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Professionalism under fire: Conflict, war and epidemics

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Abstract

Today's medical students (tomorrow's doctors) will be entering a world of conflict, war and regular outbreaks of infectious diseases. Despite numerous international declarations and treaties protecting human rights, the last few decades has been fraught with reports of "lapses" in medical professionalism involving torture and force-feeding of detainees (e.g. captured during the War on Terror) and health care professionals refusing to treat infected patients (e.g. HIV and Ebola). This paper provides some historical background to the changing status of a physician's duty to treat and how medical practitioners came to be involved in the inhumane treatment of detainees during the War on Terror, culminating in reports of "lapses" in professionalism. The Theory of Planned Behavior, which takes into account the individual, the environment and the social context, is used to explain the factors that might influence an individual's behavior in challenging situations. The paper concludes with some recommendations for medical and health professions education. The recommendations include selecting students who, as a minimum, can provide evidence of "basic" professionalism, engaging them in exploring the history of the medical profession, exposing them to contexts of uncertainty and moral dilemmas and challenging them to reflect on their responses.

> *Whether in a military uniform or not, whether a bureaucrat in an oppressive regime, whether a gatekeeper in a managed care organization, the doctor is the patient's last safeguard. To abandon that role is to defect from what medicine is about: the use of knowledge to help, heal, cure, and care for persons.* (Pellegrino & Thomasma 2000, p. 270)

Practice points

- Today's medical students will be entering a world plagued by war, conflict and regular outbreaks of infectious diseases.
- Medical and health professions education needs to prepare graduates who, in such challenging circumstances, do not lapse into unprofessional behavior.
- Selection criteria should, as a minimum, identify individuals who can provide evidence of "basic" professionalism.
- Included in their training should be exposure to contexts which requires reflection on their response as well as developing an understanding of the factors influencing why individuals behave in stressful situations.

Introduction

In medicine, professionalism has been defined as "a set of values, behaviors, and relationships that underpin the trust that the public has in doctors" (Royal College of Physicians 2005) and is the basis of a social contract between medicine and society (Cruess & Cruess 2014). Today's medical professionalism codes such as the 2001 American Medical Association Principles of Medical Ethics and the 2002 Professional Charter have been framed around Swick's (2000) professional competencies (Table 1). For Sox (2007), "the word professionalism has a particular meaning to contemporary physicians. It connotes everything that we admire in our colleagues and strive for in ourselves" (p. 1532).

With conflict, war and epidemics ravaging different parts of the world, doctors and other health professionals, because of their specialized knowledge and skills and because of an expected obligation to society, provide medical assistance or humanitarian aid either voluntarily (e.g. with Médicins sans Frontières) or as nationals of affected countries or countries offering assistance. As a result, many find themselves in the front line of the fighting (Snow 2007; Solberg 2014) or amongst sick, dying and often contagious patients (Bryan 2002, 2003; Hsin & Macer 2004; Reid 2005; Qureshi et al. 2005; Shiao et al. 2007; Seale et al. 2009; Kinsman 2012; Time Magazine 2014).

This article addresses some of the challenges facing health care professionals under demanding circumstances such as conflict and epidemics, which for some, may culminate in what has been perceived as "lapses" in professional behavior. We will describe some of the difficulties facing health care professionals during conflict, war and disease and offer some

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Table 1. Swick's (2000) nine competencies for medical practitioners. (Those in italics are relevant to this discussion, particularly #5 and 8).

1. *Subordinate own interests to the interests of others.*
2. *Adhere to high moral and ethical standards.*
3. Respond to societal needs and contribute to improving the lives of the communities served.
4. *Adhere to the core humanistic values (e.g. honesty and integrity, compassion, altruism, etc.).*
5. *Exercise accountability for self and colleagues.*
6. Demonstrate a continuing commitment to excellence.
7. Maintain a commitment to ongoing scholarship and advancement in medicine.
8. *Deal competently with high levels of complexity and uncertainty.*
9. *Reflect on one's actions.*

explanation about how context may influence behavior under challenging circumstances. We will conclude with some suggestions how, as health professions educators, we might prepare graduates for the reality of the challenges (e.g. bioterrorism, infectious disease outbreaks) they are likely to face as future health professionals.

