

Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms

A Project of the

International Dual Loyalty Working Group

A Collaborative Initiative of

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IV. Proposed Guidelines for Practice in Difficult Settings

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A) Guidelines for Prison, Detention and Other Custodial Settings

Preamble

The problem of dual loyalty and human rights is particularly challenging for health professionals who are responsible for providing health care services to prisoners. On the one hand, such professionals are subject to professional ethics and mores governing their conduct; on the other, they work within institutions primarily concerned with state and/or public security. It is inevitable that these dual obligations will at times seem to be, or actually will be, opposed to each other.

Health professionals working in prisons often willingly and knowingly comply with policies that violate one or more aspects of medical ethics, and may even participate in drawing up separate codes of 'medical ethics' specifically for use in such institutions. Others may be unsure of how to cope with situations where their ethical responsibility to the patient seems to be in conflict with state or prison policies and practices. They tend to be passive participants in unethical practices, rather than willing perpetrators of ethical violations.

In some situations, subordination of patient interests to the requirements of the state undeniably serves legitimate purposes. For example, a prison health professional who becomes aware of sexual or other abuse among prisoners themselves may in certain cases have to intervene and breach confidentiality in order to protect others from harm. Under some circumstances, particularly when public health is at risk, a health professional may have to consider betraying confidentiality for the wider public interest, for example, in combating contagious diseases. More frequently, however, elevating the interests of the state over those of the patient leads to violations of that patient's human rights. As noted above, in Chile, as well as in other South American countries, physicians participated in torture under orders from the military; in South Africa, as well as in many other countries, prison health professionals routinely failed to record or report torture and abuse of political detainees.

Numerous international codes and declarations address (directly and indirectly) the responsibilities and obligations of prison health professionals. The fact that such health professionals still find themselves facing apparently irresolvable ethical dilemmas, or even acting unethically, indicates the complexity of these situations, for which existing codes may be inadequate or incomplete. This set of guidelines intends to reinforce the principles already stated in existing codes and declarations, while

specifically addressing the dual loyalty concerns experienced by health professionals working in prisons and other closed institutions.

The Dual Loyalty Working Group has thus attempted to address the almost inevitable ethical conflict that will confront prison health professionals, by developing guidelines that build on and add to existing codes, and by suggesting ways in which institutional support mechanisms can be strengthened.

Scope and context

The following guidelines apply to health professionals who are responsible for providing health care services to persons in custody, whatever their legal situation — whether they are awaiting trial or already sentenced, detainees being held without charge or in any other form of custody. The rules apply wherever the health professional is called upon to provide medical treatment or any other form of medical expertise, whether that be in a prison itself, a police station, a holding cell, a health care facility or any other place where people are held in custody.

Guidelines

In addition to being required to adhere to the principles outlined in relevant World Medical Association, World Health Organization, United Nations, and other guidelines, health professionals who are responsible for providing health care services to those in custody should follow the following guidelines.

1. The health professional should act in the best interests of his or her patient at all times.

Commentary: While this precept may seem to conflict with others, it is the basis for medical ethics outlined in such documents as the World Medical Association's Declaration of Geneva and International Code of Medical Ethics, as well as other declarations such as the Malta Declaration on Hunger Strikes. It must continue to be the primary goal of health professionals caring for prisoners, even in situations of dual loyalty. Acting in the best interests of patients does not necessarily preclude taking steps to prevent harms to, or violations of the rights of other parties, where the health professional has information that could prevent such harms. However, the Guideline does imply that actions that are not in the interest of the patient should be considered only within a framework of exceptions described in [General Guideline 7](#).

2. The health professional is responsible for ensuring physical and mental health care (preventive and promotive) and treatment, including specialized care when necessary; ensuring follow-up care; and facilitating continuity of care— both inside and outside of the actual custodial setting— of convicted prisoners, prisoners awaiting trial, and detainees who are held without charge/trial.

Commentary: Health professionals face an ethical conflict when they are called upon to limit or deny care to prisoners, as well as when they are called upon to engage in or passively accept practices that harm the physical and mental health of the patient. This guideline makes clear the responsibility of the health professional to provide care, regardless of outside pressures, and to advocate for the health interests of the patient. This guideline goes beyond Principle 1 laid out in the UN Principles of Medical Ethics Relevant to the Role of Health Personnel in the Protection

of Prisoners, which states that health personnel have a duty to “provide [prisoners] with protection of their physical and mental health and treatment of disease of the same quality and standard...afforded to those who are not imprisoned or detained.” It is recognized that not all health professionals will be able to ensure follow-up and continuity of care outside the custodial setting, but to the extent they can, they should.

3. The health professional must be ensured, and must insist on, unhindered access to all those in custody.

Commentary: Health professionals may unknowingly deny care to prisoners when custodial officials deny them access to prisoners, often to manipulate which prisoners get care. This practice may be undertaken for a variety of reasons, including corruption, harassment or enforced discrimination. This guideline makes clear the health professional’s responsibility to ensure his or her duties are not neglected or impeded because of the actions of prison officials.

4. The health professional should examine a detained or imprisoned person as soon as possible after incarceration, and thereafter should provide medical care and treatment to such persons whenever necessary, and consistent with the principle of informed consent for such treatment.

Commentary: This guideline, building on [Guideline 3](#), ensures that health professionals are able to provide care to all prisoners within the custodial setting, especially ones who may have experienced abuse. This guideline reinforces Principle 24 of the UN Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment. Furthermore, even though incarcerated, prisoners do not lose their right as patients to be consulted on any treatments they receive consistent with the principle of informed consent.

5. The health professional must regularly inspect and report on sanitary, living and general health conditions to the custodial authority and an independent medical authority; and should, when necessary, advocate for better custodial conditions with custodial authorities and/or an independent medical authority.

Commentary: Health professionals in prison settings face an ethical conflict when their duty is to protect the health of the prisoners, yet the material and/or psychological living conditions of those prisoners, whether through lack of resources or deliberate neglect on the part of prison authorities, make that impossible. In such cases, health professionals can uphold the best interests of their patients by reporting on sanitary and living conditions. This guideline is more specific than those of other medical codes, which do not address the responsibility of health professionals to monitor living conditions in prisons.

