Preventing and limiting suffering should conflict break out: the role of the medical profession

by
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The role of the medical profession is to prevent and limit suffering; the specialization of practitioners, by offering different roles for individuals, delineates their part in that overall task. Identifying conflict as a cause of such suffering allows us to examine the role of individual doctors and of groups of doctors in undertaking the tasks specific to conflict.

Throughout history individuals have expressed the hope, and sometimes the expectation, that man is outgrowing — socially and politically — the need or will to engage in conflicts. Sadly these hopes and expectations far exceed reality. Most observers feel that the number of conflicts is escalating. This may be, at least in part, a man-made phenomenon resulting from the accessibility of all parts of the globe to television and other news crews. It also demonstrates the need not only for action to reduce the suffering of those directly and indirectly affected, but also for scrutiny of the effectiveness of action taken by the various players involved.

The nature of conflicts is also changing. Wars are no longer fought on remote foreign fields but on home ground, through-

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out towns, cities and the local countryside. Armies are often irregular groups of ill-trained individuals. There are few clear distinctions between combatants and non-combatants. The laws of war — or international humanitarian law — built up over generations are too often flouted, through ignorance as much as through malice. In all too many conflicts the role of doctors and other health care workers, which that body of international law is intended to protect, is threatened and their neutral status is questioned. Even the symbols of the red cross and the red crescent, indicating those places which should remain inviolate, are increasingly targeted. In this time of international and intra-national tension and waning regard for high legal standards, the role of the medical profession in reducing and alleviating suffering is under considerable strain.

Why is this a role for the medical profession?

In considering the role that the medical profession could and should play in preventing and limiting suffering if conflict breaks out, it is important to take into account what the medical profession is, what access its members have to decision-makers and what special knowledge or expertise they bring with them. At the same time the nature of conflicts should be explored and related to the expertise of doctors and the opportunities they might have to intervene. It should be realized that doctors may feel disenfranchised in terms of their potential role in conflict. They may be blinded by the — usually very substantial — political component. They are almost always ignorant of international humanitarian law and of the institutions that could help them to take action under that body of law, and they may have only little access to the types of data that would make them more effective in their role of reducing and preventing suffering.

It is also essential to understand that many doctors will shy away from lobbying in these difficult areas or advising on them. They may feel that they lack the relevant expertise and that it is up to others with specific knowledge and specialized skills to take action. If a more general role is to be assumed by all doctors, they must be empowered or enabled to use their knowledge, and their fear of venturing into unknown territory must be removed. Those who wish doctors to

participate more fully and exert their power and influence must deal first with these fears.

In setting out my ideas about the role of the medical profession I shall attempt to explore these areas, to identify opportunities and indeed responsibilities. I shall also attempt to identify those areas in which initiatives have been taken, and those where conditions seem right for new initiatives.

I shall talk predominantly about doctors. But doctors are just one category of health care professionals, all of whom will have similar and related duties and opportunities. So while some of what I say will relate in particular to the specific knowledge of doctors and their place in society, far more will apply to all health care professionals.

The first role that the medical profession must play is to point out the health consequences of conflicts. These consequences may extend over several generations. Doctors should encourage conflict resolution and support those who try to avert wars. In doing so it is entirely appropriate for them to be explicit about the nature of the suffering conflicts cause. They must be prepared to challenge concepts such as "surgical strike" and point out the death, disease and disability which will follow the use of arms, whether "high tech" or not.

Doctors and politics

The action that doctors take depends upon whether they see that they have a political role as a group, or whether they regard their role as confined to directly advising on health care issues. In practice, doctors should also consider how they should advise and attempt to intervene in conflict resolution. As individuals they may feel that they have nothing to offer, but collectively they are able to add their voices to a pan-professional approach. This necessarily has implications for the groups that doctors join — their national associations and the specialist societies. These organizations should respond to the wishes of their members; on occasion they should also prompt them to address new issues. Those working within such organizations, as staff or as elected representatives, should be looking for opportunities to present professional "evidence" and collaborating with their sister

organizations to ensure that the advice or evidence provided is coherent, comprehensive and compelling.