Professionalism under fire

Conflict and war

The atrocities of the Holocaust are probably the most explicit examples of crimes against humanity (Pellegrino & Thomasma 2000; Geiderman 2002a,b; Chelouche 2005, 2008). Despite universal acceptance (e.g. Geneva Conventions, Nuremburg Code) that such abuse and dehumanization should never be allowed to happen again, it has. Both the Institute on Medicine as a Profession (IMAP) Task Force Report (2013) and the United States (US) Senate Select Committee on Intelligence (2014) have made public the torture and inhumane treatment of detainees at the hands of the US Military and the Central Intelligence Agency (CIA) during the Bush regime's War on Terror which began after the events of 9/11. The 2013 IMAP report specifically described how military medical personnel were involved in monitoring oxygen saturation during water-boarding, watched for edema in detainees forced to stand in stress positions, shared information from prisoners' health records with interrogators and force-fed prisoners (Okie 2005; Clark 2006; Miles 2007, 2013; IMAP 2013; Kimball & Soldz 2014), as well as failing to document evidence of torture in many instances (Iacopino & Xenakis 2011).

The events of the 11 September 2001 led to "a new kind of war" (War on Terror), one in which the "long-accepted norm barring military clinicians from being involved in coercive interrogations of prisoners and in administering non-therapeutic drugs to soldiers" (Miles 2013, p. 117) was set aside. So began a period of obtaining information at any cost, a time in which military medical personnel participated in activities which "represent a dramatic departure from the conventional medical ethics, which are anchored in the "do no harm" principle" (Kimball & Soldz 2014, p. 1) and which violated widely accepted ethical standards set out in the United Nations Principles of Medical Ethics, the Geneva Conventions and the Declarations of Tokyo and Malta (Clark 2006; Miles 2007; IMAP 2013).

In the light of this discussion, Clark's (2006) question becomes pertinent: Is there something fundamentally wrong with our medical education system that allows well-trained medical personnel to become actively involved in abuses, or, even worse, remain silent? To place these reported "lapses" in professionalism into context, it is important to note some of the actions taken by the US government and military during the War on Terror (IMAP 2013):

(1) Individuals captured in, e.g. Afghanistan and Pakistan, were regarded as "unlawful combatants" and did not qualify as prisoners of war under the Geneva Conventions. The US Department of Justice also approved interrogation methods that would normally be considered as cruel, inhumane or degrading.
(2) The US Department of Defense instituted key changes to ethical standards and policies to rationalize and facilitate medical and psychological professionals' participation in interrogation. To this end, because they were not involved with patients, the "do no harm" principle did not apply and, by declaring physicians and psychologists involved in interrogation as "combatants", they were exonerated of their respective professions' ethical responsibilities. By 2003, a set of "medical guidelines' for interrogation existed, with medical personal and psychologists present to ensure detainees met with no serious or permanent harm.
(3) While military personnel have a duty to report abuse, often there were no clear policies or procedures to do so.

Thus, during the War on Terror, many military physicians and psychologists acted under legally binding instructions, with disobedience carrying the threat of misconduct and possible dismissal (Physicians for Human Rights 2014).

Infectious disease and epidemics

Historically, physicians' responses during epidemics have been mixed. For example, during the plague outbreaks of Europe, some stayed with their patients, often succumbing to the disease. Others fled, abandoning their patients (Huber & Wynia 2004). At that time, treating such patients was viewed largely a matter of personal choice, a charitable act or a religious obligation until the founding of the American Medical Association (AMA) in 1847 when explicit professional ethical standards around treating infected patients were formalized. The 1847 Code specifically stated "when pestilence prevails, it is [physicians'] duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives". This was strengthened in 1912 (Principles of Medical Ethics) with "When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard for risk of his own health or financial return" (Baker et al. 1999). At that time, it became a public expectation that physicians treat the sick which probably accounted for many physicians contracting and even succumbing to tuberculosis between 1920 and 1940. By the 1950s, however, the risk of epidemics had fallen dramatically and, in 1977,