6. The health professional should report to the custodial authorities and, where appropriate, to an independent medical authority any situation in which he or she becomes aware of allegations or evidence that those in custody are being subjected to torture or cruel, inhuman or degrading treatment. The health professional must, however, weigh this action against any reprisal or further punishment to the prisoner that may result. When

appropriate, the health professional should gain the consent of the prisoner before making such a report.

Commentary: This guideline builds on current principles barring complicity in torture outlined in the UN Principles of Medical Ethics and the WMA's Declaration of Tokyo, but goes further by calling on health professionals to report the abuses they may witness. When there is potential for reprisal, however, health professionals must take care to report only to those who will not misuse the information. Bearing in mind [Guideline 1](#), they should take into account the need to protect the safety of the patient. This guideline requires that there be strong institutional mechanisms to support the health professional who blows the whistle, including an independent medical authority and a supportive national medical association.

7. The health professional should certify only that which he or she has personally verified; should not falsify evidence and should ensure that complete and accurate medical records are kept for all patients.

Commentary: Health professionals are often called upon by the state, or another powerful third party, to omit, falsify, or disguise crucial information in medical records. The WMA International Code of Medical Ethics holds that health professionals should certify only what they have personally verified, but it and others do not address the specific problem of omitting or falsifying information for the benefit of a party that does not have the best interest of the patient in mind. This guideline goes further than existing codes in addressing this omission brought on by dual obligations. The guideline requires strong institutional mechanisms to support the health professional who maintains complete and accurate records as well as to support his or her patients.

8. The health professional should abstain from participating, actively or passively, in any form of torture.

Commentary: This guideline is basic to medical ethics and is supported by international human rights covenants, as well as by the WMA Declaration of Tokyo and by the UN International Code of Medical Ethics. A health professional passively participates by permitting his or her clinical findings or treatment to be used by authorities to aid the process of torture.

9. The health professional should not provide any means or knowledge to facilitate the practice of torture or cruel, inhuman, or degrading treatment or punishment; should not authorize, approve, or participate in punishment of any form, in any way, including being present when such procedures are being used or threatened.

Commentary: Health professionals, while they may not participate directly in torture or punishment, may be called upon to participate indirectly, by providing instruments to facilitate torture, by using medical knowledge to monitor torture, or by authorizing punishment. This indirect participation includes examinations to declare an individual "fit" for caning, shackles, solitary confinement or any other type of abuse, and dietary restrictions. It also includes being present while the punishment is being administered, for example, observing caning, or examining a patient in solitary confinement to declare him or her "fit" for continuation of the punishment. This guideline does not prevent a health professional from providing

necessary medical care to an individual in solitary confinement; nor does it prevent a health professional from intervening to seek removal of a prisoner from solitary confinement on medical grounds.

10. The health professional should not participate in capital punishment in any way, or during any step of the process. This includes an examination immediately prior to execution and one conducted after the execution has been carried out.

Commentary: Health professional participation in capital punishment continues to occur, despite the World Medical Association's resolution prohibiting physician participation and the many codes that prohibit physician involvement in other cruel, inhuman, and degrading treatment. Health professionals are called upon to participate in a range of activities – from preparing intravenous lines for lethal injection to certifying the death of executed prisoners. This guideline goes beyond existing codes to hold that health professionals should not participate in any part of the process, including the certification of death. We are aware, however, that in some countries, prisoners facing execution may prefer to have death certified by a health professional to ensure, for example, that organs for donation are not removed prior to death or that the individual is not buried alive. In these situations, the health professional should obtain explicit informed consent from the prisoner who is to be executed, stipulating that he or she wishes that health professional to certify death. Strong institutional mechanisms are needed to support health professionals in these positions, as many countries' laws require that health professionals do participate.

11. The health professional should respect medical confidentiality; should insist on being able to perform medical duties in the privacy of the consultation, with no custodial staff within earshot; should divulge information strictly on a need-to-know basis, when it is imperative to protect the health of others.

Commentary: Confidentiality is a cornerstone of medical ethics and is upheld in the WMA's Declaration of Geneva, among other codes. Yet health professionals are often called upon to divulge patients' confidential medical information to authorities, or may perform examinations with authorities present, constraining the extent to which a patient can speak openly with the healthcare provider. When the health of other prisoners is at stake, however, the health professional has an obligation to balance their needs with the confidentiality due the patient, for instance, in circumstances of contagious disease or prisoner-to-prisoner abuse. When confidentiality in such circumstances is breached, care should be taken not to disclose any information beyond that which is needed for the asserted purpose. Such balancing of cases should be openly discussed with peer supervisors from medical authorities/bodies outside of the custodial setting in order to guard against abuses.

12. The health professional should have the unquestionable right to make independent clinical and ethical judgements without untoward outside interference.

Commentary: Health professionals in prison settings are often called upon to subordinate their sound medical judgment in order to support conclusions or outcomes favorable to the state. This includes situations of falsifying or omitting information, but it also includes recommending treatment or action that is not in the

best interest of the patient, for example, allowing an ill patient to be transferred when the transfer will lead to further harm, or not hospitalizing an ill patient because authorities believe he is a security threat. Existing codes call for complete clinical independence. This guideline reinforces those codes and further requires that health professionals actively insist on and be granted this right. There may, however, be situations where legitimate restrictions are put on the health professional's independent judgment. For instance, a physician may be asked to prescribe medication from an essential drug list, with medicines not on the list requiring particular motivation. In such instances, the physician may legitimately accept the restriction, if it is indeed for the greater benefit of the larger community— as long as that restriction does not bring harm or untoward consequences to the patient.

13. The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.

Commentary: Health professionals in prisons are often expected to ignore or passively accept the physical restraints imposed on their patients. Many codes outline the duty of health professionals not to participate in any form of restraint except when medically determined to be necessary for the health of the patient and others (UN Principles of Medical Ethics, UN Minimum Rules for the Treatment of Prisoners, UN Principles for the Protection of Persons with Mental Illness). This Guideline goes beyond the others by permitting only a narrow exception, that health professionals should not treat a patient in restraints unless an urgent situation requires immediate action that cannot be performed safely without restraints — and even then with the minimum possible restraints.

