The role of medicine in armed conflict: Ethical and professional impacts
Moving Medicine

The Role of Medicine in Armed Conflict: Ethical and Professional Impacts, with Zaher Sahloul, MD

Jul 15, 2022

- Listen on Simplecast
- Listen on Apple Podcasts
- Listen on Spotify

Featured topic and speakers

As global citizens, we are aware that armed conflict impacts patients and our profession. What is the role of medicine and the physician in armed conflict? How can we care for our patients and ourselves amidst a global military crisis? What is the physician obligation to care for soldiers and refugees? Critical care specialist Zaher Sahloul, MD, and director of ethics policy Elliott Crigger, PhD, discuss these questions and more.

Speakers

- Zaher Sahloul, MD, pulmonary and critical care specialist
- Elliott Crigger, PhD, director, ethics policy, American Medical Association

Host

- Todd Unger, chief experience officer, American Medical Association

Listen to the episode on the go on Apple Podcasts, Spotify or anywhere podcasts are available.

Transcript

Dr. Sahloul: How can we best care for both our patients and ourselves in this global military crisis and also in the ICU? Because the burnout rate is very high among us here in
the ICU and emergency medicine. And what's the physician's moral obligation to care for soldiers and refugees?

**Unger:** That’s Dr. Zaher Sahloul, critical care specialist at Advocate Christ Medical Center at St. Anthony’s Hospital and associate professor in clinical medicine at the University of Illinois in Chicago.

Applying the lessons he’s learned during his distinguished career as a war zone doctor, Dr. Zaher Sahloul discusses the ethical and moral obligation of physicians and health care workers during times of armed conflict.

**Dr. Sahloul:** That's why you became a physician, and this is a contract between you and the society. This is the essence of being physician.

**Unger:** Dr. Sahloul is a humanitarian and civic leader. He is considered one of the world’s leading experts on the humanitarian crisis in his homeland of Syria. On this episode of Moving Medicine, he is joined by AMA’s Dr. Elliott Crigger, director of ethics policy and secretary to the Council on Ethical and Judicial Affairs. This talk was recorded at AMA’s 2022 Annual Meeting. If you’re a physician, resident or medical student, you can gain access to more great events like this one by becoming an AMA member. Visit [the AMA website].

**Dr. Sahloul:** I'm really honored and humbled to be among you. I'm a pulmonary and critical care specialist here in Chicago. I would like to present today touching on the ethical issues in armed conflict and health. And this is very interactive, so feel free to raise your hand or ask questions or interrupt me. That's the whole purpose of this presentation. I think it was mentioned, what's the purpose of this presentation and what's the role of medicine in armed conflict? What's the role of individual physicians in armed conflict? How can we best care for both our patients and ourselves in this global military crisis and also in the ICU? Because the burnout rate is very high among us here in the ICU and emergency medicine. And what's the physician's moral obligation to care for soldiers and refugees?

AMA has a statement that parties in armed conflict have a general duty to ensure that the wounded and sick receive their medical care that they require with minimal delay and without distinction, except on medical grounds. Do you agree with this statement? I think this is something we learned since we are graduated from medical school, right? This is part of the Geneva Convention 150 years ago, that regardless of what's happening in the war, doctors should be treating injured patients, regardless of these injured patients, whether they belong to this party or that party. Whether they are soldiers or civilians. And that parties to conflict should allow physicians, ambulances and doctors, and the nurses, to treat the patients without attacking them. This is enshrined in the core of medicine and that's why doctors and nurses continue to practice medicine, even during disasters and even during war.
Because the Geneva Convention, that every country has ratified, guarantees an international humanitarian law that physicians will be protected, even if they are treating soldiers who are injured from the enemy side or from their side. This is an article that I co-published in the American Thoracic Society about the war, the impact of war on health. War is the enemy of health. This is a reflection on our experience in the Syrian crisis, and also touching mostly on the pulmonary and critical care and sleep medicine, my specialty. But it has also elements of how the war affects health in general.

Let's shift gears a little bit. This is our last medical mission to Ukraine. The Ukraine is in the midst of war. That's why we have this session I was told, right, about armed conflict and health, because of the Ukrainian war. But there are wars everywhere. There's a lot of media attention, of course. You have CNN and Fox News airing all the time from Ukraine. That's why we have more attention. But there's wars everywhere, every year, in places that maybe we do not pay enough attention to.

