

# Battlefield euthanasia — courageous compassion or war crime?

Susan J Neuhaus

*The act of killing controverts the healing purpose of medicine*  
Pellegrino<sup>1</sup>

Throughout history, doctors within both military and humanitarian organisations have, often under the most difficult circumstances, endeavoured to treat the injuries and suffering of those affected by war. The modern battlefield is characterised by serious injuries, including critical and incapacitating wounds, multiple amputations and severe burns among not only soldiers but also civilians. Treatment may not be technically or physically available, medical support systems may be inadequate and there may be no options to transfer the injured to other facilities for care. Doctors in war are frequently required to make complex decisions about the limitations and appropriateness of medical treatment, and to deal with the seemingly contradictory demands of preserving life and relieving suffering.<sup>2</sup>

In this article, I seek to explore the unique roles and responsibilities of battlefield doctors, specifically in the ethical dilemma of battlefield euthanasia.

## History of battlefield euthanasia

The first recorded case of battlefield euthanasia is biblical,<sup>3</sup> but the first recorded case involving a physician (albeit indirectly) was that of Ambroise Paré in 1537, after the fall of Turin.<sup>4</sup> On encountering mortally wounded enemy soldiers, a senior French soldier “cut their throats gently”. This act horrified Paré, but he was, in turn, reprimanded by the soldier:

he answered me that he prayed God, that whenever he should be in such a case . . . he might find someone that would do as much to him, [that] he might not miserable languish.<sup>4</sup>

In 1799, Napoleon’s physician René-Nicolas Desgenettes was similarly horrified by an order (which he refused) to give lethal doses of opium to soldiers dying from bubonic plague, rather than leave them to the mercy of the advancing Marmeluk Army.<sup>5</sup> In contrast, during World War II, Jewish physicians decided to administer hydrogen cyanide to four patients unable to be moved from their hospital beds, in order to spare them the expected brutality and death at the hands of the *Sonderkommando*.<sup>6</sup> Of note, in this case, although supervised by the doctors, it was left to a nurse to act as the direct agent of death.

Also during World War II, Lieutenant Colonel John Masters recounted an episode when he and his surgeon were confronted with severely wounded soldiers in the face of advancing Japanese:<sup>7</sup>

The doctor said, “I’ve got another thirty on ahead, who can be saved, if we can carry them. These men have no chance. None can last another two hours, at the outside.”

I said aloud, “Very well. I don’t want them to see any Japanese.” Shells and bombs burst on the slope above and bullets clattered and whined overhead.

“Do you think I want to do it?” the doctor cried in helpless anger. “We can’t spare any more morphia.”

“Give it to those whose eyes are open,” I said. “Get the stretcher bearers on at once. Five minutes.”

## ABSTRACT

- Issues relating to voluntary euthanasia that are currently being debated by Australian society are distinctly different from those encountered by battlefield doctors.
- Doctors in war undertake to treat those affected by conflict; their participation in euthanasia challenges the profession’s definition of “duty of care”.
- Euthanasia must be distinguished from “triage” and medical withdrawal of care (which are decided within a medical facility where, although resources may be limited, comfort care can be provided in the face of treatment futility).
- Battlefield euthanasia is a decision made, often immediately after hostile action, in the face of apparently overwhelming injuries; there is often limited availability of pain relief, support systems or palliation that would be available in a civilian environment. The battlefield situation is further complicated by issues of personal danger, the immediacy of decision making and difficulties with distinguishing civilians from combatants.
- Regardless of the circumstances on a battlefield, doctors, whether they are civilians or members of a defence force, are subject to the laws of armed conflict, the special provisions of the Geneva Conventions and the ethical codes of the medical profession.

MJA 2011; 194: 307–309

He nodded and I went back up to the ridge, for the last time. One by one, carbine shots exploded curtly behind me. I put my hands to my ears but nothing could shut out the sound.