14. The health professional should not perform medical duties or engage in medical interventions for security purposes.

Commentary: Health professionals should never engage in medical interventions that are not in the individual's therapeutic interests, even when requested to do so by authorities for security purposes. Principle 3 of the UN Principles of Medical Ethics states that the purpose of the professional relationship must be "solely to evaluate, protect or improve ... physical and mental health [of prisoners and detainees]." For individuals in psychiatric hospitals, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care state that medication "shall only be used for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others."[224](#)

15. The health professional should not participate in police acts like body searches or the imposition of physical restraints unless there is a specific medical indication for doing so or, in the case of body searches, unless the individual in custody specifically requests that the health professional participate. In such cases, the health professional will ascertain that informed consent has been freely given, and will ensure that the prisoner

understands that the health professional's role becomes one of medical examiner rather than that of clinical health professional.

Commentary: This guideline follows from [Guideline 14](#). The World Medical Association's Statement on Body Searches holds that health professionals should participate in body cavity searches as they have the medical knowledge and skills to ensure that the prisoner is not harmed. The BMA and others, however, assert that such participation makes the doctor a wielder of force, which contravenes basic medical ethics. The British Medical Association holds that only if the doctor can ascertain true informed consent should he or she perform the search. This guideline goes beyond the WMA Statement and the BMA policy to say that the prisoner must request the participation of the health professional. Any breach of confidentiality will concern only the search and no other confidential medical information that the prisoner may confide to the health professional.

16. The health professional should, if prepared to treat a hunger striker, respect the rights and freedom of choice of a detained hunger striker regarding medical intervention and intravenous feeding without the intervention of a third party whose primary interest may not be the patient's welfare.

Commentary: Health professionals treating detained hunger strikers are challenged to uphold the sanctity of life while respecting the rights and choices of their patients. The WMA Declaration of Malta addresses this issue far more thoroughly than it is within the scope of this document to do. For the purpose of guidance in cases involving dual loyalty, where authorities may pressure health professionals to force feed hunger strikers, the health professional must not submit to the wishes of a third party whose primary interest may not be the patient's welfare.

17. The health professional should not engage or participate in any form of human experimentation amongst prisoners, unless the research will provide significant health and other benefits for prisoners and facilitate promotion of their human rights.

Commentary: The Working Group is aware that this is a controversial issue and that some existing guidelines do allow for research on prisoners, provided that voluntary informed consent is given. It is the view of the Working Group that true "voluntary informed consent" is almost impossible to obtain in the prison setting, because of the various overt and covert factors which govern the relationship between prisoner, prison staff and health professional. There may however, be some particular circumstances when research with prisoners may provide significant health and other benefits and facilitate promotion of their human rights. The Group acknowledges, moreover, that research issues are not strictly part of its mandate; it would thus welcome further discussion with and guidance from those directly involved in the ethics of research.

B) Guidelines on Health Care for Refugees and Immigrants

Preamble

States often explicitly discriminate against refugees and immigrants. As countries

seek to restrict the entry of refugees, they also limit state welfare services, including health care. Even in countries with strong traditions of state services, refugees are often denied equal access to health care. State policies restricting entry to the country and restricting access to care can bring about severe dual conflicts for health professionals.

Ethical codes of the UN and the WMA focus on the health of vulnerable groups such as torture victims, prisoners, the mentally ill, the mentally retarded, the handicapped and women. However they contain no provisions on refugees. Some human rights treaties address rights of refugees to health services. Article 24 of the UN Convention on the Rights of the Child states that every child has a right “to the highest degree of health and to access to health care” and calls on all states to assure that no child is prevented from access to health care institutions. Article 22 clarifies that refugee children have the same rights.

The European Convention on Social Rights recognizes, in Article 11, everybody’s right on protection of health, and calls on states to remove the causes of health hazards, to create health counseling and education facilities and to prevent epidemic diseases. The attachment to the Convention (item 2) holds that refugees must be treated as favorably as possible and in no case less favorable than defined in the preceding articles of the Convention.

For the health professional, guidelines are needed in two circumstances: in the evaluation of claims for asylum and in state restrictions on access to health care.

Scope and context

The following guidelines apply to health professionals who are responsible for providing health care services to refugees or immigrants and for evaluating claims for asylum. In the latter case, reference should also be made to the [Guidelines for Forensic Evaluations](#).

Guidelines

1. The health professional should recognize that refugees and immigrants have a human right to equal access to health care.

Commentary: The health professional should be guided by two fundamental human rights principles, that everyone has the right to the highest attainable standard of health and that health services should be made available on a non-discriminatory basis. When state policies limit access to health care, either through legal requirements or limitations on reimbursement for services, the individual health professional should not acquiesce.

It is unreasonable, however, to place the full responsibility for equal health care of refugees on individual health professionals facing legal or financial impediments to equal care however. Most often collective action will be required. For example, the British Medical Association’s guidelines for refugee health care demand that doctors offering an extended range of services to this group of patients get additional payments. Medical organizations can also organize voluntary medical services for this group.

2. Health professionals should not report immigrants who lack legal status to government authorities.

Commentary: The state has the responsibility for immigration matters and law enforcement. It is not part of the health professional's function to participate in law enforcement activities, and the health professional should resist where a breach of confidentiality amounts to a violation of human rights that could result in incarceration, prosecution, deportation or all three.²²⁵ In immigration and refugee matters, where there exists no likelihood of harm to a third party in the absence of disclosure, the principle of confidentiality and of making health services available to people in need should take precedence over the state's interest in using health professionals to assist in enforcement of immigration laws. Health professionals must therefore decline to report undocumented immigrant to state authorities. It may be particularly difficult for health professionals working in state institutions or on a government payroll to resist pressures to report. Strong institutional mechanisms must be in place to support them.

3. Health professionals should not disclose information gained in the course of treatment of refugees to state authorities.

Commentary: Doctors may face pressure from immigration authorities to disclose information about patients for planning, administrative, law enforcement and other purposes. Disclosing confidential information in these circumstances, however, can have potentially severe human rights consequences for the patient. By contrast, assuring refugees and immigrants that confidentiality will be respected will also aid the therapeutic mission, since it can gain trust from refugees and immigrants who may be very anxious and reluctant to give information on their health background and may be fearful of examination. Fears that information disclosed to a health professional may reach authorities should be addressed directly.

Where the health professional is engaging in examination for state authorities for purposes other than treatment, the health professional must clearly disclose the purpose of the examination and the limits on confidentiality to the person being examined.²²⁶ Proper counseling should be given to the patients regarding the uses of the information obtained by state immigration authorities.