I think as a physician, as medical societies that have influence on the society, on the narratives and also on policymakers, we have to pay attention to the wars. Not only the ones that the media pay attention to but also the wars that the media do not pay attention to. Wars in Africa, wars in the Middle East, wars in Southeast Asia, wars that are affecting millions of lives. This is our group—physicians from different backgrounds and different states who we organized under MedGlobal to go to Ukraine, a couple of weeks after the beginning of the war. Lviv after one of the sirens, that you hear it all the time, a couple of times every day. Lviv is a beautiful city in the western of Ukraine, away from the front lines. But it was attacked multiple times with long-range missiles by the Russians. You hear these sirens. This is me presenting about chemical weapons preparedness to very attentive physicians in Ukraine, who were worried that the Russians will be using chemical weapons in Ukraine, the same way they allowed the Saudi regime to use it in Syria.

This is a hero of mine and a hero for every physician. He's a co-founder of Doctors Without Borders, MSF, a French physician, Dr. Jacques Beres. He's still practicing in the war. He's 84-year-old, very fragile in health. He joined us in Ukraine. He joined us in Yemen. He joined us in Bangladesh. This person is responsible for the saving of tens of millions of lives. Because when he co-founded the MSF in 1971, there was no other organization that goes to war and disaster regions to provide help. This is all the fruit of his work.

So the impact of war on health, you have influx of injured patients. Of course, a lot of trauma patients, a lot of injuries and disabilities related to trauma, amputations, that you don't see in the peace time. You have a flight of health care providers because the war is scary and they are scared about their lives. And because of that, you have shortage of health care providers, doctors, sub-specialists, nurses and so forth. You have epidemics of infectious diseases because you will have this integration of the public health care system and you have resources more directed towards trauma, which is very expensive, and then basic public health are ignored. That's why in Syria, for example, we have an epidemic or outbreak of polio in 2013, after 15 years of absence of polio from Syria because of the
vaccination. We have in Ukraine, for example, an outbreak of measles, outbreak of tuberculosis because of the resources directed to war.

You have malnutrition in areas under siege. We've seen what happened to Mariupol in the Ukraine. But also, we've seen that in many other countries that you have areas under siege ... whether it's in Ethiopia, where you have the Tigray region under siege or Syria, where you had Aleppo under siege or the Palestinian Territories, you will have severe malnutrition because of the siege impact. Increased morbidity and mortality related to NCDs, noncommunicable diseases. People think that the mortality in the war is related to trauma. Most of the people who die in the war, they die because of NCDs, diabetes, heart attacks, COPD, pulmonary embolism and so forth. Because there's not enough resources to treat them and many of them do not have access to hospitals or routine health care. That's why you have many people, you have increased mortality and morbidity related to NCD.

Mental health crisis, of course. I don't have to expand about that. War is terrible. War, you have a lot of violence in the war. You have displacement, you have uncertainties. You have children who are witnessing violence. You have women who are witnessing violence and destruction of their homes and neighborhoods and cities. You have people who are displaced from place to place and who are not sure that they will have a secured future. Because of that you will have a lot of PTSD, depression, anxiety and that will stay for the rest of the life with the people who are displaced and witnessed war, including health care providers.

And you have, of course, the drop in life expectancy because of all of the above, deterioration of women health and disintegration of the public health care system. The average life expectancy in Syria, which was increasing gradually, like many other middle-income countries before the war. You had a shift from communicable diseases-related mortality to NCDs-related mortality, like many other countries also that went through development. Then with the beginning of the war, we had a significant drop in life expectancy because of that combination of trauma and death related to NCDs and outbreaks of infectious diseases.

This is the impact of siege. This is a child, an unfortunate child, in the city of Zabadani in Syria, which was under siege by the government itself. The United Nations mentioned in many reports that only 3.6% of the population was receiving their health needs because of the siege. So, you had increased rate of severe and moderate malnutrition. Vaccination rate is less than 25%. Fifty percent of pregnancies at least end up with a C-section because of shortage also of hospitals and providers, and medical supplies and nutritionist food were also in short supply.

According to Physicians for Human Rights, 935 medical personnel have reportedly been killed in Syria since the beginning of the crisis, 91% by the government. On average, a medical worker was killed in every other day in Syria since 2014. Physicians for Human Rights documented 595 attacks on 350 medical facilities in Syria, 90% by the government. By the way, and this is a criticism to AMA, AMA did not have a statement on the attacks on health care in Syria. I'm happy that they are paying attention to
what's happening in the Ukraine but we have to be morally consistent. We have to be morally consistent as an organization and as physicians. These are the distribution of the health care workers who were killed in Syria, between doctors, nurses, pharmacists, medical students and so forth.

