

Virtual Mentor

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From the Editor

The Physician's Role in Modern Warfare: An Ethical Accounting

In April 2004 the American public learned of the abuse of prisoners and war detainees by members of the U.S. military in the Iraqi prison Abu Ghraib. The story broke first in the pages of *The New Yorker*, while photos depicting gross violations of international accords were revealed on the television program *60 Minutes*. Similar accounts emerged the same year from U.S.-operated detention centers in Guantanamo Bay, Cuba, Afghanistan, and elsewhere. Making these reports even more alarming were allegations that physicians had been complicit with, and in some cases actively involved in, egregious maltreatment of detained individuals. These events brought worldwide attention to the American commitment to internationally agreed-upon principles of medical ethics as codified in documents such as the Geneva Conventions [1], the Declaration of Tokyo [2], and the 1997 Declaration of the World Medical Association on treatment of prisoners [3].

The U.S. government has concluded that enemy combatants are not subject to the protections defined by international accords because they do not explicitly fight on behalf of a national signatory to these agreements; others have argued that traditional principles of medical ethics are rightfully suspended in the setting of sufficiently grave threats to national security and the safety of American and allied troops. On the other hand, a preponderance of opinions published in the medical and ethics literature has decried *any* loosening of our national and individual adherence to the fundamental principles of medical ethics as they apply to prisoners of war and detainees [4-8], although it is undeniable that the nature of modern warfare has introduced novel questions pertaining to the ethical conduct of military physicians working in the context of war. Thus we devote this month's issue of *Virtual Mentor* to discussion of a few of these questions.

Central to any treatment of the physician's role in modern warfare is the problem of physicians' presence during wartime interrogations. Setting aside the larger question of whether so-called "harsh" interrogation techniques are acceptable or even strategic (which lies outside a strict discussion of medical ethics), reports alleging medical personnel's assistance with abusive treatment of detainees during questioning require that we reconsider the meaning of medical presence in such settings. Does oversight by physicians lend a false air of propriety to an otherwise condemnable practice, thereby endorsing it? Perhaps that same authority would serve to limit abuses and should instead be systematically instated. Mark Levine explains in a policy forum article that fundamental aspects of the patient-physician relationship should guide our thinking on these questions.

Although internal conflicts have challenged other nations to abide by the international prohibition against force-feeding imprisoned hunger-strikers [9], not until the current war has the American military overseen widespread refusals of nourishment by wartime prisoners as has occurred at Guantanamo Bay. In another policy forum article Hernan Reyes reviews international declarations that provide guidance on the ethical response to hunger strikes. Despite these international standards, detainees in Guantanamo are being force-fed.

A classic tension faced by the military physician is the “dual loyalty” or “mixed agency” conflict, which is a circumstance of apparently opposing obligations to the patient and to the exigencies of the military and the war effort. Wendy Orr, drawing on her experience as a prison doctor in apartheid-era South Africa, examines the case of a physician who finds himself pulled by multiple allegiances. Brian Carter, Dominick Rascona, and Gary Schwartz address some of the overarching questions such cases expose: Can a physician maintain full fidelity to the fundamental principles of medical ethics while serving as a military physician? If, as Yishai Ofran states in his case commentary, medicine is the “exact opposite of violence,” do physicians have an ethical obligation to act individually and collectively to oppose war? Justin List and Rob Walter consider similar questions in their analyses of the ethics of military recruitment on medical school campuses. And in the health law section, Lee Black uses the litigation surrounding the military’s mandatory anthrax vaccination program to examine the tension between military objectives and patient autonomy.

Guerrilla warfare tactics and terrorism employed against the U.S. and its allies are cited as justification for many of the new governmental and military policies that conflict with established medical ethics norms. Is there still a place for the 150-year-old tradition of medical immunity on the modern battlefield? Michael Gross refers to the Israeli-Palestinian conflict in his review of the topic, while Stephen Xenakis and Yishai Ofran provide case commentary to suggest that, regardless of asymmetric commitments to ethics principles on behalf of warring parties, the patient-physician relationship is inviolable and may indeed be a force for peace.

Many have suggested that inadequate ethics education in medical and military training is partially responsible for ethics violations committed by physicians in the context of the current (as well as past) wars. Edmund Howe of the Uniformed Services University of Health Sciences provides insight into the training military physicians receive in medical ethics, detailing how it has been restructured in response to modern war tactics and the attendant challenges to ethical and professional conduct. We need to look harder and with more honesty for the true causes of unethical conduct among physicians, and maintain awareness that, as Dr. Howe concludes, “like all other present and future physicians, [we] are and always will be at risk for acting in ways that are morally suboptimal and even unconscionable.”

In 2005 the Institute for Policy Studies reported that more than one million U.S. troops had been deployed overseas since September 11, 2001 [10]. Physicians and medical students are likely to encounter individuals in their practices who have been to war, some of whom may have witnessed or been the victims of violent conflict. In the clinical pearl this month, Richard Mollica draws on his extensive clinical and research experience to present practical tools for providing sensitive, effective care to combat veterans and other survivors of extreme violence. In stark contrast to the men and women of the military, civilians typically rely on the stories and images presented by the media for information about the ramifications of our activities overseas. A 2006 article in the *International Journal of Health Services* argues that physicians and public health practitioners have a responsibility to seek unsanitized images and narratives of the suffering and destruction that war begets. In our journal discussion, David Boren examines the potential conflict between victims' right to privacy and efforts to disseminate images of the consequences of war.

In questions of medical ethics, answers are often elusive. That does not mean, however, that firm answers do not exist, or that right cannot be distinguished from wrong. My primary goal in assembling this collection of essays was to bring attention to the threat posed to international principles of medical ethics by the selective application of the protections they were meant to guarantee. Secondly, I hoped to bring into proximity writing by individuals whose opinions too seldom intermix within the same publication. I am proud to have such a diversity of authors represented in this issue of *Virtual Mentor*, although it was not possible to capture the full range of opinions that exist on these highly polarizing topics. As always, we welcome readers' thoughts and reactions at virtualmentor@ama-assn.org.

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