4. Health professionals should not participate in medical examinations on behalf of the state for the purpose of determining a refugee's eligibility for entry into the country except in cases where public health and preventive measures are needed to counter the risk of epidemic. Screening or testing is only permitted with prior informed consent. In case of repatriation the results of medical assessments and necessary treatment programs should be provided to the refugee.

Commentary: In some countries immigration authorities rely on medical techniques such as X-ray or dental screening to seek to determine the age of the refugee or immigrant. They may also engage in examinations purporting to engage in "fitness to travel" when forced repatriation is likely. These examinations are often superficial and misused and rarely include an assessment of the overall health of a refugee e.g. a psychotrauma caused by war atrocities or other kinds of violence. This high potential for serious abuse should lead health professionals to avoid participation.

5. Health professionals should insist that medical services for refugees and immigrants, and examinations for determination of status include interpreters.

Commentary: Health care services usually do not provide interpreters. They rely upon relatives or friends (often children) for translation. This practice violates medical confidentiality and the principle of neutrality. The enormous stakes for the individual in cases of examinations also supports the need for interpreters.

6. Health professionals acting as evaluators in asylum procedures and court procedures should be aware of potential dual loyalty conflicts if providing treatment to refugees as well.

Commentary: Although this separation of function would provide the greatest protection of the human rights of refugees, in practice it is rare, either because there are few health professionals with specialized knowledge in transcultural medicine, refugee health and refugee trauma, or because the state does not take adequate steps to avoid role conflicts. Health professionals should urge that the separation of function be instituted.

C) Guidelines for Health Professionals in the Workplace

Preamble

Health professionals frequently provide a range of services at the workplace to employed persons. Such services may include direct clinical care such as periodic health examinations, curative and rehabilitative care, preventive education, and health promotion interventions directed at high-risk individuals. In addition, health professionals at the workplace are frequently called on to provide services where the primary motivation is neither therapeutic nor clinical, but evaluative. These may further a legitimate administrative or institutional purpose. For example, medical personnel are frequently called upon to provide medical reports in support of compensation claims, to evaluate a candidate's fitness for a particular job, or to provide expert opinion on the sickness record of a particular employee in the context of a perceived absenteeism problem. At other times, health professionals have the responsibility of conducting measurements of potential hazards to workers' health as part of industrial hygiene programs.²²⁷

In such circumstances, the health professional is subject to expectations from a third party, usually an employer. At the same time, the health professional has ethical obligations towards his or her patient. As a result, he or she is faced with the problem of dual or divided loyalty.

Dual loyalty conflicts at the workplace may be exacerbated by potential conflict generated by adversarial employer-employee relations.²²⁸ Usually such conflicts arise out of a contractual relationship between the health care provider and the company, which is also the employer of the worker-patient. Conflicts also arise vis-à-vis non-business employers, however, for instance, workers' trade union, or the government safety department, which may seek confidential information for purposes of addressing a perceived health hazard at a workplace.

The presence of a dual loyalty conflict at the workplace does not inevitably result in violation of workers' rights. It can, however, if inadequately managed. Health professionals may, for instance, subordinate independent therapeutic judgment in order to promote an objective of the employer, thus placing workers at further risk of injury. The Dual Loyalty Working Group has attempted to address such ethical conflicts by drawing on recognized human rights standards in developing guidelines which build on and add to existing ethical codes.

Scope and Context

These Guidelines apply to health professionals responsible for providing occupational health services to employed persons. Occupational health service provision is taken to cover the full range of preventive, promotive, curative and rehabilitative services for persons at the workplace, and includes both direct health care and occupational hygiene services. These Guidelines are a particular application of the [Guidelines for Forensic Health Professionals](#) and apply to clinical care as well as to health professionals' non-clinical obligations, such as monitoring workers to meet statutory requirements.

Guidelines

Health professionals responsible for providing occupational health services should adhere to the following guidelines, in addition to the principles outlined in relevant national and international professional ethical codes.

1. Health professionals should exercise independent judgment²²⁹ in their clinical management and non-clinical assessment of the worker/patient.

Commentary: This is a particular application of [General Guideline 4](#). Generally, independent judgment requires the health professionals to act in the best interests of patients at all times and ensure that occupational health service provision remains focused on the promotion of the health of the workforce, regardless of the role (therapeutic or non-therapeutic) he or she is asked to play. Cost may be regarded as a legitimate consideration if the occupational health service is seeking to identify the most cost-effective way to attain a health objective. However, it is not ethically acceptable to subordinate independent judgment to cost considerations nor to trade off a health objective as too costly to achieve based upon a company's concerns solely to minimize costs or maximize profits.

Third party requests for clinical judgments that benefit their interests are, in the occupational setting, common but misguided. Requests to limit sickness absenteeism, or favor a particular conclusion in a medical assessment should not influence the clinical judgment of the health professional. Occupational health professionals should not be party to the misuse of a clinical examination as a means to dismiss workers.

Where requests from third parties pose irreconcilable ethical and human rights conflicts, the occupational health professional should consider withdrawing his or her services, as long as this does not disadvantage the patient unreasonably. Occupational health professionals should avoid any judgments, advice, or activities that may endanger trust in their integrity and impartiality. Treating all workers in a non-discriminatory manner, basing judgments on scientific knowledge and technical competence, and respecting diversity and equity at the workplace will help to

establish a relationship of trust and confidence in the health professional among all stakeholders.

2. Even when acting in a non-therapeutic role in relation to the patient, such as that of independent evaluator, a health professional cannot ignore the ethical obligations to the individual patient, to which he or she would be subject in a typical clinical encounter.[230](#)

Commentary: Even when acting in a non-therapeutic role, such as assessing employees for purposes of fitness for work, disability, or compensation, the health professional must conduct the assessment in a manner that complies with ethical and human rights norms.

Importantly, the health professional should inform the patient before the assessment that he or she is acting in a non-therapeutic role and should make sure the patient understands the implications of this role. This gives the worker-patient the opportunity to take responsibility for choosing another health care provider or refusing the examination.

If the employee consents to the examination, the health professional should conduct the examination with respect for the patient's dignity and autonomy, using his or her independent judgment and knowledge of the workplace to reach a considered assessment of the worker's fitness. The findings of the examination and tests and the contents of the report should be discussed with the worker prior to submitting the report, which, again, should only contain details relevant to the purpose of the examination.