There are few examples of civilian situations in which issues like these are confronted, although it is conceivable that natural disasters or a terrorist attack could produce both the overwhelming casualties and the breakdown of medical support structures required to produce such a scenario. In the days following Hurricane Katrina in August 2005, a doctor and two nurses were arrested on charges of homicide involving patients in Memorial Medical Centre, Louisiana. The hospital’s capacity to provide standard medical care for its patients had been crippled. Patients and refugees were crowded together for days with no lighting, no elevators, no toilets, no running water, no refrigeration or air conditioning, and no telephones. Evacuation had been slow and hundreds remained, including the sickest patients who could not be moved. Some clinicians were said to have ended the lives of some patients before leaving the hospital themselves.<sup>8</sup>

## Definitions and distinctions

The term euthanasia derives from the Greek — “good death”. There are many caveats on the term, but it is most usefully defined as “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering”.<sup>9</sup>

Euthanasia, particularly in a military setting, must be distinguished from “triage”, which provides an ethical framework for

deciding on priorities of care in resource-limited (predominantly mass-casualty) environments. There is no doubt that in these situations, patients with overwhelming injuries may be triaged to “expectant care”. The overriding priority in all such cases is care, compassion and respect for human dignity and human life. The patient is provided with comfort until he or she either dies or the situation changes and resources become available to provide treatment.

Similarly, it is important to distinguish euthanasia from discontinuing life-prolonging measures (eg, removing ventilators) in situations where death is an inevitable consequence. These decisions are based on the futility of ongoing medical treatment and on the potential harm of continuing care. Although the outcome is the same — the death of the patient — the distinction lies in intent, method and responsibility.<sup>10,11</sup>

Although each of these raises its own ethical complexities, particularly in war, I will not discuss them further here.

### Moral questions and medical accountability

The historical cases illustrate the complexity of a doctor's position in considering euthanasia in war. No one would doubt the agony or overriding compassionate intent that lies behind a soldier taking such a decision on behalf of a comrade, but the involvement of doctors, as physicians and healers, in such acts is less morally clear.

Doctors have long considered themselves bound by the key tenet of the Hippocratic oath “*primum non nocere*” (first do no harm). Over time, some prohibitions within the oath have been removed, including those to surgery and abortion. Although morally offensive to many doctors, it is possible that, in the future, the profession may lift prohibitions to doctor-assisted suicide. Of note however, even in Hippocrates' time, the Greeks permitted euthanasia or suicide as an alternative to a lingering and painful death.<sup>12,13</sup> It is the specific involvement of physicians which was proscribed.

The underpinning ethical principles involved in battlefield euthanasia are primarily questions of patient autonomy, beneficence (doing good) and non-maleficence (not doing harm). This presupposes that there is a simple choice between preserving life and relief of suffering. However, the immediate needs of a suffering human cannot be ignored, and complex and difficult choices must be made.<sup>14</sup>

Autonomy (an individual's right to determine his or her outcome) is inevitably compromised in times of war. Soldiers are obliged to follow orders, civilians live under conditions of martial law and/or occupation — all parties are subject to circumstances that deny freedom of action.

In the Netherlands, where voluntary euthanasia is legal, complex processes exist to ensure that patient consent is valid and appropriate.<sup>15</sup> In war, such judicial process or peer review is seldom available. The confusion of war, the impact of fatigue, fear, hopelessness and fear of future suffering will inevitably influence the clarity of decision making. In a controlled elective situation, it is considered imperative to exclude patients who have depression from euthanasia. In a country at war, the effect of endured privations, occupation and atrocities could be argued to produce a kind of collective depression that extinguishes hope for the future.

In both the Napoleonic War and World War II examples provided above, euthanasia was justified, in part, by the desire to

avoid a greater suffering — that promised by capture or torture by an encroaching enemy force. However, it is necessary to question the certainty of that future outcome and to discount the effects of rumour or flawed intelligence.

In none of the examples above was there clear consent from the patients. It could be argued that, even if they had requested otherwise, it may still be in their best interests to be killed painlessly and not abandoned to the enemy. This represents a slippery slope from non-voluntary euthanasia (where the patient is unable to request) into involuntary euthanasia (where the patient is able to request, but is not consulted and their views are not respected).<sup>12</sup>

### Unique position of the doctor

Regardless of the moral arguments for and against euthanasia in a battlefield setting, the issue of medical involvement must be addressed separately. Doctors hold a unique position of trust in the community. Participation by doctors in euthanasia carries a grave risk of undermining public trust in the profession. Many would consider that:

even if a dying person is pleading for the relief that only death can promise, a clinician who kills a patient arguably betrays his or her commitment to their [doctor–patient contract].<sup>8</sup>

A further concern is the potential for role confusion, applicable particularly to uniformed doctors; the distinction between a doctor acting in the interest of the patient or becoming an instrument of political or military purpose.<sup>1</sup> Throughout history, states have sought medical legitimacy and complicity for corrupt purposes, the most notable being the Nazi regime.<sup>16</sup> Equally, euthanasia involving potential witnesses against war crimes, or to avoid sensitive military information falling into enemy hands, constitutes politically motivated murder.

