

Terrorism – doctors and wrongdoing

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ABSTRACT The world is now well-used to terrorism, but doctors and the wider public are particularly shocked when those whose actions harm others are members of our profession. Unfortunately, the record shows that doctors are not strangers to such actions, and while few doctors deliberately harm their patients or others, we are drawn from the societies in which we live and share the characteristics of those societies. We may not know why individuals embark on harming others, and we certainly have no evidence-base for preventive action, but we should consider how the risks of such actions might be reduced. Possible actions include better selection for medical school, more liberal education during and after medical school, better supervision of professional aspects of training and correction of deficiencies, and closer scrutiny of untoward occurrences in medical practice. Our College, with its worldwide membership should support the development of such measures.

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Terrorism is one of the unhappy features of our times, and none of us, wherever we live, can feel immune from its reach. Quite possibly, it has always been with us, but perhaps never has it been so widespread, so ruthless or so all-pervasive. The nature of terrorism, its causes, its justification and its effectiveness are beyond the scope of this article, but it may be worth reflecting briefly on doctors who deliberately harm others, when the UK's most recent experience has been at the hands of doctors.

It is easy to assume that terrorists are poorly educated, young, male, lacking in employment or future prospects, and living without hope in circumstances of oppression. This is by no means always the case.¹ The terrorists who destroyed the Twin Towers on 11 September in New York were well-educated, and those who carried out the London bombings on 7 July were educated UK citizens who could have used the democratic process to convince others of their cause. The makings of terrorists, it seems, come from within individuals as well as from the conditions in which they live. So, we may be dismayed that the terrorist attacks in London and at Glasgow Airport in June 2007 seem to have been perpetrated by doctors, but should we have been surprised? After all, is it not the purpose of the medical profession to help the sick and injured? The medical profession teaches that the sick and injured come before self, and '*non nocere*' (do no harm) is one of the oldest of medical injunctions.

Well, all this notwithstanding, a simple Google search under 'doctors' and 'terrorism' provided almost two million references to medical activity in this area, and recent articles by members of our profession, Richard Smith (a Fellow of

our College) in the *Guardian* newspaper,² and Simon Wessely in the *New England Journal of Medicine*,³ have reminded us of the damage doctors do to others. Their medical role call includes leaders of organisations most recognise as terrorist, such as George Habash (Front for the Liberation of Palestine), Mohammed al-Hindi (Islamic Jihad), and Ayman al-Zawahiri (Al-Qaeda), leaders of oppressive regimes such as Hastings Banda (Malawi) and Che Guevara (Cuba), the medical servants of oppressive regimes such as Josef Mengele and Karl Brandt (Nazi Germany), and Radovan Karadzic (Serbia), and what one might regard as 'free-lancers', including Ikuo Hayashi (Japan) and Harold Shipman (UK). Notable is the fact that these men have no nationality, race, religion or culture in common. They were, however, all intelligent enough to be educated as doctors. Wessely³ suggests that intelligence, dedication, commitment, ambition and status are not the central factors in terrorism, but rather a lack, or loss, of empathy for others and for their welfare. He suggests a line is crossed when an ideal 'becomes detached from any consideration of the consequences of one's actions for other people', to which could be added the point at which a decision is made that achieving an ideal comes above all other considerations. Whatever the causes, we have to recognise that doctors are as capable as any others of evil, including terrorism.

It is important to keep this matter in perspective, as doctors deliberately harming their patients or others are a very small proportion of our profession, but our profession should consider whether anything can be done to reduce the chances of such incidents and make such activities more likely to be detected quickly. This is not only important for the public good in preventing terrorist

incidents, but also for the safety and confidence of every patient who puts his or her life into the hands of a doctor (and for their relatives). It is also essential to maintaining the reputation of our profession.

So, what might our profession do in an area likely to remain for some time evidence-free in respect of measures of proven value? Medical professionalism is important, but excellent declarations on medical professionalism are available,^{4,5} and more are unlikely to help. Rather, we should recognise that there is nothing certain we can do, and whatever could be done would need to extend throughout professional life as we do not know the point at which a doctor becomes a danger. Some of the things we could look at include the selection of medical students, the education medical students and doctors receive at and after medical school, their supervision, and the monitoring of everyone's day-to-day medical work.

Selecting for admission to medical school is a fraught business, but could we do better in selecting those most likely to become the best doctors (and how do we define 'best')? Several UK medical schools have introduced the UK Clinical Aptitude Test to try to identify such individuals,⁶ but, at best, it will take years to discover whether this actually works. What about the education and supervision students receive in medical school? Would a more liberal education in a necessarily vocational course promote intellectual development, open-mindedness and tolerance,¹ though it may be wondered how an overcrowded medical

curriculum could accommodate this goal. Papadakis and colleagues⁷ found that doctors in trouble with regulatory boards in the US were more likely to have shown unprofessional attitudes and behaviour as medical students, and that appropriate training and experience could improve their performance, emphasising the value of supervisions. Perhaps more time should be given to teaching and discussing the bases of ethics and the nature of professionalism in postgraduate training, and to looking at how trainees can experience professionalism in practice by being part of medical teams with a strong professional ethos. Finally, prompt investigation of unexpected adverse patient events would emphasise the importance of vigilance in detecting wrong-doing as well as error, and reassure our patients and their relatives.

The public has particularly high expectations of doctors. We hope that all professionals will have our best interests at heart, but we particularly need to know that this is the case for doctors. This pressure to be perfect is understandable but, while doing what we can, we need to remind the public that we are part of our societies and share the strengths and weaknesses of those societies. Can we be expected to do more than other sections of society? Meantime, our College includes senior clinicians who work in many different countries and cultures, and we could contribute much to a discussion on these topics as well as to the implementation of improvements. This would be in keeping with the aim of our College to contribute to the highest standards in patient care.

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