For over 100 years, the following provision was found in the AMA code of ethics. I think all of us agree with that, when pestilence prevails it is their, physicians', duty to face the danger and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives. Do we agree about that? Not everyone agrees though on these issues. I'm sure that there is back and forth on this statement.

Host: So, if I could just take this time out to introduce Dr. Elliot Crigger. Dr. Elliot Crigger is currently director of ethics policy and the secretary for the Council on Ethical and Judicial Affairs, or CEJA, within the AMA. Dr. Crigger came to the AMA in December 2007 from the National Center for Ethics and Health care of the VA. They have hands-on ethics training on staff at the Hasting Center, a private nonprofit research organization devoted to medical ethics and the life sciences. Dr. Crigger supports CEJA, which we all know is the body within the AMA charged with maintaining the code of ethics. The CEJA team will provide research support and develop draft documents for CEJA review and approval, as well as providing administrative and logistical support to the council. Other words, he does a lot of reading, writing, and will help us discuss how to best balance competing values in tackling the ethical issues in health care, such as limited resources, the greater good, et cetera. Dr. Crigger's education was at the University of Chicago and received a joint PhD in anthropology and linguistics in 1991. Thank you again so much.

Dr. Sahloul: Actually, a case presentation maybe would be nice, if I can mention these actually real stories. And then we have your opinions about the ethical issues raised in these stories and also the opinions of physicians here. So Dr. Nader is a Syrian and a physiologist in the village of Interma in the outskirts of Damascus. He oversaw a small rural hospital that accommodates 20 patients. In the early hours of August 21, 2013, he received about 700 patients in just a few hours. Many arrived with respiratory failure, suffocating slowly, foaming and convulsing. He could save only few by placing them on life support with limited resources or access to respirators. It was a chaotic scene. People were screaming. He chose to save the youngest as they had longer lives to live. Despite the heroic effort of Dr. Nader and his team throughout the night, by the morning of August 21, 141 of the patients died, including 66 children. Many doctors and nurses had symptoms of exposure ... which basically, that was sarin gas that was used in August 21, 2013, the largest massacre by the government, after a few hours of contact with their patients.

And that was in Ghouta, Syria in 2013. I'm sure you remember the scenes from that incident. So what goes in your mind as a physician with this influx of a large number of patients? Which happens in the war, mass casualties, whether it's related to chemical weapons or bombing, or a long-range missile. What should your main ethical principles that are different than peacetime?
Dr. Crigger: Well, I'm not so sure that they are all that different from peacetime, frankly, because the fundamental ethics still apply, right? You are there to treat people who need you. And CEJA's opinion on disaster preparedness speaks to disasters, natural or manmade. I think it is challenging though. I think one of the things you immediately come to think about is, what are my crisis standards of care? How do I allocate the four people I have to the 700 patients we have? I think there are a variety of ways of thinking about that. But the one thing the code is pretty clear on, is that you do it on the basis of medical need, not on the basis of affiliation or social status or economic considerations. Once you've identified that cohort of patients who all have the same medical need and you've still got too many patients for your resources, then you begin to make more fine-grained distinctions. Who's likeliest to benefit, who's likeliest to survive? In the end, you're going to have to recognize that you cannot provide all the care that's needed. You have to find a way to support the people who are doing what they can in impossible circumstances. There's no way around the fact that you cannot save everyone and you have to live with that.

What you have to be able to do is ask yourself as you're making these decisions, have I thought through all the parameters here? If someone comes up to me, can I explain why I made the decision I made in as compelling a way as possible? It won't necessarily get you agreement from everybody. But being able to say why is perhaps at the heart of ethics. And being present, being there, doing what you can. Recognizing that you have a responsibility, even at risk to yourself, even when pestilence prevails. And other than that, to do what you can not to exacerbate existing discrepancies or disparities, which is going to be incredibly difficult. We already saw that with COVID here, I think, which we can consider a natural disaster and not to participate as an agent of the state. I'm paraphrasing the code here. But if you look at the very end of chapter 9, there are opinions on capital punishment, on torture, on interrogation. Those are basically, physicians ought not to be the servants of the state. They are the servants of patients. That's a different kind of risk that physicians are expected to take, right?