Some authors argue that, provided doctors are given a “moral distance”, physician complicity in euthanasia can be justified in some circumstances.<sup>14,17</sup> This raises questions about whether there is a distinction between the doctor as the instrument of death and the arbitrator of death — is it possible to remove the doctor from the act, if not from the decision of death?

Another consideration is the method of death. Many modern modalities can alleviate pain and suffering, although, admittedly, not all are available or in ready supply on the battlefield. It could be argued (as was justified in Master's case,<sup>7</sup> above) that using a scarce resource (eg, morphine) in the face of expected large numbers of future patients may be inappropriate. It may be necessary to use a weapon instead.<sup>17</sup>

Two courts martial demonstrate the difficulties in distinguishing intent to relieve suffering, or mercy killing, from deliberate killing of wounded (enemy) combatants. In 2005, a United States army officer was convicted of “assault with intent to commit voluntary manslaughter” after shooting a wounded Iraqi insurgent.<sup>18</sup> In 2010, a Canadian officer was found guilty of “disgraceful conduct” after allegedly shooting an unarmed Taliban soldier in Afghanistan.<sup>19</sup> Neither incident involved doctors, although the defendant in the latter court martial “acted on advice of the medic”. Conversely, recently published memoirs of an Australian surgeon describe shooting a woman, mortally wounded in Kosovo in 1999, and again raise issues of the unique role and obligations of a doctor.<sup>20</sup>

## Doctors' obligations in war — the laws of armed conflict

As with civil society, war is governed by rules. Australia is a signatory to the Geneva Conventions, which are binding. The actions and responsibilities of doctors are covered in the special provisions of the Conventions, and form the basis of ethical military medical practice.<sup>2,21</sup> In essence, there are three conditions:

- first, doctors may not partake in direct combat activities;
- second, doctors must treat all casualties of war on the basis of medical priority without regard for their status as enemy, coalition or civilian; and
- third, doctors have a moral responsibility to speak out against atrocities committed by any party.

The Geneva Conventions (First Geneva Convention, Articles 12 and 15; Second Geneva Convention, Articles 12 and 18; Protocol 1, Article 10 and Protocol 2, Article 7) prohibit euthanasia.

Doctors serving with the Australian Defence Force are governed by both Australian military regulations and Status of Forces Agreements, making them accountable for acts committed on overseas territory or involving foreign nationals.<sup>22</sup> Australian nationals serving in overseas conflict may equally be accountable to that nation's legislation. Australian legislation (*Euthanasia Laws Act 1997* [Cwlth]), while allowing for palliative care and withdrawal of life-prolonging treatment, prohibits intentional killing of a patient.<sup>23</sup>

## Conclusions

War is the ultimate failure of human relations. When participating in war, the moral principles enshrined in Australian law and in the Geneva Conventions apply regardless of the circumstances of the conflict. No doctor would wish to be placed in the invidious position represented in this article. For those who have made such choices, we can only have compassion.

When a society goes to war, it is to uphold and enforce its values over those of another society. Doctors hold an important role in society and in providing care for those harmed by the consequences of war. It is imperative that doctors' professional values and ethical and legal responsibilities in these difficult circumstances are clear.

## Competing interests

None identified.

