New aspects of military medical ethics regarding the participation of Hungarian Defence Forces in peacekeeping operations

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All members of the healthcare system, whether civilian or military, confront ethical challenges. Military medicine presents some additional ethical challenges due to issues raised by mixed agency. The mixed issues are accentuated on the battlefield because the physician has a legal obligation to place the interests of society (and the military mission of protecting and defending this society) above those of the soldier. The Geneva Conventions advocate medical need, while NATO operational directives emphasize distributing medical care solely based on military salvage.

Hungary and the Hungarian Defence Forces, as member of NATO, participating in peacekeeping operations, face new ethical challenges in combat health support. Working in multinational atmospheres we must know that laws differ significantly from one country to another while ethics is applicable across national boundaries. The article analyzes and summarizes the actual conceptions about military medical ethics, particularly triage regarding peacekeeping operations (non-combatants, civilian population, human right abuses).

There are added factors encountered on the battlefield that have no civilian counterpart. On the battlefield, decisions must be made immediately and often without all the data one would like. Most likely, medical officer will not have time for deliberation and reflection on all consequences.

Attention is called to the necessity of the education and ethical training of the military and medical personnel and organisation of ethical forums suitable for discussing ethical issues, and to the new, transitional situation in Hungary which is not yet mature for judging ethical issues.

Introduction

Throughout the last decade, the Hungarian armed forces have taken gigantic steps in transforming a basically static, nation’s defence oriented force into a mission oriented military. In January 2007, the HDF participated in 28 peace operation missions in 14 countries on 4 continents, with a total of 941 soldiers. On 3 November 2004, after 136
years, military conscription in peacetime was suspended in Hungary. The human capital of the new, all-volunteer force is better prepared to meet the challenges of long-term peace support operations. The military training continues to become more “internationalized”, since Hungarian forces generally operate under international or multinational command when participating in peacekeeping operations.¹

The changing climate of contemporary warfare creates new challenges for bioethics, too. Low intensity war, war on terror, non-conventional warfare also forces non-caregiving dilemmas as it tests the willingness of medical personnel to lend their expertise to interrogation or weapon development.

Still, a quarter century ago, Hippocratic ethics, exemplified by the oath, the so-called “deontological” books of Hippocratic Corpus (dealing with the oath, precepts, the law, decorum, and physician), and dozens of codes of medical ethics were taken for granted as the source and foundation for the ethics of the patient-physician relationship. Today this foundation is no longer secure. In recent times, medical ethics has been greatly influenced by developments in human rights. Four general principles of contemporary bioethics: (1) autonomy – respect patients’ preferences in medical care, (2) beneficence – physicians responsibility to act in the patient’s best interest, (3) non-maleficence – do no harm, and (4) distributive justice – micro and macroallocation of sources.

Ethical dilemmas multiply during armed conflicts as the ethical principles of war add to those of peacetime medicine. Military medical dilemmas are generated in greater assortment by competing principles and interests.

During an armed conflict, dilemmas of medical ethics arise in several distinct settings as medical expertise is used for either healing or non-healing purposes and in the context of conventional and non-conventional war.

Ethical problems of triage are problems of distributive justice in cases of scarce medical resources and scarce medical knowledge. When medical capacity is limited, healthcare providers must withhold treatment from the most severely injured whose cases are so time-consuming that attempting to save their lives would result in many more deaths. Military physicians in the past obeyed orders to treat lightly injured casualties first so that these service members can return to combat quickly. This practice is the focus of intense ethical debate.

**Historical overview**

Physicians have been regular fixtures in armed conflict since ancient times but were able to offer wounded soldiers little more than comfort, bandages, and rudimentary surgery. Seriously wounded soldiers died of their wounds. Battlefield care was
primitive and amputation the only surgical method of choice. Most premodern weaponry did not inflict fatal injury. Wounded soldiers most often died of infection, gas gangrene, sepsis, and tetanus, while a great many more uninjured soldiers succumbed to disease – dysentery, typhoid fever, typhus, plague, and smallpox.2 The scope and destructiveness of warfare increased drastically with the Napoleonic wars (1779–1815). The enormous deployment of troops, increased numbers of casualties, and complex logistics posed unprecedented problems and could lead Napoleon’s medical staff to develop “flying” ambulances to evacuate the injured, dedicate trained personnel to provide care, and institute triage to effectively utilize scarce medical resources.

Despite the adaptation of these innovations, disease continued to take more lives than combat injuries until World War I. Military tactics were slow to change in the wake of quickly developing military technology. Following World War I, the state of military medicine improved dramatically. Advances in medical technology, together with the introduction of motorized transport to evacuate the wounded, increased survival rates for the seriously injured. Moral dilemma arose with penicillin at the time of World War II.