In Syria, we've seen it. We're seeing it in the Ukraine. I'm not sure what else to say, other than that war is not healthy for children and other living things, to quote my own past. The code doesn't say anything specifically about war, they just say natural and manmade disasters. But I think there's so much in it, opinions on organ transplantation and allocation of resources that all speak to the same, medical need is the first criterion and the ability to provide competent care. And even if you're not the best specialist, if you're all that's available, you do what you can.

Dr. Sahloul: All of us agree with this. Any other ethical issues are raised based on this story, that is very common actually in war. You have mass casualties. So as a physician, first of all, there's not time to think, so you have to be ready before the war. That's why it's important to have preparedness in many of the centers. You work in the emergency room, right? So you want to make sure that your emergency room has policies and drills on these issues, and that you are ready to step beyond your expertise in the war as a physician. You may be the only pediatrician in that place but you are now
going to be dealing with many other injuries. So you want to make sure that you are also ready to step beyond. And also you want to protect your mental health. These things are traumatic. Maybe I can ask the group, if you don't mind, how do you protect your mental health if you're a physician in the midst of a disaster? I think all of us faced that in COVID but manmade disasters are different. What kind of tools do you use in your place, in your hospitals, to protect your mental health, to prevent burnout?

I think the ability to switch off, not everyone is able to do that. Sometimes you are able to compartmentalize, which I think is a very good skill to have, and some people cannot do that and you cannot switch off. But in war zone, of course, people, physicians and nurses are worried about their families and the safety of their families, which add another dimension. About their income, because that will be affected. That adds another dimension. About them being killed in hospitals, if hospitals were targeted.

The WHO, I think, so far reported more than 250 health centers in Ukraine were targeted by the Russians and I mentioned what happened in Syria. So all of these will add to the psychological trauma. I mean, I don't have the magic bullet. I think every individual have different ways to deal with these issues—meditation, exercise, family support, compartmentalization, switching off. Most hospitals do not have enough resources for health care system, even in the United States. Imagine if you're in a country that have very limited resources. I think you want to add something.

Dr. Crigger: I will ask anyone who served especially in MSF, that when you are in a conflict zone, when you're in that kind of acute situation, you have each other. You have the team of health care professionals and for the most part, you don't have hospitals telling you what you can … you have to be the decision-makers. It's not nearly enough of a resource but you know you're all there for the same reason. You know what you're all going through. It's not quite that social contact in the same sense but you do have the resource of being together in that. I speak partly from my familiarity with medical personnel who came back from Vietnam, right? They had each other, even if they couldn't rely on anything else. Again, that's not enough but it's a huge resource in and of itself. I think that we don't think about ... we think about, what can I do? It's what we can do, and how can I help the person sitting next to me, who's having a worse moment right now than I am?

Dr. Sahloul: I totally agree. I think the burnout system is going up because of the changing guidelines and the fact that we’re ... I mean, I'm probably from the old world, where we practice medicine a certain way now. You have different ways in practicing medicine, and you have to do this and that. So that's really affecting the psyche of physicians and nurses in the ICU. We have more than 50% of our nurses leaving the ICU and going to different type of work. This has to be addressed from the policy level.

But I agree with you and I don't have the right answer. In the war situation, besides what you have mentioned, also you don't have access to technology that we take for granted here. We don't have access to medical supplies in many war situations, that you know you can treat this patient if you have
medical supplies. But you don't have medical or surgical supplies and this patient will die because of lack of that.

One of the very tying themes that I've seen in many local physicians, treating their communities in the war, that if we pay attention to them ... in Ukraine, for example, one of the doctors told me, "The fact that your team came from the United States, to us make us feel safer." So if we pay attention to people in war situation and make sure that they know that we are paying attention, sending them supplies, sending them ... if you're able to volunteer, that will make a huge difference in their mental health. No matter what you can do as a physician, you're going to create long-term mental health issues.

In crisis situations, decision-makers must use a sound ethical framework as they shift from trying to achieve the maximum benefit for individual patients, to trying to achieve the maximum benefits to the community. I think we agree about that. As a critical care specialist or emergency room physician, you're directing all of your attention to this one particular patient who is very sick. The whole situation is going to shift that frame of reference to the whole community.