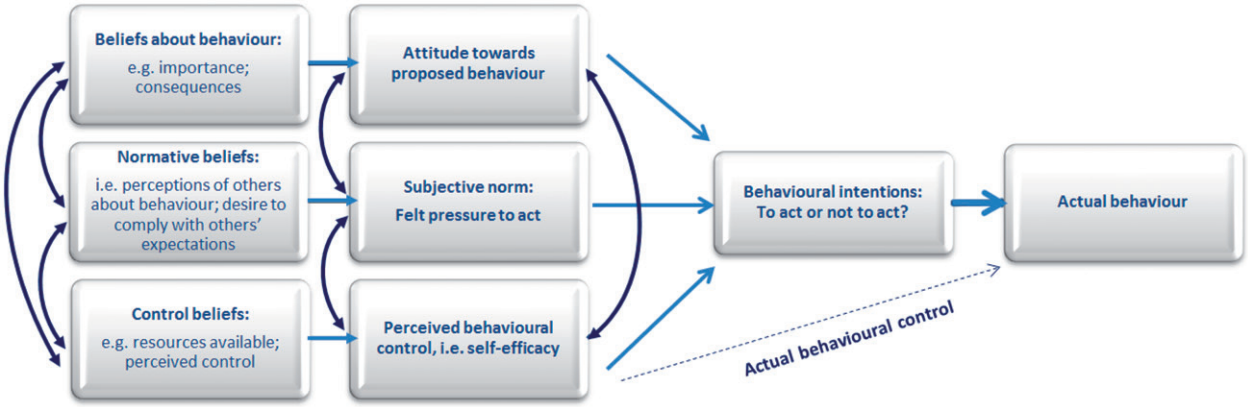

Figure 1. Outline of the theory of planned behavior (adapted from Ajzen 1985).

the principle of care relating to epidemics was removed from the Principles of Medical Ethics (Huber & Wynia 2004).

With the emergence of HIV in the 1980s and with two generations of doctors having had no experience of outbreaks or epidemics, some medical practitioners refused to treat infected patients. This fuelled the first discussions in about 30 years about physicians' duty of care in such instances. Eventually, the AMA stated that "A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is [HIV] seropositive" (Huber & Wynia 2004, p. W8). The issue of duty to HIV patients thus related to non-discrimination (Huber & Wynia 2004) or "disability" (Reid 2005) rather than the profession endorsing a broad social duty to treat during epidemics.

Recent outbreaks of Ebola, avian flu and SARS (severe acute respiratory syndrome) have provided opportunities to further explore medical professionalism in the context of emerging health threats. While altruism led to many individuals risking their lives to serve affected patients, the behavior of others could be deemed to be more self-serving: Compensation requests, failure to report for work and refusal to put oneself at risk (Straus et al. 2004; Reid 2005; Shiao et al. 2007; Seale et al. 2009; Kinsman 2012; Silva 2014; Yakubu et al. 2014). Perceptions of these actions have ranged from self-preservation to abandonment of duty (Reid 2005; Kinsman 2012).

The discussion thus far has provided a historic account of what may have contributed to physicians violating the rights of detainees or declining their duty to treat during infectious disease outbreaks and epidemics. Thus, when faced with a crisis, there will always be those health professionals who choose to remain true to their professional ethical obligations, while others will not. We will next explore why individuals might behave differently under challenging circumstances.

Towards an understanding of behavior

Understanding what underpins behavior may help to explain why health care professionals chose to behave differently when faced with moral challenges. The Theory of Planned Behavior (TPB) provides a useful framework for understanding behaviors over which individuals have the ability to exert self-control (Ajzen 1985) (Figure 1). In this theory, behavior is primarily dependent on the intention of an individual to perform a behavior, which is influenced by his/her personal beliefs, what his/her social contacts think about his/her actions and whether there are significant barriers to undertaking the act. These three beliefs are in turn mediated by an individual's attitude towards the behavior, the social pressure to respond (i.e. subjective norm) and a sense of whether he/she has the skills, knowledge, time and resources to be able to respond (i.e. perceived control) (Ajzen 1985; Connor 2013, 2014). Any behavior is therefore a complex relationship involving the individual and social influences, including environmental factors (e.g. threat, peer pressure, law). An individualistic perspective of medical professionalism therefore does not fully explain how physicians develop and act as professionals, especially when their fundamental professional values and beliefs are challenged (Martimianakis et al. 2009).

