CLINICAL ETHICS

The challenges and ethical dilemmas of a military medical officer serving with a peacekeeping operation in regard to the medical care of the local population

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Medical Officers serving with their national contingents in peacekeeping operations are faced with difficult ethical decisions in regard to their obligations to the local civilian population. Such populations may be under-resourced in regard to medical care, and vulnerable to abuse and exploitation. Though the medical officer may support the local medical services, he/she should never undermine these resources. Adopting a human rights approach and observing the requirements of ethical medicine, aids the doctor in prioritising his/her duties. At times there may be conflict with one's own military superiors. It is wise to discuss potential difficulties prior to setting out on the mission. Human rights abuses cannot be ignored. The medical officer has a duty to do his/her best to report their observations so as to prevent abuse or to bring it to an end.

Military medical officers are assigned to support the military personnel involved in peacekeeping operations. Their primary duty of care is to the peacekeepers. In this regard they are supported by the medical support section of the Department of Peace Keeping Operations (DPKO). The mission statement of the medical support section of the DPKO is: "[the] United Nations Support Mission is to secure the health and wellbeing of members of United Nations Peace Keeping Operations, through planning, coordination, execution, monitoring, and professional supervision of excellent medical care".¹ Nothing is mentioned about providing medical support for the surrounding civilian population. Though many peacekeeping military medical officers do this in practice.² There is a requirement that they are sensitive to the social and cultural needs of the local population and are able to liaise seamlessly with the aid agencies.

The obligations and challenges of military medical officers attached to peacekeeping operations toward the civilian population, has only been partly explored. The author previously examined some of these issues, in relation to UN military psychiatry in 2000.³

Military medical officers have an ethical obligation to provide what medical aid they can to the surrounding indigenous population. Their ethical obligations in this regard have been largely ignored in the literature.

In their *Regulations in Time of Armed Conflict (Declaration of Havana)*, published in 1956, the World Medical Association stated: "medical ethics in time of armed conflict are identical to medical ethics in time of peace". They make no distinction between doctors serving purely in the military from other doctors working in a civilian practice. The *Declaration of Havana*⁴ was to function as the World Medical Association's translation of the Geneva conventions into practical guidelines for doctors.⁵ The first regulation of the *Declaration of Havana* states that: "The primary obligation of a physician is his professional duty; in performing his professional duty the physician's supreme guide is his conscience". The declaration also emphasises that the key duties of physicians are focused on the relationship between the physician and the individual patient, which includes maintaining patient confidentiality,

acting in the best interest of the patients, and respecting the rights of patients. The WMA document, *Regulations in Time of Armed Conflict 3rd revision*,⁶ is currently under review by a working group composed of members of the British and German Medical Associations.

The Boston based organisation, Physicians for Human Rights, recognised that there were unique factors that they considered were specific for peacekeeping operations. In their report, *Dual Loyalty and Human Rights*, published in 2003, they state: "In such operations, military health professionals confront the medical needs of the civilian populations in the area of their assignment; yet they may be subject to rules and regulations preventing them from providing professional assistance to civilians".⁷ They recommend that medical personnel should resist the culture of their military colleagues and remain loyal to the ethical standards of their civilian medical colleagues.

There are natural tensions between the military medical officers and their military colleagues. In his commentary on the role of the Dutch Battalion in the fall of Srebrenica in 1995, Lt Col Vermeulen reported there were major differences of views between the leadership of the military unit and its medical staff.⁸ He failed to recognise that the unit's medical officers also had an ethical obligation to the surrounding civilian population as well as being subject to military law. The Dutch military medical officers were bound by the international code of ethics promulgated by the WMA in 1983, which states: "a physician shall give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care".⁹

During peacekeeping operations care for the local population is normally provided by the civil local authorities, or by international aid agencies. Peacekeeping military medical officers usually become involved when these resources are either absent or inadequate. When peacekeeping military medical officers are involved in providing medical aid, they

Abbreviations: DPKO, department of peacekeeping operations; KHO, Dutch Defence Hospital Organisation; OIOS, Office of Internal Oversight Services; UNHCR, United Nations High Commissioner for Refugees; WMA, World Medical Association

should consider the following areas: (a) medical obligations and humanitarian law; (b) the cultural and social sensitivities of civilians at a time of war, and (c) the allocation of medical resources.