I think we tend to look at what's the best I can do? In situations that are impossible to begin with, the more relevant question might be, what's the least bad thing I can do? Is there a worst outcome overall that I can ameliorate or prevent, as opposed to what's the best I can do for people? Because I think you then set yourself an impossible goal, right? And it's okay working to least bad. In ethics, we often say, what's the least bad decision I can make? What's the least bad analysis I can make? Because that's what's going to hurt people less than striving, making the best the enemy of the good.

I totally agree. So the best possible medical care is what you are striving for. So the goals of crisis standard of care: save more lives than would be saved by business as usual. Help conserve and stretch medical resources because you have limited resources and you want to save them for as many patients as possible. We've seen that in Ukraine where many hospitals ... and Syria of course, and many other places, are struggling to sustain their medical supplies because they are consuming a lot of medical supplies for their trauma patients. So how can you, and of course, the role of the Ministry of Health and the supply chain that we've heard a lot about in the last few years, is disrupted during the war.

So how can you conserve what you have, to save as many patients as you can? The principles of dealing with limited resources, which we do not learn in medical school or training, should be applied there. Give critical resources to those who need them and will benefit the most, of course. Prevent overuse of scarce resources and hoarding. We've seen that in the war situation where you have many places that are hoarding medical supplies or medications because they're not sure whether they will get medical supplies in the next month or so.
Protect at-risk groups against discrimination in access to care because this happens in the war more than the peace situation. It happens in the peace situation but in the war, it's even more exacerbated. So you want to make sure that you are fair and you are equal to everyone and that you protect especially high-risk groups—different ethnicities, different religious groups, different affiliations, religions, sexual orientation because they will be affected more during the war. Ensure patients and families trust that they will receive fair access to the best care possible under the circumstances. Transparency is very important. You want to add?

Dr. Crigger: I was just going to say, I mean, I think one important thing under transparency is, acknowledge what you can't do. But promise, here's what I'm sure I can do and here's what I will try to do. I think another piece of that is, in these situations, there is no I. There is only we. Even for the patients receiving care, you have to help locate them within their communities, right? That we are all doing this for one another. I don't know how well that sells, mind you.

Dr. Sahloul: So as a physician, what will you be thinking when you are seeing a patient in the war situation? Can we definitely treat this patient, first of all? Sometimes you are able to treat that patient in the peace situation but not in the war situation. If you're going to need to spend six hours in surgery for this particular patient and you're going to need to consume a lot of medical supplies in the peace situation but that is different in the war. Maybe this patient will not be triaged as such and you basically leave this patient to die. Do we have the expertise and the supplies to save his or her life, and will others suffer from a lack of supplies if expanded on this potentially mortal patient? So, these are different ethical questions that you will face in a disaster situation than in the peace situation.

The principles that you've talked about, the allocation of resources. There are different ways to look at allocation of resources. For example, treating patients equally, like during vaccination campaigns or ICU organ donations. So, you'll try to treat all patients equally. Or favoring the worst off, as we do in the emergency room or in the ICU, or organ donations.

So you favor the ones who are the worst in term of prognosis. Or maximizing total benefit that we do in the disaster and the war situation or pandemics, because you want to impact as many people as possible. And also prognosis, which is life years. So if you have younger patients, you may favor that patient; if you have two equally injured patients and you can direct only resources to the younger ones. Because their life year prognosis is better than the other ones. And rewarding social usefulness, which happens also in some pandemics and organ donations, people who were organ recipients from before. You want to add more about this principle?

Dr. Crigger: Well, I think I want to run a little bit of nuance around it too, is that one way to look at allocation ... all of these are correct. I won't ever say anything is incorrect, right? It's best available. But there's also a sense of, how could treating this patient benefit others? I think that's clearly the case in a public health emergency. This person can be a vector for and many others. If I can treat him/her, I can help preserve health for these others. So, there's also this, again, it's locating that individual within
a community and that's a little bit different from what's the overall benefit to the community? It's what's the trajectory of that benefit? How do I affect that benefit in the world?

I think we failed miserably to do that when we thought about essential workers here in the pandemic. Again, we can come back to some really recent examples. We allowed people to take risks that they didn't have to. We could have meliorated the risk for them. We could have prioritized them for vaccination because they knew their living situation was such that they were exposing 12 other people in their household. So having a sense of what the context is that you're going into too, and that's much more typical when you're going into a war situation that has just erupted. But I think that's one of the things that impresses me about MSF is, they have acquired ... almost the hard way definitely, a sense of how can we function when we're there, we already know going in. I think part of that may be training for American physicians to say, listen, if you are, we need to have you available. You do have a duty to your international colleagues. Let's help get you ready for what you're going to face there, that you may face in a similar way here but with very different constraints. I don't know if that made any sense at all.