Of note is that in assessing employees with recurrent absence due to illness, the role of the health professional is to provide advice to both the employer and the employee. Other than providing advisory information, however, the health professional should not be involved in absenteeism control, which is the job of management.[231](#)

3. Health professionals should maintain confidentiality of medical information, and not disclose clinical information not directly germane to the purpose of evaluation.[232](#)

Commentary: No medical information about a worker should be revealed to a third party, including employers, without the express consent of the worker concerned unless the following apply. 1) Revealing such information is clearly in the interests of the worker concerned; 2) The information required is germane to the specific determination of the worker's fitness for the job, and is consonant with the precise requirements of the job; 3) Release is required by overwhelming public health considerations and is mandated by law.

Confidential medical information obtained in the course of periodic or pre-placement examination should not be revealed to an employer except to the extent it is relevant to the worker's fitness to do the job and any limitation of function. Thus, for example, medical tests should only be permitted as part of a fitness examination if they are relevant to the requirements of the job. On the other hand, the health professional should reveal anonymous group data from biological monitoring, as part

of his or her responsibility to bring any workplace risks to the attention of management.[233](#)

4. Health professionals must release information regarding workplace hazards to affected workers or the appropriate authorities, where definable harm – either existing or threatened – to the worker-patient, other workers, or third parties outweighs the right of the company and of the patient to privacy.

Commentary: As in normal practice, health professionals are obligated to share the results of medical testing and examinations with the worker-patient, and to counsel the patient on the implications of such findings. Health professionals may come under pressure to omit certain information from reports that have statutory or financial implications for the employer, so as to protect the company from legal or financial liability. Under no circumstances, however, should such considerations induce the health professional to alter his or her judgment in determining the best course of action with regard to hazard or risk communication for the worker-patient or worker-patients.[234](#)

[General Guideline 12](#) requires that health professionals report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities. Where wider knowledge about the existence of hazards or of occupational disease or disability in a workplace may help to reduce health risks to workers, the health professional has a responsibility to act upon such information to the best of his or her capacity.[235](#) The health professional's action should be aimed at ensuring that communication of the data prompts removal or control of such hazards. The first step is to inform workplace management, stressing the need for timely remedial action. If attempts to address the hazard through routine management channels fail, the health professional should 'blow the whistle' on the existence of such hazards to an appropriate body (professional, employer, governmental, trade union, or other) that can take action to remedy the hazard. These considerations also apply where a health professional is aware of hazards posed to families of workers or to neighboring communities as a result of workplace processes.

Companies often invoke commercial secrecy to prevent disclosure of information about hazardous workplace conditions. This appeal is unjustified, however. The specific hazard posing a health risk rarely reveals proprietary agents or processes. Even where it might do so, considerations relating to the prevention of disease and disability should take precedence over commercial secrecy. As mentioned above, in such a circumstance, the occupational health professional should urge the company to release the information. If this fails, he or she should "blow the whistle" and consider resorting to court action to secure legal protection. Occupational health professionals should, as a preventive measure, make sure that health considerations override secrecy clauses in their employment contracts.

Occasionally, an occupational health professional may identify information relating to the fitness of a worker that places fellow workers or third parties at risk of harm or injury. In such circumstances, the health professional is justified in breaking confidentiality, but only after he or she has counseled the patient carefully and sought the patient's informed consent, and such counseling does not itself compel voluntary disclosure.

5. Health professionals should ensure that any audit or regulatory monitoring undertaken to ascertain risks to workers, their families, or the neighboring community, is undertaken with the highest standard of scientific integrity.

Commentary: The inspection or monitoring of workplaces for potential hazards (such as dust or chemicals), whether by outside agencies or by in-house professionals, is critically important to detect the presence of conditions that may threaten the health of workers, their families, or the neighboring community. It is well recognized that advance knowledge of such inspections often prompts management to clean up the workplace in advance of the inspections.

Health professionals should avoid participating in actions designed to create a false impression of safe conditions at the workplace, and should draw any such action to the attention of inspecting authorities. If possible, the health professional should prevent selective monitoring from taking place, rather seeking to ensure that representative monitoring provides a true picture of the extent of any workplace hazards. Similarly, where possible, the health professional should maintain medical and environmental monitoring records intact, accessible for statutorily mandated inspection.

6. Health professionals should support other occupational health professionals facing conflicts arising from dual loyalty conflicts.

Commentary: Occupational health professionals have collegial obligations to fellow professionals facing pressure to compromise ethical standards. Not only is this obligation part of one's professional identity, but it is also necessary to strengthen the ability of the profession collectively to establish ethical and human rights norms and standards that protect others. Experience has shown that such support from peers is among the most powerful counters to pressures on occupational health professionals to abandon ethical principles. See [General Guideline 15](#) and [Institutional Mechanisms](#).

7. Health professionals should identify and declare any conflicts of interests before helping disseminate research findings or formulate policy for the control of occupational health hazards.

Commentary: Occupational health professionals should seek to disseminate existing health and safety knowledge, support research to identify and control new hazards, and publish such findings.²³⁶ Additionally, they should participate in policy formulation for the promotion of workers' health and the control of occupational hazards, through serving on expert committees, regulatory reviews, and other policy structures. In doing so, however, they should be explicit about the existence of any conflict of interests, for instance, financial, that may burden independence.²³⁷ Declaration of existing or potential conflicts of interests establishes transparency in research dissemination and policy formulation.

D) Guidelines for Health Professionals Engaged in Forensic Evaluations

Preamble

The job of a forensic health professional is to document, obtain, preserve or interpret evidence. Forensic health professionals are often called upon to engage in evaluations for courts or administrative bodies. In criminal cases, forensic health professionals²³⁸ may be asked to evaluate whether a person is criminally responsible for his or her conduct, whether a person is competent to stand trial, and even whether an element of an offense has been established, e.g., intoxication. Forensic health professionals may also examine victims of crimes, e.g., rape or assault victims, for the purpose of gathering evidence. In civil cases, they may engage in evaluations in divorce, child custody, disability benefits, workers' compensation and other cases.²³⁹ In applications for political asylum, health professionals may be asked to establish medical evidence of torture. Health professionals engaged in treatment may also be called upon to provide evidence about a person to a court or other adjudicative body. For instance, a physician may be asked to provide information about a person's medical condition in connection with an application for social benefits.²⁴⁰

All these functions are designed to assist the state in gathering and presenting evidence to decision-making bodies, rather than to assist or treat the person subject to evaluation. As a health professional, however, the evaluator retains a duty to respect the human rights of the person being evaluated and to adhere to ethical standards of the profession, including the duty to inform the person about the nature and objectives of the examination.