MEDICAL OBLIGATIONS AND HUMANITARIAN LAW

Humanitarian provisions of the laws of war do not apply to UN peacekeeping soldiers, as they are not party to the conflict.¹⁰ The UN is not a state, and the UN is not a signatory to the Geneva conventions of 1949,⁵ or to the two additional protocols of 1977. Nevertheless, the UN has adopted the position that UN troops are bound to comply with the “principles and spirit” of the conventions applicable to the conduct of military personnel.¹¹ The additional protocols of 1977¹² stipulated that one was not permitted to distinguish between the wounded other than on medical grounds, and that medical staff, were “not to be forced to refrain from acting”.

Article 20 of the *Convention on the Safety of United Nations and Associated Personnel*, published in 1994,¹⁴ recognises the “applicability of international humanitarian law and universally recognised standards of human rights as contained in international instruments, in relation to the protection of United Nations operations and United Nations and associated personnel and the responsibility of such personnel to respect such law and standards”.

Article 14 of the *Fourth Geneva Convention* prepared by the International Committee of the Red Cross in 1949,⁵ deals with hospitals and safety zones for the treatment of the sick and injured combatants and civilians at a time of war. Section 8 of article 513 allows sanctuary for the “frail, aged, children under 15 and expectant mothers and mothers of children under seven”. For the peacekeeping military medical officer who is not a party to the conflict, there is the presumption that the neutrality of the UN peacekeeping force will be respected.

In keeping with the “spirit and principles” of the Geneva conventions, the peacekeeping military medical officer is obliged to honour article 605, which states that “all possible measures shall be taken at all times to collect the wounded, sick, and shipwrecked and to ensure their adequate medical assistance”. This was not honoured during the eventual fall of Srebrenica in 1995 and the peacekeeping military medical officers were admonished in a report by the Dutch Defence Hospital Organisation (KHO), for having “failed to provide adequate medical assistance to civilian casualties in a reprehensible way”.¹⁵

Paragraph six of the *Declaration on the Protection of Women and Children in Emergency and Armed Conflict* (1974) states: “Women and children belonging to the civilian population and finding themselves in circumstances of emergency and armed conflict in the struggle for peace, self determination, national liberation and independence, or who live on occupied territories, shall not be deprived of shelter, medical aid or other inalienable rights” [emphasis added].¹⁶

In the Srebrenica disaster, there was conflict over “essential stock” (medical supplies) for the Dutch soldiers in case of emergency. This rationing of the “essential stock” led to the “unnecessary death” of a Bosnian woman.¹⁷

It is recommended by the British Medical Association (BMA), that army doctors should thoroughly discuss ethical and potential dilemmas that may arise, in advance of deployment. The BMA’s recommendations were made in 2001, as a direct result of the KHO’s report on the behaviour of the Dutch military medical officers at Srebrenica.¹⁸

All doctors have obligations to report human rights abuses.¹⁹ Doctors are often among the first to witness evidence of torture, massacres or of other forms of cruel and degrading treatment. Non-governmental organisations

(NGOs) and human rights organisations have argued that human rights issues are central to peacekeeping, and that human rights should be part of every peacekeeping mission and complex field operation that is launched.²⁰ Physicians for Human Rights recommend that military health professionals should take steps to report violations of the Geneva conventions.⁷

An Australian aid worker recounted that in Rwanda, Australian peacekeepers were instructed to hold their fire when Tutsi forces began to shoot into an encampment of Hutu civilians at Kicho.²¹

This ethical requirement to report abuses can possibly lead military medical officers into conflict with their own military authorities, who may be struggling to maintain a semblance of neutrality and impartiality. Impartiality is one of the key principles of UN peacekeeping. Where a peacekeeping force is perceived to have lost impartiality “there can be no prospect of preserving the confidence and cooperation of conflicting factions”.²² Initially, when peacekeeping was being developed, it was influenced by the superpower competition of the time. As a result peacekeeping became an improvised alternative that was not specifically provided for in the UN charter.²³ Because of the politically sensitive nature of any type of third party involvement in a conflict situation, the new mechanism had to respect three basic principles: the consent of the parties to the conflict; the non use of force, and impartiality.²⁴ Since the end of the cold war, there has been more of a focus on the humanitarian and human rights issues associated with peacekeeping.

The report of the Panel of UN Peace Operations²⁵ stated that, in cases “where one party to a peace agreement clearly and incontrovertibly is violating its terms, continued equal treatment of all parties by the UN can in the best case result in ineffectiveness and in the worst may amount to complicity with evil”.