When the wonders of penicillin were new, but recognized, and the supply heartbreaking meagre, a small shipment arrived in North Africa. The hospital beds were overflowing with wounded men. Many had been wounded in battles; many had also been wounded in brothel. Which group would get the penicillin? Heroes who had risked their lives, some of whom were dying, or soldiers with venereal disease? The penicillin was given to those infected in brothels, they were a matter of days to free the beds and return to the front.3

Another fact that had an influence on triage was the increasing number of civilians being injured or killed during the conduct of contemporary wars. Civilian death as a percentage of all deaths in selected 20th century wars: World War I – 14%, World War I – 67%, wars of the 1980s – 75%, wars of the 1990s – 90%, many of them children.

In about 400 B.C., Artaxerxes, the Great King of Persia sent emissaries to Hippocrates to ask him “with the promise of a fee of many talents”, to help in the treatment of Persian soldiers who were dying of the plague. Hippocrates is reported to have diminished the emissaries, stating that he would never “put his skill at the service of Barbarians who were enemies of Greece”.4

This concept leads to questions of international legal issues of conducting war.

Medical care has long been provided in accordance with a rationing plan in one specific situation, battlefield medicine. In recent years, triage rules have been refined and applied to other disasters, such as earthquakes and hurricanes. The rules of triage and its rationale are stated in a handbook of military surgery as follows:
Priority is to be given to the slightly injured who can be quickly returned to service, the more seriously injured who demand immediate resuscitation or surgery, the hopelessly wounded... the military surgeon must expend his energies in the treatment of only those whose survival seems likely, in line with the objective of military medicine, which has been defined as “doing the greatest good for the greatest number” in the proper time and place.5

International, legal, and ethical issues

There have been two concepts of war over the centuries. One holds that war was pursued without moral or legal restraints (“war is hell”), while the other contends that war is limited by the requirements of morality and law. This latter concept is the basis for just war doctrine and other sources of moral guidance as well as for the international law of war.

Contemporary international war conduct law is based on three principles: military necessity, humanity, and chivalry. Military necessity requires that all war conduct be proportional to a legitimate military end, permitted by a responsible commander, and subject to review.

Specific areas of international war-conduct law based on these three fundamental principles are: belligerent status under the law of war, means and methods of destruction, prisoners of war, belligerent occupation, sanctions for the laws of war and the subject in relation with triage is the protection of the wounded and sick.

Provisions for the protection of the wounded and sick go back to the 1864 Red Cross Convention. Protection of the wounded and sick on land was also provided in the 1929 Geneva revision of the 1864 Convention, and in the current 1949 Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field (GWS). Protection of the wounded and sick at sea was provided in the 1907 Hague Convention and is presently provided by the Geneva Convention for the Amelioration of the Condition of the Wounded, Sick, and Shipwrecked Members of Armed Forces at Sea (GWS-SEA).

Article 12 of the 1949 GWS Convention prescribes the treatment to be given to the wounded and sick. It prohibits any discrimination on the basis of nationality, gender, religion, or political opinion. Torture or subjection to biological experiment is prohibited. Proper treatment of women is demanded.

The Hungarian law also prohibits any discrimination on the basis of nationality, gender, religion, or political opinion.
World Medical Association (WMA) declares that “medical ethics in times of armed conflict is identical to medical ethics in times of peace”. The Statement on Medical Ethics in the Event of Disasters adapted by the 46th WMA General Assembly Stockholm, Sweden 1964 gave policy according to this problem. Disaster situations are characterised by an acute and unforeseen imbalance between the capacity and resources of the medical profession and needs of the victims or the people whose health is threatened, over a given period of time.

Inadequate and/or disrupted medical resources on site and the large number of people injured in a short time present a specific ethical problem. Providing medical services under such conditions involves technical and organizational issues that add to ethical issues. World Medical Association therefore recommends the following ethical attitudes in the physician’s role in disaster situations.

Triage poses the first ethical problem owing to the limited treatment resources immediately available in relation to the large number of victims in varying states of health. Triage is a medical action of prioritizing treatment and management based on making a diagnosis and formulating a prognosis. Patient survival will depend on triage. It must be carried out quickly, taking into account the medical needs, medical intervention capabilities and available resources. Vital acts of reanimation may have to be carried out at the time of triage.