There exists an inevitable tension between a health professional's role as forensic evaluator contributing to the development of evidence in a legal proceeding and his or her role as a health professional with a duty of loyalty to the individual²⁴¹. This tension is magnified when loyalty to the state or a third party contradicts medical ethics and implicates the human rights of the person being evaluated, e.g., medical evaluations for corporal punishment. The health professional cannot resolve this tension by claiming that the evaluative role frees him or her from ethical duties to the individual being evaluated.²⁴² Rather, the tension must be resolved by performing the evaluative role consistent with the human rights of the individual.

Human rights standards have been established regarding the health professional's role in torture and participation in the death penalty.²⁴³ More general standards for forensic evaluations, however, are needed.

Scope and Context

The following guidelines apply to health professionals engaged in forensic evaluations on behalf of the state or other third party. They apply wherever the forensic professional is called upon to evaluate – whether in a criminal setting or a civil setting. Additional, more particularized guidelines have been drafted for evaluations of refugees and asylum seekers as well as evaluations in the workplace. These guidelines do not apply to forensic evaluators retained by the person, for example, for his or her criminal defense.

Guidelines

1. The judgment of the forensic medical evaluator must be completely independent of influence by the state or other third parties.

Commentary: The single most serious threat to the human rights of individuals being evaluated comes from forensic medical evaluators who fashion medical judgment to serve state or powerful third-party interests. Although the function of the medical evaluator may result in findings that are not in the interests of the individual (e.g., to support a criminal conviction or to support the denial of benefits), the medical evaluator must never distort documentation or tailor findings to achieve outcomes desired by state or private actors on whose behalf the professional is making the evaluation, no matter how worthy the evaluator believes these outcomes to be. These distortions can occur by making findings or interpretations that are not supported by the facts, or by refraining from making or failing to disclose fully findings that are warranted by the facts.

Although this guideline appears self-evident, there are many examples of medical evaluators permitting their allegiance to a state or state policies to distort their findings, either by making determinations favorable to the state or, more commonly, by failing to make or disclose findings. In doing so, medical evaluators become complicit in the violation of the human rights of the person being evaluated. For example, German doctors examining Bosnian refugees, seeking to support a government interest in excluding the refugees from the country, failed to include evidence of Post-Traumatic Stress Disorder in their reports despite ample evidence of its existence.²⁴⁴ In Turkey, health professionals failed to record evidence of torture or abuse in detention.²⁴⁵ In South Africa, medical cover-ups were very clearly documented in the "Gluckman files."²⁴⁶

2. The medical evaluator should disclose to the person being evaluated the purpose of the evaluation, the fact (where applicable) that the examination is not confidential with respect to the entity seeking the evaluation, and the findings. In the event the evaluatee is mentally incompetent to understand the purposes and findings, disclosure should be made to the person authorized to act on the evaluatee's behalf. Individuals being evaluated should also be informed of any oversight mechanisms that exist.

Commentary: Any individual examined by a health professional has legitimate reason to expect that the information will be used for the benefit of that individual, not for some other purpose, and will be held in confidence. It is therefore incumbent upon the health professional engaged in a forensic evaluation to explain when these assumptions, valid in other circumstances, do not apply.

Disclosure of the purpose of the examination and the findings is required by the human right to due process of law. It is also the responsibility of the institution to give a hard copy of the forensic evaluation to the individual being evaluated, his personal doctor outside the institution and/or another individual (family member) chosen by the subject.

3. In any report, the medical evaluator should explain the reasons for his or her conclusions and indicate where the evidence is insufficient to support certainty concerning these conclusions. The medical evaluator should indicate or make note of alternative interpretations of his or her findings.

Commentary: In many cases, the findings of the evaluator lend themselves to alternative explanations. In other cases, the findings are themselves equivocal. Medical evaluators working for prosecutors or other state agents are often under

pressure to provide an interpretation of findings that is most favorable to the state. The forensic health professional should resist these pressures and instead provide his or her best judgment about the proper interpretation of findings, including the limitations of the findings. This can often be accomplished by providing alternative explanations of the findings in the report that the health professional believes are supportable.

4. Forensic evaluators cannot ignore the obligation to treat a person in distress and must take steps either to offer treatment or to refer the person to another clinician for therapy when the person's condition requires.

Commentary: This guideline is consistent with the principle that a health professional does not forego the therapeutic role and concomitant obligations simply because the professional's skills are used in a particular instance for evaluation. The health professional should offer emergency treatment when qualified to do so and in all cases make an appropriate referral for medical care when the person's condition warrants.

5. A forensic evaluator should not include clinical information about the person being evaluated that is not germane to the purpose of the evaluation.

Commentary: The forensic evaluator may ascertain that the information he or she obtains from the history, physical and additional examination of the evaluatee includes matters that are irrelevant for the party on whose behalf he or she performs the forensic evaluation. This clinical information is within the boundaries of professional confidentiality.

6. The forensic medical evaluator must not engage, directly or indirectly, in practices that aid or support torture or cruel or inhuman treatment or punishment.[247](#)

Commentary: Health professionals should absolutely not participate in evaluations whose purpose or effect is to facilitate torture or cruel or inhuman treatment. Such participation extends not only to engaging in acts that themselves amount to torture or cruel or inhuman treatment, but also to evaluations that can help the torturer determine the individual's "suitability" for torture, ability to withstand torture, or medical condition as a session of torture continues. A health professional can, of course, provide medical attention to a victim of torture where treatment does not amount to a de facto involvement in an interrogation to allow continued torture.

7. The forensic health professional should not participate in evaluations incident to legally sanctioned executions and corporal punishment.

Commentary: International norms against medical participation in legally-sanctioned executions are well-established.[248](#) Evaluations used for executions include competency for execution and certification of death. With respect to corporal punishment, the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment excludes pain or suffering arising from lawful sanctions from the definition of torture, but the Declaration of Tokyo prohibits physician participation even if the person is guilty of an offense. Accordingly, health professionals should not participate in assessments of medical condition before

corporal punishment or in monitoring medical condition during the course of and after punishment.