It is simply not acceptable for doctors' organizations to pass on to others the responsibility for finding opportunities to speak out, to lobby, campaign or otherwise influence the decision-makers. Doctors have in many fields demonstrated their ability to sway public opinion. As individuals they are, in most countries, respected by the general population They are among the best educated and best paid members of society. Their education and knowledge is a common bond between them, and they are thus readily able to organize themselves as a group, especially for the exploration of science and medicine. These factors should be used for the benefit of "public health", which must include lobbying and other interventions to ensure that politicians and the populace understand the nature of suffering caused by conflict. Doctors should also seek opportunities to predict the potential suffering and to reduce that as well.

Sometimes doctors state that they cannot become involved in campaigning against conflict, or against certain weapons, or indeed even for certain standards in humanitarian aid, because they say they are not "qualified" or expert. But this does not stop doctors from discussing smoking, or HIV disease and public policy. They simply need to see conflict and weapons placed in a clear public health perspective.

Doctors reluctant to engage in this debate must realize that their reluctance will be welcomed by those who wish to keep the humanitarian arguments in the background or to foster the fear, prejudice and anger which are the prerequisites of public support for conflict. In the early days of both the Falklands War and the Gulf War, the voices of those in the UK who warned that British troops would inevitably be injured or die were not welcome. An explicit understanding of the cruelties and suffering of conflict is not conducive to public support for those who wish to engage in conflict, and in that phase humanitarian appeals and calls for caution do not suit their purpose.

The use of medical knowledge in conflicts

Whether doctors and other health care professionals want the role or not, it is inevitable that their skills and knowledge will play

some part in conflicts. By easing the direct suffering of combatants on the battlefield, by reducing the body count, they may make war more acceptable. It was said during the Vietnam War that public support for the anti-war message was directly related to the number of body bags shipped back home. If the medical care had been less well organized, less efficient and less successful, more combatants would have died and the war might have been more widely rejected by the public at an earlier date. It is agreed by many medical organizations that in situations where doctors see individuals who have been subjected to fundamentalist punishments, they should not collaborate in order to ease the suffering, for example by performing the ritual amputations. No one has suggested that doctors should take the equivalent approach to war by denying medical care; but the corollary is that they must be very explicit to the public about the suffering they are seeing and treating.

Doctors are uniquely positioned to monitor the effects of a conflict on the whole population, as well as identifying those most seriously affected. It is health care workers, and especially doctors, who sign death certificates, who treat the injured and record both the cause and effect of the injury. They also track and treat epidemics and diseases due to deprivation, whether from poverty or for social reasons, and do so with regard to combatants and non-combatants alike. Doctors are used to dealing with statistics, particularly epidemiological data. These statistics need careful interpretation. There is much in common between the interpretation of general epidemiological data and the interpretation of trends in weapons injuries.

Medical neutrality

When doctors treat the wounded they are ethically obliged to do so without consideration of the sex, race, nationality, religion or political opinions of the wounded person, or of any other criteria. Because of the obligation to offer their services to whoever needs their help, the concepts of medical impartiality and of medical neutrality were born. This, in terms of international humanitarian law, effectively rules out health care workers and institutions as legitimate targets. But one of the changes observed over the last decade has been

a decline in respect for their role, and a deliberate targeting of doctors and of hospitals, in recent conflicts. When health care and its providers are put in jeopardy in this way, those agencies that provide aid workers and facilities may be forced to reconsider doing so. In Rwanda, Bosnia-Herzegovina and Kosovo there was clear evidence of the targeting of doctors and medical facilities. Similar problems have also been seen in Sierra Leone, East Timor and Chechnya, where health professions were attacked alongside other civilians. Authorities targeted doctors who were fulfilling their ethical obligation to practise their skills without discrimination.