For Ginsburg and colleagues (2000), context is important in influencing individual factors in this model. In terms of military medical personnel, dual loyalty, the need to balance the medical needs of patients in the face of a duty to an employer, has been used to explain why physicians have been seen to act "unprofessionally" in challenging circumstances (Sidel & Levy 2003; Clark 2006; Snow 2007; Miles 2013; Kimball & Soldz 2014; Solberg 2014). As Powell (2005) has pointed out, the ethos of an organization or a cause can be internalized, prompting actions which the individual would not normally perform. Such acts might include medical personal being aware of (and not reporting) or participating in physical or psychological abuse or torture. Gross' (2006) provocative debate on nationalism vs. morality in challenging circumstances such as conflict considers the rights of the individual (the prisoner) and "the greater good" (national security). In his view, a physician's duty, like any citizen, is to consider the humanitarian issues involved and question national directives. He argues, however, that there may be times, in the interest of national security, that a physician is

required to certify that a detainee is medically fit to undergo interrogation because the benefit to the nation outweighs the needs of the individual. In terms of the TPB, the subjective norm (i.e. social pressure to respond) would thus be a powerful motivator to comply.

In Sidel and Levy's (2003) view, the majority of medical military officers enter the service in response to a call to legitimate duty: to dedicate themselves to minimizing the harm of their countrymen who may become military patients serving their country. At the time of writing his chapter in 2003, Rascona pointed out that the majority of medical officers entering the US military medical corps received some sort of scholarship which is "a system of indentured servitude because at no time may a military physician choose to 'opt out' and repay the government in any other way than service" (p. 324). In terms of the TPB, this too is likely to have implications on individuals' personal intentions to act versus the social pressure to conform.

In terms of understanding responses to epidemics and public health issues, several authors have provided useful insight into how individuals respond and what might underpin their actions (Straus et al. 2004; Reid 2005; Qureshi et al. 2005; Seale et al. 2009; Connor 2013, 2014; Silva 2014). Of particular relevance in this context are Reid's (2005) debate on risk and the duty to care and Connor's (2014) TPB modeling on the intention of health care workers to respond. Reid's (2005) discussion, sparked by the SARS epidemic revolves around the risk health care workers faced and the unrealistic social expectation to treat, irrespective of their personal well-being. For Reid (2005), unrealistically, "the social contract forming the professions leaves us with no one but the licensed healthcare professionals to turn to in an emergency" (p. 353) and "posing the issue of duty of care solely in terms of an obligation to others in conflict with self-interest fails to capture the real moral dilemmas faced by healthcare workers in an infectious epidemic" (p. 358). In Reid's (2005) opinion, it should be incumbent upon society to equally share in the responsibility during such episodes by, for example, ensuring appropriate health care infrastructure and by having appropriate precautionary regulations.

Connor (2013, 2014) found that the intention to respond to public health emergencies is influenced directly and foremost by perceived behavioral control, followed by the subjective norm, and, to a lesser extent, by outcomes beliefs. The decision to respond to a disaster is thus a complex balance between personal (e.g. knowledge, skills, duty to patients vs. loved ones), contextual and environmental (e.g. natural disaster vs. biological or chemical) and social (e.g. response role) factors (Connor 2013, p. 5). Yakubu and colleagues' (2014) article on the ethical obligations during the recent Nigerian Ebola outbreak identifies just this in the face of no clear guidelines: "In the absence of clear guidelines, healthcare workers face a moral dilemma. Their conscience urges them to treat all patients, but convergence of failed health system factors, the danger to life, emotional considerations like danger posed to family and friends, and the absence of commensurate compensation for engaging in high risk service can make following one's conscience costly" (p. 1).

Addressing the challenges: Implications for medical and health professions education (and beyond)

Bryan (2003) explains some health care professionals risking their own lives for the greater good in terms of two types of professionalism, which he calls basic and higher professionalism. All health care professionals should demonstrate basic professionalism. Higher professionalism, however, becomes important in challenging situations. Higher professionalism is a calling, often with little or no prospect of reimbursement, is virtue-based and usually involves substantial personal risk. Time Magazine's recent Person of the Year issue, which recognizes the heroic work of some of those involved in dealing with the recent Ebola outbreak in Liberia, exemplifies this higher professionalism: "Doctors who wouldn't quit even as their colleagues fell ill and died; nurses comforting patients while standing in slurries of mud, vomit and feces" (http://time.com/time-person-of-the-year-ebola-fighters/). As many individuals with such a calling will apply to study medicine and other health professions, the challenge is to ensure that our admission criteria include such individuals, even if they are not the highest academic achievers (Box 1).