Existing guidelines prohibit indirect as well as direct participation, since furthering the infliction of pain without therapeutic purpose and the taking of life²⁴⁹ violate a health professional's duty. For example, a forensic medical professional may be asked to assess a person's "suitability" or competence or tolerance for torture, isolation, or aversive treatment, without actually participating in the event. But the assessment is a crucial dimension of the process and thus is prohibited.

8. The forensic health professional who, while acting in an evaluative role, witnesses (the sequelae of) torture and cruel, inhuman and degrading treatment or punishment, should proactively report these cases.

Commentary: Forensic reports are commonly produced upon request of certain parties, for example, the prosecution. Forensic medicine is in this respect a reactive or responsive discipline. However, the health professional may witness torture or other abuses, which should be reported even when there is no request for forensic reporting. Examples are child abuse, domestic violence, torture, and police abuse.

E) Guidelines for Military Health Professionals

Preamble

Health professionals working in institutions that serve state interests, where human rights are easily at risk, are most likely to be confronted with dual loyalty conflicts. Among these, military health professionals face unique conflicts. They must navigate their way between very different and sometimes antagonistic or even irreconcilable goals: on the one hand, to preserve life, attend to the sick, and reduce suffering (the obligation of the health professional), and on the other, to support killing and inflicting harm on the enemy (the obligation of the military officer or soldier).

As long as the interests of the patient and the military organization are in line with each other, dual loyalty conflicts can be avoided. As one military physician put it: "What's good for the patient is good for the military, and you want a fit, happy troop." But even in peacetime the two objectives may conflict. The military health professional is a member of civil society's health professions subject to ethical and human rights standards and goals. As such, the military health professional attends to the soldier who is sick, wounded, or in need of other medical attention and who, like any other patient, seeks the expertise, counseling, and support of his doctor or nurse in privacy and confidentiality. Indeed, this medical function is protected by international humanitarian law, which forbids warring parties from interfering or obstructing efforts by medical personnel to care for the sick and wounded, regardless of affiliation.

From the military's point of view, however, even treatment goals can be subordinated or reinterpreted to reinforce military objectives. For example, usual principles of triage demand that in medical emergencies health professionals attend to the most seriously injured first. But in battle the commander may compel the physician to attend first to soldiers with less severe wounds as a means to return them to battle quickly and maximize force strength; meanwhile the most seriously injured suffer or may die. Similarly, treatment of sick or traumatized soldiers in both

physical and mental health may differ from standard civilian protocols in order to serve military purposes, for example, preparing the soldier as soon as possible for new battle engagements rather than seeking the best long term outcome for the patient. Soldiers are often not entitled to exercise informed consent regarding medication and vaccines. Indeed, even interventions to promote the health and well being of soldiers are designed to further the fitness of troops for battle or other military tasks.

In more extreme circumstances, the ethical medical role can be even more severely compromised. A military health professional may be requested to declare troops fit for engagement even when they are not. The health professional may be called upon to participate or advise in interrogation of suspects of terrorism, insurgency, or espionage to an extent that may amount to torture or cruel and inhuman treatment, to prepare (and be present at) executions, or to administer pharmaceutical substances or vaccines to soldiers (own or enemy) without medical justification. He or she may be called on to participate in biological, chemical or pharmaceutical research and experimentation where civilian protocols, regulations and supervision are reduced or absent. When such research takes place in secrecy – often for legitimate reasons of national security – the military health professional may be required or asked to yield to security interests and forego medical ethical principles and professional codes of conduct.

These dual loyalty conflicts place the health professional in an untenable position. In some of the above examples the practitioner is put in a situation where the underlying conduct violates human rights. In other cases the health professional may be called upon to support a violation of the laws of war, such as supporting acts of violence against a civilian population. Further, during engagements and missions, military health professionals are likely to witness human rights violations on the battle field or in peace-enforcing actions. Yet their duty to report these violations may be inconsistent with the perceived needs of the combat unit.

A complex dual loyalty problem may arise in jurisdictions where military service is voluntary and members of the armed forces are generally held to have voluntarily waived some of their rights by choosing to join the armed services. As patients, they take some responsibility in advance for deciding the extent to which they are willing to “give up” their rights, including, for example, the right to doctor-patient confidentiality. However, this agreement does not mean all of a military patient’s rights are necessarily waived and health care providers should therefore not exceed what is “necessary” in any disclosure. Indeed, it is debatable whether the waiving of rights by conscripts could be reasonably accepted as voluntary.

Health professionals engaged in peacekeeping face other dual loyalty conflicts. In such operations, military health professionals confront the medical needs of civilian populations in the area of their assignment; yet they may be subject to rules and regulations preventing them from providing professional assistance to these civilians.

Military health professionals – being members of the troops and placed in the hierarchical chain of command²⁵⁰ – thus face an extraordinary set of medical-ethical and human rights conflicts. The following Guidelines are meant to address these conflicts. The Guidelines follow the World Medical Association’s Regulations in Time of Armed Conflict in insisting that the health professional in the military is bound by the same standards of practice as civilian health professionals.

Scope and Context

The following Guidelines apply to military doctors and other military health professionals, both in times of combat and in peacekeeping and peace-enforcing operations. These guidelines apply both to the individual health professional and to the military institutions and civil authorities and organizations related to the services of the military health professional.

Guidelines

1. The military health professional's first and overruling identity and priority is that of a health professional.

Commentary: Although this guideline appears self-evident, many military organizations teach physicians that they are officers or soldiers first and physicians second. As such, they are supposed to make their medical skills available exclusively for military purposes. In some countries, such as France, the military physician is trained in a separate military medical school, rather than trained as a military doctor after graduating from civilian medical school. Even where such training takes place, the primacy of the medical function should always be reinforced, even if there exist circumstances where the needs of the military prevail over the needs of the soldiers.

2. Civilian medical ethics apply to military health professionals as they do to civilian practitioners.

Commentary: The starting point for the conduct of military health professionals should be the ethical and human rights standards of civilian professionals, with exceptions only for absolutely essential military purposes. These exceptions should be reviewed on a regular basis. Where deviations from normative ("regular") medical ethics are proposed, such deviations should be subject to careful review and oversight by a suitable structure such as a medical ethical commission with membership that includes an adequate number of civilian health professionals skilled in ethical issues.