The New York based organisation, Human Rights Watch, recognised there were structural problems that it considered damaged the credibility and effectiveness of peace operations. They believed that the UN approach to peace and conflict resolution was complicated by “misguided neutrality, diplomatic caution, and diplomatic blackmail”.²² In the 1990s the incorporation of human rights issues into some peacekeeping mandates led to less resistance on the part of on site mission leaders of peacekeeping operations to the revelations of human rights abuses.²⁶

Physicians have increasingly recognised that the promotion of health often requires the protection and promotion of human rights.²⁷ Military medical officers share in this duty. Indeed they are more likely to be in situations where they will observe human rights violations first hand. Documenting human rights violations is important to establish responsibility for criminal acts, and ultimately prevent future abuses. In many ways it is akin to preventive medicine.

SOCIAL AND CULTURAL SENSITIVITIES

There is a requirement for adequate familiarisation with the indigenous culture prior to setting out on the mission. For missions where multiple languages and cultures are involved, there is a requirement to communicate one’s ideas, goals, and objectives to the local population, while sustaining mutual understanding and respect for each other’s customs and cultural sensitivities. Local people may have expectations that are different from those of the foreign peacekeeping contingent. An example is provided by the need to assess the population’s humanitarian needs. The population is aware that it is being assessed, and if there is a lack of action, this can lead to an enormous sense of frustration. A decision may have been reached by the peacekeeping force that a threshold for humanitarian intervention is higher than

that which the indigenous population expects. Rubin asked if it was unethical to do an assessment in the first place, if there was the possibility that it would be followed by lack of action.²⁸

Refugees, and the internally displaced in particular, can regress in their behaviour, particularly those who suffered serious losses during their flight. Commenting on Croatian refugees, Klain and Moro noted that they expect gratification for their suffering, but in most cases these expectations are unrealistic. They can be distrustful and in constant search for someone to blame for what has happened to them. They are wary of strangers, including peacekeepers and aid workers.²⁹

The peacekeeping contingent should not see itself as a factor outside the events happening around them. They should view themselves as one element in a situation, not some *deus ex machina* immune to criticism, accountability or control. General Dallaire, the commanding officer of the UN mission to Rwanda (UNAMIR), at the time of the genocide in 1994, declared of peacekeepers and their relationship to the conflict: "we are intertwined by the very nature of the crisis".³⁰

The support of the local population is essential to the success of a peacekeeping operation. Lack of local support not only hinders the operation in the implementation of its mandate and the conduct of its daily activities, but can also pose a physical danger to the mission's personnel. Respect for the cultural traditions and social mores of the local population is essential. Providing medical services is part of the "peace building" component of the mission. The military medical officers' dealings with the local population can benefit from the advice provided in the UN document *Multidisciplinary Peacekeeping: Lessons From Recent Experience*.³¹ It states that a peacekeeping force: "is best advised to work through local authorities and community elders, provided these do not contradict accepted international standards of human rights and humanitarian law". It further advises that great caution should be taken in identifying the correct community leaders, as it can often be difficult to identify who actually represents the community.

War has a destabilising effect on the community. In the 1990s many of the wars involved regimes at war with sectors of their own society. The traditional ways for handling crises may be ineffectual, which can leave people feeling vulnerable and helpless. War tears apart the social fabric, and community structures may not be able to fill their customary role as a source of support and adaptation.³² It would be a mistake to view the local population in terms of victims, even though some will have developed physical and emotional problems secondary to the conflict.

A key element of modern political violence is the creation of states of terror to penetrate the entire society as a means of social control. Mozambique in the 1980s is an example: Renamo guerillas murdered around 150 000 peasants, displaced three million others, and left the social fabric of large areas in tatters.³³ Such factors can leave the population vulnerable to exploitation, not only from the warring factions, but also from those who come to aid them.

The potential of exploitation by peacekeepers and humanitarian agencies arose in 2002. Two consultants who had been commissioned by the United Nations High Commissioner for Refugees (UNHCR) and Save the Children (UK) reported that there was widespread sexual exploitation of refugees by humanitarian aid workers and peacekeepers in Guinea, Liberia, and Sierra Leone (UN press release: Allegations of widespread sexual exploitation in West Africa refugee camps not confirmed by United Nations investigations, 22 October 2002).

The Office of Internal Oversight Services (OIOS) of the UN conducted an investigation at the request of the United

Nations High Commissioner for Refugees. They found that no allegation against UN staff could be substantiated.