## Author details

Susan J Neuhaus, CSC, PhD, FRACS, Associate Professor of Surgery  
Department of Surgery, University of Adelaide, Adelaide, SA.  
Correspondence: padrneuhaus@apsa.com.au

## References

- 1 Pellegrino ED. Societal duty and moral complicity: the physician's dilemma of divided loyalty. *Int J Law Psychiatry* 1993; 16: 371-391.
- 2 Neuhaus SJ, Bridgewater F, Kilcullen D. Military medical ethics: issues for 21st century operations. *Aust Defence Force J* 2001; 151: 49-58.
- 3 Samuel 31: 2-4: The holy Bible. New century version. Dallas Tex: Word Publishing, 1991: 276.
- 4 Keynes G, editor. The apologie and treatise of Ambroise Paré —1585. New York: Dover Press, 1968: 21.
- 5 Peterson RKD. Insects, disease, and military history: the Napoleonic Campaigns and historical perception. Reprinted and adapted from *Am Entomol* 1995; 41: 147-160. <http://entomology.montana.edu/historybug/napoleon/napoleon.htm> (accessed Feb 2011).

- 6 Keneally T. Schindler's list. New York: Simon & Schuster, 1982.
- 7 Masters J. The road past Mandalay. New York: Harper and Brothers, 1961: 253-254.
- 8 Forced abandonment and euthanasia: a question from Katrina. Goliath Business Knowledge on Demand, 2007. [http://goliath.ecnext.com/coms2/gi\\_0199-6523854/Forced-abandonment-and-euthanasia-a.html](http://goliath.ecnext.com/coms2/gi_0199-6523854/Forced-abandonment-and-euthanasia-a.html) (accessed May 2010).
- 9 Harris, NM. The euthanasia debate. *J R Army Med Corps* 2001; 147: 367-370.
- 10 Reade MC. Medical assistance to civilians during peacekeeping operations: wielding the double edged sword. *Med J Aust* 2000; 173: 586-589.
- 11 Baker R, Strosberg M. Triage and equality: an historical assessment of utilitarian analyses of triage. *Kennedy Inst Ethics J* 1992; 2: 103-123.
- 12 Rachels J. The sanctity of life. In: Humber H, Almeida R, Clifton NJ, editors. Biomedical ethics review. Clifton, NJ: Humana Press, 1983: 29-42.
- 13 Gillion R. Suicide and voluntary euthanasia: historical perspective. In: Downing AB, editor. Euthanasia and the right to death: the case for voluntary euthanasia. London: Peter Owen, 1969.
- 14 Beam TE, editor. Military medical ethics volume 2. Section IV: Medical ethics in the military. Falls Church, Va: Office of The Surgeon General, United States Army, 2003: 384-394. [http://www.bordeninstitute.army.mil/published\\_volumes/ethicsVol2/ethicsVol2.html](http://www.bordeninstitute.army.mil/published_volumes/ethicsVol2/ethicsVol2.html) (accessed May 2010).
- 15 Tak PJP. The Dutch criminal justice system. Organization and operation. 2nd revised edition. Den Haag: Wetenschappelijk Onderzoek en Documentatiecentrum, 2003.
- 16 Lifton RJ. The Nazi doctors; medical killing and the psychology of genocide. New York: Basic Books, 1989: 4-6.
- 17 Swann SW. Euthanasia on the battlefield. *Mil Med* 1987; 152: 545-549.
- 18 *United States v Rogelio M. Maynulet* Criminal App No. 20050412 United States Courts of Appeals for the Armed Forces. Decided March 3, 2010. <http://www.armfor.uscourts.gov/opinions/2009SepTerm/09-0073.pdf> (accessed Nov 2010).
- 19 National Defence and the Canadian Forces. Courts martial results. 5 Oct 2010. *R v Capt Semrau*. <http://www.jmc-cmj.forces.gc.ca/rcm-cmr/2010-eng.asp> (accessed Nov 2010).
- 20 Jurisevic C. Blood on my hands: a surgeon at war. Melbourne: Wild Dingo Press, 2010.
- 21 Moskop JC. A moral analysis of military medicine. *Mil Med* 1998; 163: 76-79.
- 22 Australian Government Department of Defence. Defence Support Group. Defence Legal. Directorate of international agreements & arrangements (digaa) links. Status of forces agreement (SOFA). <http://www.defence.gov.au/legal/dagts2.html> (accessed Oct 2010).
- 23 Australian Government. ComLaw. Euthanasia laws act 1997. Act — C2004A05118. <http://www.comlaw.gov.au/Details/C2004A05118> (accessed Feb 2011).

(Received 21 Jun 2010, accepted 22 Dec 2010)

□