Not all doctors faced with challenging situations will, however, act against their fundamental moral principles (Perl 1948; Leyton & Locke 1998). A sociological perspective provides a useful insight, highlighting the dynamic relationship between individual agency (freedom to choose from a range of valued options and outcomes) and the social structures within which the individual is working and living (Archer 1995). The development and maintenance of individual agency is complex but depends on a clear moral purpose and a well-developed professional identity (Korsgaard 2009). We believe that medical and health professions education has

Box 1. Developing graduates with high moral standing under pressure: Recommendations for medical and health professions education.

- As a minimum, select students who can provide evidence of "basic" professionalism. More importantly, however, we need to search for evidence of "higher" professionalism, the "calling", e.g. in personal statements, volunteer work undertaken. We acknowledge, however, that this may produce another set of problems, i.e. students specifically selecting such placements to enhance their personal statements, etc.
- Ensure that all students engage in voluntary work during their training to develop a sense of social responsibility. This would also contribute to their emerging professional identities, which Cruess et al. (2014) believe needs to be explicit both in terms of experiencing the culture of health care and being aware of the need to develop a strong professional identity.
- Introduce history of medicine sessions to explore why professionalism may lapse. An interdisciplinary approach, e.g. with psychologists, would help to explain why human behavior might change in different contexts. This would also involve moral reasoning and the evaluation of risk.
- Identify opportunities for stress exposure training (Hancock & Szalama 2008). Liaising with the armed forces and police may be useful since they are training providers.
- Provide opportunities, e.g. through simulation, in which students are placed in situations with risk and moral challenges so that they can experience how they would react. Reflection and debriefing are essential.

a responsibility to assist individuals to develop a strong moral purpose, with well-constructed personal and professional identities and to explore how these may be challenged. This can be done by selective prompts for discussion (Lifton 2000; Hsin & Mercer 2004) and by fostering a constant reflective approach to practice thereby creating an increased awareness of the influence of social structures on one's behavior (Archer 2003).

By developing students' reflective skills, medical and health professions education can assist students (and later, as professionals) maintain their moral purpose in difficult situations. Students (and health professionals) need to reflect on how they might behave during challenging times, based on their own beliefs about their behavior, as well as the outcomes of the behavior (i.e. their behavioral beliefs). Using the TPB, students can be provided with scenarios in which personal risk needs to be evaluated, taking into consideration the possible variables, e.g. outcomes (e.g. personal benefit or loss), opinions and involvement of colleagues (i.e. normative beliefs), incentives (e.g. financial or social gains) and barriers (e.g. unsafe working conditions).

We also need to make our graduates aware of the need to continue to develop the skills required to deal with challenging situations. This is particularly important for those joining the armed forces or who volunteer during civilian crises. Although ethical guidelines have emerged from the experiences of medical personnel during the War on Terror (e.g. 2012 British Medical Association toolkit for ethical decision-making for doctors in the armed forces), understanding how humans behave in a range of challenging contexts and examining how one might respond if confronted with similar scenarios, will contribute to developing the skill of reflection as an tool to regulate our graduates' actions when under pressure and to ensure the maintenance of a True North on their moral compass.

Conclusions

For Huber and Wynia (2004), "In such situations [i.e. war, conflict, epidemics], the duty to treat must be maintained by pre-existing ethical rules, buttressed by societal expectations and widespread discussion and acceptance amongst physicians of our shared moral imperative to care for people who are suffering. Like other public service professions, including the fire and police forces, some risk is part of the job description of medical professionals" (Huber & Wynia 2004, p. W9). As risk will always be part of any health profession, those entering such professions need to be acutely aware of the challenges that lie ahead and the public expectations of how they should conduct themselves in such situations. For Huber and Wynia (2004), three features are essential in confronting situations: Recognizing risk, a well-developed professional identity and a public expectation to treat. Medical and health professions education therefore must prepare graduates with the skills to tackle these future challenges, including being awareness of the potential for lapses in professionalism.

Glossary

Theory of Planned Behavior: This theory builds on Fishbein and Ajzen's (1975) theory of reasoned action, which states that behavior can best be predicted from an individual's intention or willingness to undertake an action.

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