Triage should be entrusted to an authorized, experienced physician, assisted by a competent staff. The physician should separate victims as follows:

a) victims that can be saved but whose lives are in immediate danger, requiring treatment straight away or as a matter of priority within the next four hours;
b) victims whose lives are not in immediate danger and who are in need of urgent but not immediate medical care;
c) injured persons requiring only minor treatment, who can be treated later on by relief workers;
d) psychologically traumatized victims needing to be reassured, who cannot be taken care of individually but who might need reassurance or sedation if acutely disturbed;
e) victims whose condition exceeds the available therapeutic resources, who suffer from extremely severe injuries such as irradiation or burns to such an extent and degree that they cannot be saved in the specific circumstances of time and place, or complex surgical cases requiring a particularly delicate operation which would take too long, thereby obliging the physician to make a choice between them and other patients. For these reasons, all such victims may be classified as cases “beyond emergency case”. The decision to “abandon an injured person” on
account of priorities dictated by the disaster situation cannot be considered “failure to come to the assistance of a person in mortal danger”. It is justified when it intends to save the maximum of victims.

f) Since cases may develop and thus change category, it is essential that the situation be regularly reassessed by the official in charge of the triage.

From the ethical standpoint, the problem of triage and the attitude to be adopted towards victims “beyond emergency case” fits within the framework of the allocation of immediately available means in exceptional circumstances beyond human control. It is unethical for a physician to persist, at all costs, at maintaining the life of a patient beyond hope, thereby wasting of scarce resources needed elsewhere. However, the physician must show his/her patients compassion and respect for the dignity of their private lives, for example by separating from others and administering appropriate pain relievers and sedatives.

The physician must act according to his/her conscience considering the means available. He/she should attempt to set an order or priorities for treatment which will save the greatest number of serious cases that have a chance of recovery and restrict morbidity to a minimum, while accepting the limits imposed by the circumstances. The physician should pay particular attention to the fact that children may have special needs.

Beam suggests that the requirement of considering military need may arise in “extreme conditions” when the mission’s success (or even the safety of the field hospital) depends on having as many soldiers at the frontline as possible. Various international declarations state that triage decisions should depend only on medical need, although it is not clear if they absolutely prohibit Beam’s extreme conditions triage.

These concerns about military necessity and patients interests suggest four possible approaches to battlefield triage. 1) “Medical needs” triage: prioritization of patients only according to injury severity, no matter the circumstances or what side the casualty is on. 2) “Salvage value” triage: prioritization of friendly service members according to their likelihood of fighting again. 3) “Allegiance” triage: prioritization first to allegiance and then according to need. Friendly troops receive treatment first, then civilians, finally enemy soldiers. Within each group, care is provided according to medical need. 4) “Limited Social utility” triage: prioritization is identical to medical needs triage, except in extreme conditions when the walking wounded may receive treatment first.

**Discussion**

The First and the Second Geneva Conventions state: “Only urgent medical reasons will authorize priority in the order of treatment to be administered” (Geneva Conventions I, II,
1949, Article 12, Paragraph 3). The only reason for treating one patient before another shall be because his wounds require more urgent care, independently of any non-medical considerations” (Protocol I, 1977b, Article 10, Paragraph 453). However, actors and interests multiply during war in recent time. Combatants and non-combatants, enemies and allies, states and individuals, citizens and soldiers, prisoners of war, wounded and the dying, those who can return to combat duty, and those who cannot, all litter the battlefield. For instance, the Hungarian medical service took part in providing medical care after the Kabul bomb attack against the German convoy which was heading home on 7 June 2003. The records of the care shows that 35 people (33 Germans and 2 Afghans) needed medical care, 7 of them were severely injured (6 Germans and 1 Afghans); 6 persons died on the spot and 7 in hospital. Care was provided according to the rules of mass casualty care. The Mass Casualty Plan of the field hospital was prepared with the contribution of the Hungarian Clinical Director.

It may be derived from the data of the injured that, when determining the priorities of care, the care providers had to ponder whether their own lightly injured casualties or the severely injured attacker should be given priority for care.

The Geneva Conventions advocate medical needs, while the NATO’s operational directives emphasize distribution of medical care based on military salvage. There are no insiders or outsiders in the field of ethics. Everyone has ideas about what is morally wrong and what is right. Some may object that in a culturally pluralistic world like ours, the idea of a stable foundation for medical ethics binding on all physicians across national and cultural boundaries is an anachronism.

Another prevailing attitude about the medical profession rigorously defended in recent years by Edmond Pellegrino and David Thomasma. They assert that physician has ethical obligations that transcend self-interest, exigency and even social, political and economic fences. By emphasizing a transcendent obligation, they wish to shield the doctor-patient relationship from competing interests that sometimes overwhelm modern medical care, and may threaten a patient’s trust and jeopardize his or her well-being.

The fundamental values of medical ethics, such as compassion, competence and autonomy, along with physicians’ experience and skills in all aspects of medicine and healthcare, provide a sound basis for analysing ethical issues in medicine and arriving at solutions that are in best interests of individual patients and citizens and public health in general for all countries.