Upholding medical ethics includes the obligation to obtain informed consent for treatment. The health professional should consider his or her relationship to the individual under treatment or evaluation as comparable to a civilian health professional-patient relationship rather than as part of a military hierarchy. In considering modes of treatment, a health professional should engage in the same kinds of dialogue with a patient about medical procedures as he or she would in civilian practice. Adherence to civilian informed consent practice does not imply that there will never be circumstances where consent is not required, but rather that the same standards should apply as in civilian health practice. For example, compulsory vaccinations should only be administered without consent in the military to the extent that such vaccinations can be administered in the absence of consent in civilian practice. Even though joining the armed forces may imply 'voluntary' waiving of some patient rights, this does not relieve the health professional of responsibility to apply general rules of obtaining informed consent.

3. The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society.

Commentary: Many military organizations consider the health professional as part of the chain of command who must thus disclose information concerning patients to his or her commanding officer, whether that officer is a health professional or not. This blanket abrogation of the confidentiality principle is not always necessary to achieve military objectives, however. Information about a person's medical condition may be needed to make a determination for fitness to serve, but this function is no different from fitness to work determinations in the civilian employment context (except that soldiers are not permitted to withhold consent and leave the position). Military health professionals can provide their opinions and disclose their medical judgments about fitness for duty, extent of disability (and projected length of disability), or required restrictions in a soldier's scope of responsibilities without providing detailed medical information and without sharing the information with personnel not directly involved in the assignment decision. The information disclosed should be made known to the soldier.

Divulging confidential information simply on the basis of command interests should, as in civilian society, be regarded as unethical behavior. Exceptions to this general rule should be reviewed by a mechanism similar to that applicable in civilian life as described in [General Guidelines 7 and 8](#).

4. The military health professional is a member of the national and international health professionals' community.

Commentary: In many, if not most, countries the military medical community identifies itself with the military rather than with the larger medical community. This identification may be due in part to training and organization, but it is also psychological. Military health professionals sometimes feel that they are not an accepted part of the civilian medical society. In other circumstances they do not separate their role from that of the military generally. The supremacy and priority of the military health professional's identity as a professional can be promoted by this Guideline as well as by the membership of military health professionals in national and international associations.

5. The military health professional should treat the sick and wounded according to the rules of medical needs and triage.

Commentary: The Geneva Conventions require medical attention according to usual medical practice for persons outside of combat, whether civilians or wounded enemy soldiers. Thus, a guideline requiring adherence to the usual rules of triage should not be controversial. Because this principle is so often breached, it warrants repetition.

Existing international human rights and humanitarian law and international professional codes of conduct support the responsibility to follow the rules of triage. The military health professional should ensure on the basis of a pre-engagement agreement that he or she will be able to treat civilians of his or her "own side" and civilians and military (POW and otherwise) of the "enemy side" or those caught in between, with the understanding that medical need and triage be the exclusive criteria for selection. A similar guideline should apply in peacekeeping operations where emergency medical care is needed.[251](#)

Finally, the usual rules of triage should apply with respect to soldiers within a health professional's own unit. As indicated above, the military's goal in returning the

maximum number of wounded soldiers to battle as quickly as possible often results in different rules of triage than those applied in civilian life. In the military context, the least wounded may receive treatment first, while treatment for the most seriously wounded is delayed. The delay in treatment increases the risk of death to the more severely wounded. This practice should be considered unacceptable.

6. Health professionals should not participate in research or development of chemical or biological weapons (CBW) that could be used for purposes of killing, disabling, torturing or in any way harming human life.

Commentary: Military health professionals may be called upon to apply their specific expertise for offensive chemical and biological weapons research. Such projects to develop weapons of mass destruction against civilian populations are often shielded by formal or informal secrecy and immunity. Military health professionals have participated in horrific chemical and biological weapons experimentation²⁵² on human beings, hidden behind a wall of secrecy and immunity. This guideline prohibits such participation because it is fundamentally inconsistent with human rights.

Any research involving methods to protect human beings from the effects of CBW weapons, or with materials that could directly or indirectly contribute to CBW weapons, must be subject to systems of ethical review and scrutiny. Such systems of ethical review and scrutiny, even when conducted in secrecy due to national security concerns, should have built into them mechanisms for civilian participation in the oversight of research.

7. The military health professional should refrain from direct, indirect and administrative forms of cooperation in torture and cruel, inhuman and degrading treatment and punishment at all times, including in wartime and during interrogation of prisoners.

Commentary. The Guideline prohibiting civilian health professionals from participating in cruel and unusual treatment and punishment applies to military health professionals as well. Military health professionals have been called upon to assist in interrogation of prisoners and, in some cases, domestic dissidents. Despite their military status, however, these professionals are bound by existing prohibitions on medical participation in torture and cruel and inhuman treatment. Special attention should be given to practices such as certifying fitness of individuals to undergo intensive forms of interrogation, to be punished for non-cooperation, or to be subjected to medical and/or pharmaceutical 'treatment' after such interrogations or punishments.

8. The military health professional should refrain from direct, indirect, preparatory and administrative participation in capital punishment, both within the military court martial system and elsewhere.

Commentary: Many countries that have abandoned capital punishment for criminal offenses permit its use in military courts. In such cases the military health professional is likely to be involved when he or she is requested to declare the sentenced prisoner fit for execution. International codes prohibiting the participation of medical personnel in capital punishment and contain no exceptions for the military

setting. It is never justified for health professionals to participate, directly or indirectly, in capital punishment.

9. Military health professionals should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities and report human rights violations perpetrated by their own troops as well as by others.

Commentary: Military health professionals should maintain their independence and report human rights violations as civilian health professionals do (see [General Guideline 12](#)). The military health professional should especially take steps to report violations of the Geneva Conventions.

10. The health professional should not engage or participate in any form of human experimentation among members of military services unless the research will provide significant health and other benefits for military personnel and facilitate promotion of their human rights.

Commentary: It is the view of the Working Group that true “voluntary informed consent” is extremely difficult to obtain in the military setting, because of the various overt and covert factors which govern the relationship between military personnel, their chain of command and the health professional. There may however, be some particular circumstances when research with military personnel may provide significant health and other benefits and facilitate promotion of their human rights. The Working Group acknowledges, moreover, that research issues are not strictly part of its mandate; we would thus welcome further discussion with and guidance from those directly involved in the ethics of research.