The Kosovo conflict provides a comprehensive case study of how health workers continue to carry out their work in accordance with their ethical obligations, how they are attacked for doing so and how eventually they become sought-after targets. At the same time, conflicts in the former Yugoslavia show how the neutrality and safety of health care institutions have been systematically violated. In part this reflects the problems of international humanitarian law, which in turn reflects the nature of historical conflicts between States. There is an evident need for the difficulties that arise when wars are within States to be covered more clearly by humanitarian law. Even where the conflicts fall outside the scope of the 1949 Geneva Conventions, the duties of doctors continue to be governed by international codes of ethics. Thus doctors are equally bound to help all patients regardless of nationality, politics, race, religion, etc., and indeed regardless of their own personal safety, but the protection that they are offered by customary law and international treaties may be limited.

Members of armed forces of States and rebel groups have recently flouted the neutrality of health care institutions, which are entitled to protection under the Geneva Conventions and customary international law. In the conflict in Sierra Leone UN peacekeeping forces (from Nigeria) were reported to have stormed a hospital and executed about 28 patients, including two children, who were suspected of being rebels. The fact that rebel forces had apparently committed similar atrocities is no defence; if UN troops ignore international humanitarian law there can be no hope that others will respect it.

Medical neutrality has a purpose. It honours the Hippocratic ethical tradition in medicine. In doing so it acknowledges that by protecting medical personnel and the facilities in which they can work, the suffering engendered by war can be alleviated. Doctors must therefore take part in a systematic campaign to persuade States to recognize explicitly the importance of medical neutrality, regardless of the political circumstances in which they find themselves.

Because of their concern about the increasing number of breaches of medical neutrality, a number of health care professional and human rights organizations have been working for some time to lobby for a Special Rapporteur on Breaches of Medical Neutrality under the UN system. The idea behind this would be to gather data on breaches and to investigate how and when they happen. There should also be the possibility to take action against States which allow violations to happen. Such a rapporteur would base his/her work on the existing codes of medical ethics. The level of support for this concept is growing — perhaps directly reflecting the increasing recognition of the occurrence of breaches. The very fact of explicitly recognizing medical neutrality in this way should increase its status and respect for it.

It is obvious that the collection of data by a rapporteur requires action by all health professionals. First, they should continue to honour their ethical obligations, and secondly they should systematically report any violations and record the role of the State, the army or others in giving rise to such violations.

Quite apart from violations of neutrality and even the treatment of individuals, doctors see a wide variety of diseases around areas of conflict. Much of the morbidity and mortality in conflict — the suffering — stems from the "classical" public health effects of hostilities. Simply put, destruction of the infrastructure leads to illness and death. In times of conflict, even where the civilian population is not displaced, there is often a disruption of water supplies and sewage systems, as well as power supplies and thus heating, lighting, refrigeration and air-conditioning. Food supplies, too, are disrupted and in many countries this also means incomes disappear for farmers. All this raises the likelihood of epidemic disease and especially of diarrhoeal diseases

alongside the other killer diseases of vulnerable young and old people. Doctors are inevitably involved in planning for the containment of these diseases in the non-combatant population, and in many cases in the displaced population.

The medical lessons of conflict

Even where doctors deny themselves a role in local, national or international politics, the medical profession has always been involved in conflicts. Throughout history, healers and later trained health care workers of various types have offered help to those injured in battle. Since Solferino health care workers have increasingly played a major role in assisting those displaced by war. The development of services has mirrored the development of training for different categories of health care workers.

In some cases conflicts have sparked intensive developments with regard to the quality of training, service provision or pure medical research. Florence Nightingale's observation of the poor organization and delivery of nursing services to injured soldiers in the Crimean War has had a lasting impact on the training of nurses, at least in the United Kingdom. The need to aid injured servicemen with extensive burns during the Second World War was a major factor in developing the management of burns, and of reconstructive plastic surgery.

Despite these examples of dealing with crises, too little time has been spent considering what could be done more systematically by those health care workers, and especially the medical profession, to reduce and alleviate the suffering inherent in conflict.