The OIOS identified several factors that contribute to potential exploitation of refugees, noting aspects of refugee camp life, camp structure, camp security, and aid distribution. They advised that remedial action be taken by the UNHCR and the UN Department of Peacekeeping Operations. Refugee camps have a regimenting and containing aspect to them, which places the aid agencies in a position of power in regard to the refugees.³⁴ If offenders belonging to the United Nations are identified they could be considered to be immune from the legal process of the host government under article 5 (section 18a) of the *Convention on the Privileges and Immunities of the United Nations*.³⁵ When this protection is used, it is expected that the officials or peacekeepers will be prosecuted by their respective home authorities. The secretary general, or the security council, can waive the immunity, under section 20 of the convention.

Though populations may have endured years of war and terror, it is unwise to assume that they are in some way rendered helpless and vulnerable. The resilience of people should not be underestimated. As Summerfield noted, even in the refugee camps in Rwanda, after the genocide of 1994, 57% of the people saw their future as being good, and 75% felt they were able to protect their families and themselves.³³

THE ALLOCATION OF MEDICAL RESOURCES

In his address to the International Peace Academy, the secretary general of the UN, Koffi Annan, stated: "our impartial benevolence is not neutral in its effects" (UN press release: Secretary general's address to the International Peace Academy on 20 Nov 2000, SG/SM/7632, 20 November 2000.)

Humanitarian assistance can be manipulated by warring factions and unscrupulous regimes, for their own political purposes. Particularly in complex emergencies, humanitarian aid can fall into the hands of the warring parties.³⁶ An example of this is the situation that arose in Goma, Zaire, in 1994. The refugee camps were under the strict control of the Interhamwe and the ex FAR (Forces Armées Rwandaises). This led to some of the humanitarian supplies being obtained by the génocidaires who ran the camps and launched military raids into Rwanda.³⁷

In 2000 Reade discussed the effects of having a UN military hospital that treated civilian patients as well as military patients, in Bosnia and Herzegovina.³⁸ The hospital was primarily to serve 8000 Stabilisation Force for the Former Yugoslavia (SFOR) troops. It was well provisioned and had excess capacity. The hospital authorities tried to impose guidelines that would not undermine the local practitioners, and would encourage the civil authorities to build up a civil medical infrastructure. The plan was to deal only with civilian major surgical cases and civilian medical emergencies. Communication difficulties led to patients being fully medically examined to establish the extent of their illness. By the time this was done, it was difficult to turn the patients away without giving medical treatment.

The primary responsibility for the care of a population falls upon the local authorities. It is only if they fail, or are unable to meet their humanitarian duty, that humanitarian organisations should step in to remind them of their responsibilities toward the victims, and if necessary, to take the practical measures required.³⁹

Many troop contributing countries provide humanitarian relief through their respective contingents, outside an international framework policy, or an integrated command and control centre.⁴⁰ This has the undesirable effect of making aid distribution uneven. If the mandated area of peacekeeping operations has a mixed hostile population, it can be perceived that the humanitarian and medical aid

favours one population over another, as the different contingents in the operational area will have different levels of humanitarian and medical resources.

One commentator said the lesson of Srebrenica was that the home government of the peacekeeping contingent had a duty to ensure that sufficient facilities were available to provide for the troops and the civilian population, "in a qualitative responsible manner under varying circumstances".⁴¹ This ignores the fact that the peacekeeping forces, once deployed, are the responsibility of the UN, and not of their national governments. Clasper, in a discussion about military medicine in general, states: "Military and civilian planners must also prepare for a full range of eventualities, with adequate resources for the care of the civilian population at risk, including pregnant women and young children".⁴² Currently, United Nations contingents are expected to bring in 90 days supply of medical consumables when entering into the mission area.³¹ These supplies are supposed to be for their own use. To bring in medical supplies for the civilian population as well may make the operation too unwieldy and prohibitively expensive for some troop contributing countries.

CONCLUSION

United Nations peacekeeping military medical officers can often be faced with ethical dilemmas in regard to their duties of care toward the surrounding civilian population. They are frequently unprepared for the challenges facing them in this regard, and there is little guidance available to them. This area of medical ethics is only now being explored.

These areas of ethical dilemmas also are present for soldiers serving in national armies in times of war. The doctor may not have control of his medical supplies, but he/she does have control over his/her medical expertise. This expertise should be for the benefit of the most needy, independent of status, in a conflict zone.

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