a 3 year International Working Group. It must be noted this dual loyalty is not a peculiar dilemma of the military doctor; the prison doctor will have many of the same issues. Indeed even the civilian practitioner faces a similar problem, when faced with notifying the ‘authorities’ about a communicable disease (or a dangerous patient) without the consent of the patient. A summary of the guidelines are given in Table 1.

- 1) The Military Health Professional’s first and overruling identity and priority is that of a health professional.
- 2) Civilian medical ethics apply to military health professionals as they do to civilian practitioners.
- 3) The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society.
- 4) The military health professional is a member of the national and international health professionals’ community.
- 5) The military health professional should treat the sick and wounded according to medical need and triage

Table 1. Summary of the recommendations of the International Dual Loyalty Working Group (Military Guidelines) [3]. These are the top 5 – a further 5 were produced that refer to torture, research for CBRN, experiments on humans, capital punishment and human rights.

These would therefore put an obligation on the Intensivist to accept and care for anyone sick in their hospital. This is supported by most Medical Rules of Engagement, or Eligibility matrices, which usually end with the statement that Life / limb saving procedures must be offered to all. It should also be noted that the World Health Association declared that ‘Medical ethics in time of conflict are identical to medical ethics in time of peace’ [4].

So it can be seen that whatever the prevailing military necessity, there is an absolute obligation in law, under international convention and from most bodies of ethics to admit a sick patient in the hospital, whatever their background, and to the Intensive Care Unit if required because of their medical condition. It is here that the real ethical problems lie:

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Field Intensive Care Units have limited beds and limited personnel, so to continue to work they rely on patients being evacuated promptly. This is no issue for 'friendly forces', who will be taken down well trodden paths to their home country's medical facilities as soon as possible (often within 24 hours). However, usually the political will is for local nationals to stay in country, where local hospitals may be hugely under resourced. This means the ICU may not have ventilators or oxygen, so evacuating a critically ill patient to them is fraught with difficulties. Yet keeping them on the Field ICU will block beds and possibly impact on military operations. This has been noted recently by the Canadian Medical Forces; *'Physicians— caught in untenable ethical quandaries between their duty to provide emergency treatment— and their obligation to "move them along"— knowing that they are all but issuing death sentences'* [5].

In essence the issue then becomes; should the patient be kept until cured, or should they be transferred out to whatever facility is available, as soon as possible? It can be seen then that the argument starts to centre on the doctor who wishes to do the best for his patient (the medical necessity model), and on the commander, who wishes to do the best for his mission (the military necessity model). There is very little written on this, and so one has to fall back onto the standard ethical principles of autonomy, beneficence, non – maleficence and justice.

Autonomy

This is essentially the right a person has to decide matters for themselves, in other words the right to self determination. It is within this principle that the concept of informed consent lies, that a person has the right to be given the information with which to make a decision as to whether or not it is in their interests to have the treatment. Once the patient has taken that decision, the practitioner should respect that person's will.

However most critically ill patients lose this right, as they are, in general, incapacitated, so unable to make take on board information, synthesise it and make a valued judgement on it. In these cases it falls to the medical practitioners and nursing staff to make judgements on behalf of the patient, based on what they know of the patient's will, and the progression of the disease. It would not be right, for example, to institute intensive therapy if it were felt to be futile, whatever the patient's background. It is more difficult to gauge the patient's will, especially when they are from different cultures. It is important to try to talk to near relatives and friends to ascertain if the patient had made any wishes known, but it rare that they would be allowed into the hospital. Even if they were, it is unlikely that the issues of the ICU will have been discussed in countries where ICM doesn't really exist.

It is generally agreed that these are difficult decisions, even in UK civilian hospitals, and made more difficult by being in the Field. Therefore the assumption is made that the patient would want all available measures, unless it can be shown conclusively that they would not. This is a brave assumption and may not necessarily be true, in countries with different cultures and different health care systems – the assumption should possibly be the other way.

Beneficence

This is the obligation 'to do good', although this can be difficult to define. What may 'do good' for the patient may not 'do good' for the society and vice versa. Indeed these come into conflict regularly, for example the obligation to 'do good' to society and report a notifiable disease, even if this is against the consent of the patient. The whole concept of triage is based around 'doing good' for society, at the possible expense of the person.

So it can be argued that beneficence refers to society, more than the patient. As the society that the military field hospital serves is the military, this obligation would, on the face of it, actually prevent civilians being admitted to the ICU. However

the ultimate society the military serves is the one from which it drawn, if that society has deemed wars should be fought under certain rules of conduct, the military needs to adhere to these. The UK has signed the Geneva Conventions, which obligates care to civilians.