It is a truism that war causes deaths, but equally war causes suffering. That suffering has a number of causes, which are directly or indirectly related to the nature of the war, the weapons used, its duration and the steps taken by governments and other authorities to moderate its effects. Unless we first identify and consider those factors we can do little to ease or limit suffering. The risk is greatest for those on and near the actual combat zone; however, the nature of modern wars means that the persons at risk include those who do not leave their homes. It cannot be overstressed that today's wars are fought not on

distant battlefields, but around the towns and villages in which the general population live.

Much of the suffering and many of the deaths are a direct effect of weapons. The traditional role of the doctor in response to this has been to consider the effects of the weapon in terms of the injury it causes and to prepare responses to deal with that injury. Thus medicine in conflict has studied the effects of burns and developed protocols to deal with them and to reconstruct damaged tissues afterwards. In the same way surgeons in conflicts have made enormous progress in the management of burns, bullet wounds, anti-personnel mine injuries and so on. In the United Kingdom it is acknowledged that some of the most important advances in the management of trauma came from Northern Ireland, where the trauma often resulted from incidents including bombings and "punishment shootings" which were part of the so-called "troubles".

In some countries the conflict can include the organized targeting of some individuals and their subjection to ritual punishments. The conflict may be between those who pursue fundamentalist beliefs and those who have espoused a less absolutist regimen. Medical activities on either side can be seen as support for their cause, rather than as a manifestation of medical impartiality. In these circumstances doctors have to decide whether to collude with those effecting the punishment, or whether they should oppose them. This has been a significant problem for doctors working for various agencies in Afghanistan. Should they help the Taliban to carry out punishment amputations under Shari'a law, should they help to treat the prisoners afterwards, or should they take a purist view of refusing to help in any way, acknowledging that this could increase the morbidity and mortality levels. In seeking solutions agencies are effectively considering not only the individual who is being punished but also the impact their refusal could have on future punishments.

Furthermore, doctors offering medical aid in conflict zones may become aware of human rights abuses. The existence of the International Criminal Tribunals for the former Yugoslavia and for Rwanda, and in future of the International Criminal Court, means that these doctors may have to be prepared to give evidence. Certainly

their epidemiological data is likely to be of use in preparing evidence to show whether certain forms of mistreatment were planned and may indeed amount to war crimes. While gathering data may be possible, agencies face a further dilemma in considering when to speak out about the abuses they have observed. Speaking out early might alert other agencies, and indeed the UN, to the need to intervene, but it might also lead to ejection of the agency and increase the global level of suffering.

In addition, doctors have to consider how to persuade agencies providing emergency relief and other humanitarian assistance to gear their aid and services to actual needs.

Damage to the civilian infrastructure, displacement of parts of the population and disruption of supply lines, agriculture and other industries lead at least to poverty and often to extremes of deprivation. These social conditions are not only an immediate danger but also have long-term effects, especially on young children. The ill effects of the conflict will thus go on for many years beyond its apparent limits.

Rape as a weapon of war

Other "weapons of war" must today be considered to include rape. Throughout history it has been a part of warfare, but is increasingly occurring on an organized basis in modern conflicts. Rape is used in a variety of ways, for instance as a genocidal agent often accompanied by the deliberate transmission of HIV; as a weapon to cause continuing shame, especially for Muslim women in recent conflicts; and in the form of enforced prostitution, including the use of comfort women by the Japanese in World War II. The International Criminal Tribunals for the former Yugoslavia and for Rwanda have recognized rape as a war crime and in some cases as a form of attempted genocide. Doctors dealing with rape victims have to be sensitive to cultural issues, to the women's psychological and physical condition and to the need to present evidence to criminal tribunals. Too often the services provided for these women do not take their needs and cultural requirements into sufficient account. In providing such services doctors and the agencies for whom they work

must discuss service needs and cultural settings with the women themselves.