Medicine is a profession. The term ‘profession’ has two distinct although closely related meanings: an occupation that is characterized by dedication to the well-being of others, high moral standards, a body of knowledge and skills, and a high level of autonomy; and all the individuals who practise that occupation. The medical profession...
can mean either the practice of medicine or physicians in general. Military as a profession is characterized by dedication to the well-being of all society and means the practice of military and soldiers in general. There are three essential military purposes served by an ethical system in combat: restraining the military personnel from committing atrocities, enabling people to carry out missions that may require them to kill and perform other morally aversive acts, and strengthening resistance to combat stress breakdown.\(^{11}\)

The military medical personnel faces the conflict originated both from the medical and military professions. Ethical issues arise when the physician is forced to choose between the benefit of an individual patient and the needs of the army. In this case the needs of the army mean the needs of the society.

As it was mentioned above WMA declares that medical ethics in times of armed conflict is identical to medical ethics of peace. Another opinion as M. Gross concludes, difficult dilemmas inevitably arise during armed conflicts, and medicine is not above the fray, “medical ethics in time of war cannot be identical to medical ethics in peacetime”. Bioethical dilemmas arise when fundamental moral principles conflict, and during war competing bioethical principles must not only contend with one another but with the overriding principles of military necessity and reason of state that animate any issue of military ethics. Actions and interests multiply during war. Combatants and non-combatants, enemies and allies, states and individuals, citizens and soldiers, prisoners of war, the wounded and the dying, those who can return to combat duty and those who cannot, all litter the battlefield. Medicine is called on to cure, and sometimes to kill. The patient’s right to life and self-determination shrinks, human dignity strains under the barrage of military necessity, and calculations of expected utility move beyond a patient’s or patients’ welfare to embrace intents of the nation, state and the political community it represents. War transforms contracts and subordinates the doctor-patient relationship.\(^{12}\)

In the meantime unconventional war, insurgency, and limited war pose more difficult problems. During conventional war, medicine will often content itself with conforming to the broad dictates of humanitarian law and laws of armed conflict. Sometimes these laws also serve the principles of medical ethics. Unconventional war, particularly insurgencies, guerrilla war, and other forms of low intensity conflict exacerbate the tension between medical and military ethics and conventions of war themselves strain under the burden of protecting combatants, non-combatants, and political communities.
Many contemporary issues confronting bioethics and armed conflict now plague the Middle East: torture, terrorism, violations of neutrality, low intensity warfare, non-lethal weaponry, and armed intervention.\textsuperscript{13} 

Taking a closer look, it is often difficult to free oneself from raw emotion the daily news evokes.

“Confirmed or reliably reported abuses of detainees in Iraq and Afghanistan include beatings, burns, shocks, bodily suspensions, asphyxia, threats against detainees and their relatives, sexual humiliation, isolation, prolonged hooding and shackling and exposure to heat, cold and loud noise”.\textsuperscript{14} These include deprivation of sleep, food, clothing, and material for personal hygiene and denigration of Islam and forced violation of its rites. Abuses of women detainees are less well documented but include credible allegations of sexual humiliation and rape.

Civilians are often in great need in health services, not only for war-related injuries and psychological trauma but also for ongoing health needs, such as diabetes, etc.

Except in very special circumstances in which military physicians are specifically assigned to provide medical care for civilian populations, however, military physicians may not provide such care – not even for those whose need is greater than that of the military personnel. Unless the command structure for military physicians specifically requires them to base priorities for medical care on medical need, no matter whose need is involved, care for civilians may have low priority or none at all.

Bradley had evaluated the ethical models for battlefield triage by four criteria.\textsuperscript{15} These are a) ethical acceptability b) compliance with international standards c) effect on military mission d) political acceptability.

Allegiance and salvage value triage are ethically tenous, politically unacceptable, and militarily questionable. This leaves medical needs triage and limited social utility triage. Medical needs triage may appear to be more consistent across all situations. However, the belief that physicians never owe loyalty to anybody but the patient is overly simplistic. Dual loyalty occurs in public health and court-ordered forensic psychiatry, for example. In these cases, limited, controlled, and necessary subordination of the individual’s wishes is acceptable (Bayer and Fairchild, 2004). Society survives because it can demand reasonable sacrifices of individuals when necessary. Limited social utility triage attempts to balance needs of society with medical needs of individuals by allowing the military some flexibility in its triage practices and therefore the most reasonable triage model. Proper implementation will require training for military medical personnel and commanders so that they properly distinguish the military need from simple military expediency.\textsuperscript{16}
Conclusions

The military medical personnel and military officers participating in peacekeeping operations face new ethical challenges in combat health support. Working in a multinational atmosphere they must solve the health care mixed agency problems cooperating in the interest of the patient, soldier, and balance the needs of the society (military mission) with the medical needs of individuals. The limited social utility approach is the most applicable ethical model in battle situations.

The author directs attention to the importance of education and discussion of ethical issues in the phases of preparation for, accomplishing, and evaluation of military missions.

References

12. ibid 9, 1–25.
13. ibid 9, Preface