In addition to this treating civilians can be seen as a force for good in the direct conduct of the conflict. The Australians certainly found the 'hearts and minds' won by their Field hospital looking after locals beneficial in Rwanda [6]. It should however be noted that many more lives may have been saved by primary health care and public health measures than Intensive Care; this is where the effort for this is usually best placed [7].

There is also an obligation here to use the local healthcare service for the good of society. It is important to not build dependence on the military as sooner or later the military force will go, leaving behind the local healthcare systems. It would be a disaster if the military mission could not stop because the local healthcare system had not been developed. This has a special relevance to ITU, as many country's local healthcare systems will not include this level of therapy. This is not a uniquely military problem. In 1992, several hundred ophthalmologists offered their services to Aid agencies to undertake cataract operations. This was declined largely on the basis that the agencies were trying to build up the capacity of the developing world to look after itself, as it was felt aid money can never be guaranteed. The surgeons were also offering the highest standard of care, whilst the Aid agencies were developing cheaper alternatives with wider applications. It was accepted that in the short term more would go blind, but in the longer term more would be helped [8]. Of course there are further issues if the country has a purely private system, by treating for free in the Field Hospital, a local doctor may well lose his livelihood. These arguments would make it difficult to admit a civilian patient to the ICU.

It is also worth considering the issue of beneficence with regards to a patient. 'Doing good' does not merely refer to prolonging life, if this will be of such poor quality that death may be more 'beneficial'. This brings all manner of personal judgements, which can only be based on the practitioner's experience. This will almost certainly be different from the experience of the patient, and especially if the patient is from a totally different culture. It would therefore be arrogant for the doctor to make presumptions on the patient's behalf based on an incomplete knowledge of the country in which they are based. The level at which remaining alive is worse than dying may well be different.

Non-Maleficence

This is the obligation to not harm a patient – *primum non nocere* (*first do no harm*). Some have noted that this phrase starts with the word 'primum (first)' so this should be the prime principle of medical ethics. It is however difficult to think of any drug or medical intervention that is entirely without risk of harm, so this obligation needs to be balanced with beneficence.

This principle throws out many interesting arguments about ITU treatments, e.g. at what level of risk of adverse event would non maleficence outweigh beneficence? It doesn't really help with the arguments about treating civilians on the unit, save to say one could interpret leaving a patient who required critical care outside an ITU as 'doing harm'.

Justice

This is the right to receive what is deserved. This right clearly has a cultural context, as it has to be for society to decide what it wishes to provide and therefore give the individual the right to receive. Society therefore defines a standard of care, and it would not be right for the field Hospital ITU to provide care to a different standard. Therefore if the host country hospital does not have an ITU, then it would be wrong to admit a local

civilian to the Field Hospital ITU.

The difficulty in this argument occurs when the standard of care defined by the society of the country staffing the ITU, is different from the standard defined by the country that the Field Hospital is in. It becomes even more difficult if economic issues mean that the host country can not achieve its desired standard of care.

Discussion

It can be seen from the above arguments that there can not be a clear answer to this problem. The desire of most practitioners' would be to treat the patient according the clinical priority, irrespective of background and if this meant early evacuation then that should happen. It does however ignore the need to develop local healthcare and the political fact that evacuating local nationals to other nations will rarely be acceptable at governmental level. Therefore there has to be an acceptance that these patients will, at some point be placed back into their own healthcare systems at some point in their illness. Indeed even if they were evacuated to another nation, at some point they would need to come home to their families and enter their healthcare system.

As the military desire is to keep the limited beds for military personnel, then the easy option would be to not admit local nationals into the military health system at all. This would avoid the hospital practitioner ever having to face the problem of separating care based on nationality. However this would essentially mean separating them at the first point of contact with the military, i.e. the soldier. It is surely unfair to put this responsibility on him, probably the least qualified person to make the decision – and it merely hides the fact that it is going on from the hospital doctor.

Possibly the best time to separate the patients is at the initial admission to hospital – military to military hospitals, locals to civilian hospitals. However all the above arguments can still be made, as the patient surely has a right to be delivered to that hospital safely? If the local ambulance systems are not refined

enough to do that, then these patients will have to come to the military hospital and then onto the ITU.

Conclusions

This brief paper will never be able to cover all of the ethical issues involved with treating local civilians in the Intensive Care Unit on operations. However other authors have noted that one of the problems is that they simply had not appreciated it would be a problem, and therefore had not discussed it. It is hoped that this paper will start that discussion for commanders and clinical staff alike, before they deploy – so they are better able to face the dilemma when it occurs.

It is probably best to leave the final words to the reported words of an Afghani doctor:

'Don't try to protect us against ourselves. We want to be involved in taking care of our own patients' [9].

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