There are many theories about the reasons behind rape — ranging from natural expressions of rage and sexuality to organized campaigns to destroy the morale of the enemy, and even to genocide. In a certain sense they are largely irrelevant — with the exception of genocidal acts, which have particular legal significance. What matters is that they leave behind victims who will need the support of doctors and other health care workers. It is easy for doctors to think of the immediate physical consequences of rape and to ignore the longer-term psychological and social consequences. When considering their role in service provision these workers will, in order to provide the right services, have to understand the context in which the rapes took place, the respective society's attitude towards the raped woman, and the availability of other services such as genito-urinary medicine, abortion and psychological support.

Sensitivity to societal and cultural factors is important for all aspects of medical and health care. The need for it is most acute in relation to sexual activity. Services to help women who have been raped must recognize the cultural context in which the women live. This must include sensitivity to religious and other factors, as well as appropriate "independent" translation services.

War and public health

Much of the other suffering can be said to have a direct "public health" cause. It arises from the disruption of social and societal infrastructures. This can be of direct or indirect origin, i.e. physical disruption of main water supplies, sewage pipes and communications networks including roads, or movement of populations away from settled towns and villages to refugee camps that have no infrastructure.

Historically, conflicts often included the "sacking" of cities, sometimes after a prolonged period of siege. The defeated city would be razed to the ground, not least to stop its inhabitants from retaining any power or ability to resist their conquerors. In the 20th century cities were devastated by the "blitzkrieg". Both had the

same effect. They destroyed housing, water-supply systems and sewerage and brought down power supplies. The effect upon the civilian population was much the same. Those who were not injured or killed by the original destructive force lost their shelter and supplies of safe water. The medical conditions seen are also similar: diarrhoeal diseases, malnutrition and hypothermia/exposure, as well as the direct physical sequelae of collapsing buildings, etc.

Conflicts also create wasteland, especially by the contamination of land by anti-personnel landmines. The presence of these devices renders land unusable, and often causes widespread malnutrition. While the injuries caused by exploding landmines are well catalogued, the still commoner diseases of deprivation are less comprehensively described.

In these circumstances the population suffer both physically and psychologically. Trauma of the latter kind are particularly common in displaced persons. In our attempts to help them survive we often forget or ignore the consequences of displacement. These include disruption of the familial and societal support networks, plus a potentially permanent sense of insecurity, of excessive concern for one's physical safety.

Using specialized medical knowledge

Doctors who are part of the political process in their countries act like any other politician, in that they renounce their clinical credentials. It is unreasonable to expect them to use their clinical knowledge or to exert all their diagnostic and therapeutic "arts" in conflict resolution and prevention. But if they are lobbied by other health care workers and presented with clinical and public health information, they should be better able than other political colleagues to assess this information and apply it to clinical circumstances. Moreover, their ability to defend themselves against charges of inhumanity may be reduced if it is clear that they had the specialized knowledge to understand the data presented to them in terms of the effects upon the population. There are various ways in which doctors could take action:

- Doctors could encourage radio and television services to depict war and conflicts as they really are, showing the devastating effects that weapons have on individuals. They should vehemently oppose the sanitization of war by news media, as this makes conflicts more acceptable to the general public.
- Doctors should use their specialized medical knowledge to comment on conflicts. They should point out what the actual effects will be. They should be explicit about human suffering, making it clear that limits are impossible to enforce and that suffering will extend far beyond the combat zone and the combatants themselves.
- Doctors should discuss the epidemiology of conflict, and especially the public health issues, such as the diseases and deaths that will follow disruptions of water supplies and sewerage or the displacement of populations. If doctors feel that they lack the necessary specialized knowledge, they should be helped to understand that much of what they can do in reducing suffering has to do with public health and epidemiology. A minimal understanding of the epidemiology of warfare gives them the tools for significant and effective interventions.

The SIrUS Project

These are of course not the only ways in which doctors can bring their expertise and influence to bear. The ICRC's SIrUS Project has clearly identified the role that doctors and others play in the legitimization — or not — of new weapons.[1] Using medical knowledge, gained in conflicts, of the effects of weapons to identify the types of injury they can be predicted to produce puts health workers in a new position. It enables them to give objective answers to some of the questions raised by new weapons. While it is still unclear how much this project will affect the licensing procedure for new weapons, it is inevitable that it will have some impact.