Dr. Sahloul: Of course. These are the principles of dealing in austere environments or limited resources. How to prepare, conserve, substitute, adapt, reuse and reallocate. Are you all familiar with these principles? No? This should be taught in medical school. I mean, we've seen that in COVID in the United States, right? We don't have abundance of PPEs. I mean, I remember the first few months where I was given a face mask with a bag that I write my name on it, and then it stays with me for a few days.

I never imagine that this will happen in my hospital, which is a tertiary center in Chicago. But we do not have unlimited resources even in the United States of America. We can talk about that but there's a lot of details about dealing with limited resources. I think this is something that we should be spending more time in training to do, whether it's medications ... like right now, we have a shortage of contrast in my hospital. They're short, so we cannot order CT to rule out PE. So we are substituting, right, with VQ scan, which is less ... so we're using the principle of substitution. If you have a shortage of fentanyl, what do you use to adapt to that? But you have also to plan and prepare and conserve and so forth.

The city of Khan Shaykhun in northern of Idlib, was attacked by sarin gas also in 2017. So, chaos, a lot of people who are injured. You're not sure what's happening. Of course, the Syrians are accustomed to use of chemical weapons. More than 300 times chemical weapons were used since 2011, including nerve gas and choking agents, chlorine. They are decontaminating the victims with very basic things, like just spraying water on the victims. I've known physicians who died because of the exposure to victims of nerve gas because they did not have proper PPEs.

Dr. Abdurachman is a Syrian orthopedic surgeon. He was performing surgery on an injured patient in an underground field hospital in Northern Hama. The hospital was built underground for protection of
medics and patients. Hospitals were attacked routinely by the Syrian regime and Russia. More than 580 hospitals were bombed in Syria. There was a report of barrel bomb in the area that did not explode, which is a sign of chemical weapons. Chemical weapon agents were used more than 300 times in Syria. Dozens of patients arrived in the hospital with typical symptoms of exposure to nerve gas.

Dr. Abdurachman continued to operate on his patient. He developed blurry vision, tightness in his chest and severe weakness. His eyes began tearing and his breathing became heavier. When he told his colleagues that he was unable to continue working and that he needed help, they injected him with atropine and rushed to intubate him. He had cardiac arrest and died, joining a long list of Syrian doctors and nurses who died or being killed on duty; 935 health care workers were killed in Syria from 2011 to 2022.

The ethical question that this story raises is, if you are a physician practicing in an area that has disaster, would you stay or would you leave? Of course, I mean, the courageous answer, and maybe all of us would like to say, yes, you should stay and treat your patient. That's why you became a physician, and this is a contract between you and the society. This is the essence of being physicians. If you don't do it, that mean many people will suffer and no one will step up to replace you. So, all of these things that will basically encourage people to stay or physicians to stay, and nurses.

But also there's competing ethical issues here.

**Dr. Crigger:** I think what is the central point is, I can only be useful if I can still be functional and my patients deserve it. My colleagues deserve it. Again, how can we give one another those respite moments, that support? Although the code doesn't speak directly to institutions, it has a lot of implications for institutions. Institutions, insofar as they share in the goals of medicine, which purportedly they do, they have an obligation to protect their staff. They have an obligation to recognize the kind of needs. They may not be able to meet all those needs but they have to make a sincere effort to do so.

Whether that's providing PPE, whether it's providing a safe space. Whether it's arranging for childcare for someone who's at home. All of those things that make it possible for the institutions and their professional staff to do what they're there to do. I think that's another lesson I hope we will learn out of this, is that there's no such thing as a doctor and a patient. And there probably never has been but there certainly isn't today. Because physicians operate in context, and those contexts have to take ... in my view and I think the council would agree and you can argue that it's in the code, medicine is a moral activity. If you're going to be engaged in it in any way, you share the obligations that flow from that moral activity.

**Dr. Sahloul:** Thank you.
Unger: You can subscribe to Moving Medicine and other great AMA podcasts anywhere you listen to yours or visit ama-assn.org/podcasts. Thank you for listening.

Disclaimer: The viewpoints expressed in this podcast are those of the participants and/or do not necessarily reflect the views and policies of the AMA.