But the development of this project also demonstrates that there are many individuals who do not want medical involvement in

1 Robin M. Coupland, FRCS, and Peter Herby, "Review of the legality of weapons, a new approach: The SIrUS Project", IRRC; No. 835, September 1999, p. 583.

the assessment of weapons. The antagonism that some have shown raises questions about the reasons for this reluctance. Do they really believe the issue is too complex? Or that the epidemiological data is too insubstantial? Or are they afraid that a cool scientific assessment with a humanitarian core will limit the freedom of States, weapons designers and manufacturers to produce "new" weapons. The technological advantage that some States have over others could diminish if medicine were to ally itself with international humanitarian law and control the development of some types of weapons.

The SIrUS Project brings me back to the beginning of this article, namely the role of doctors not only as individuals but within organizations. Within countries doctors can act together and attempt to exert political influence. By grouping together internationally, doctors can have even more influence, not least because such groupings can avoid apparent party-political stigmata. The efficacy of such groups is seen in the work of International Physicians for the Prevention of Nuclear War, Physicians for Human Rights and many other organizations in which doctors form a significant part. The World Medical Association, as an organization of the national medical associations of many countries, could be one of the most powerful of such groups. But it also brings to light one of the problems: many of its member associations are unused to undertaking high-profile actions, especially where to do so might bring them into conflict with their governments or others. Those members who do take such actions must help those who have not yet done so; the alternative is for the World Medical Association to become a group which lobbies only for the good of its members and not for "public health". Associations such as the Turkish Medical Association have acted in exemplary fashion to highlight human rights abuses domestically. Their willingness to embrace the broader humanitarian role of doctors should help others to explore the actions they could take.

Conclusion

In summary, doctors have three main roles. The first is to attempt to minimize the suffering caused by conflict by applying their specialist knowledge and skills to those who are affected. The second is

to use epidemiological principles and collected data to attempt to reduce the potential for such suffering. The third is to avoid the medical sanitization of war and instead to show the true face of the suffering it inflicts and work to ensure that this will change public and eventually political opinion. The role of doctors is not unique, many others can do some or all of these tasks. Doctors are, however, at least unusual and perhaps even unique in the potential depth and breadth of the knowledge, authority and respect that they can bring to accomplishing them. If they fail to engage in this endeavour, then they will continue to be occupied by the treatment of reducible and possible preventable morbidity.

The reluctance that many doctors feel about engaging in such difficult debate and decision-making can best be overcome by organization: grouping together both nationally and internationally gives depth of knowledge and skills, depoliticizes key decisions and encourages international debate. Doctors *can* prevent suffering or reduce it to a minimum. By joining forces they can make this happen.

Résumé

Prévenir et limiter la souffrance en cas de conflit : le rôle de la profession médicale

par VIVIENNE NATHANSON

Prévenir et limiter la souffrance, tel est le rôle principal de la profession médicale. Dans cet article, l'auteur décrit les tâches spécifiques qui incombent au personnel médical, en particulier aux médecins, en situation de conflit ou de guerre. Après avoir examiné, notamment, la position du médecin face à la politique, la neutralité du personnel médical et les possibilités qu'il a d'influencer le choix des méthodes et moyens de guerre que feront les belligérants, l'auteur définit les trois rôles que le médecin peut et doit assumer :

- *mettre à disposition ses connaissances professionnelles et son expérience afin de limiter la souffrance des victimes de conflits armés ;*
- *sur la base de l'expérience acquise lors de conflits, tenter de réduire tout ce qui peut provoquer la souffrance ;*
- *tenter d'influencer l'opinion publique en luttant contre le risque de tomber dans le piège de la guerre « propre », par des témoignages sur le vrai visage de la souffrance qu'elle engendre.*

Avec son expérience professionnelle unique et l'autorité que lui confère sa tâche, le médecin peut, mieux que quiconque, tenter de rendre la guerre moins cruelle.