

Virtual Mentor
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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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Lhasa Ray
MS4
Albert Einstein College of Medicine
New York, NY

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Clinical Case

Recruiting for Military Scholarship Programs on Medical School Campuses

Commentary by Justin M. List, MAR, and by Robert J. Walter, DHCE

Three months of the first year of medical school had passed, and, in addition to the fields of anatomy and histology, Amanda was beginning to learn more about her classmates. She'd been pleased to discover that she had quite a bit in common with many of the students she'd met; like her, they not only had a fascination with human biology and pathophysiology but were also motivated to help others and to prevent or alleviate suffering.

When an e-mail went out to the first-year class announcing an upcoming visit by a military recruiter, Amanda assumed that her friends would agree that the military had no place in an academic institution dedicated to the promotion of health and the safety of individuals and communities. She was shocked to hear her lab partner say, "Actually, I'm in the Health Professions Scholarship Program. My husband and I have a young child, and putting us into debt for my education just wasn't an option. So, I'll do some military service after my residency, and the Army will cover the entire cost of med school. I don't see any conflict in being a military doctor. I'll make a huge difference by giving care to people who are working to keep us all safe and secure."

Commentary 1

by Justin M. List, MAR

This case provides a snapshot of the diverse feelings people attach to the U.S. military and its methods of recruitment. Amanda and her friend undoubtedly have different perceptions of the military, its actions and influence, and its potential impact on the practice of medicine. Amanda might be against a military recruiter presence on campus because she assumes that military demands compromise the ethical behavior of physicians in some way; thus her concern for her classmate. Conversely, Amanda's friend might assume that practicing medicine in the military will allow her the same freedoms in professional conduct that any civilian physician has. Both assumptions contain some truth.

Since the topic of recruitment on campus can provoke heated discussions, let's elucidate what makes concern about military presence at a medical school disconcerting for Amanda. After all, it is less likely she would be so upset if other governmental agencies that provide loan forgiveness in exchange for service, such as the U.S. Public Health Service Corps or the Global Health Fellows Program of the

U.S. Agency for International Development (USAID), were to recruit at her campus. What concerns attached to the military's presence might shape her views?

My comments on the ethical issues raised with military recruitment (i.e., Health Professions Scholarship Program) at medical institutions, posit that it is ethically permissible in theory for the military to recruit medical students as long as baseline military ethical and professional guidelines satisfy universal ethical standards of the medical profession at large. At the same time, I suggest that prudential concerns that have ethical implications might cause specific individuals to justifiably deny, protest, or hesitate in allowing active recruitment on campus.

Guidance for Decision Making: Ethical and Prudential Concerns

There are two baseline ethical guidelines that, I believe, we must consider in evaluating how the military interfaces with medical students and the medical profession. They are: (1) how military medical ethics compares, in general, with universal declarations of medical ethics, and (2) where military ethics stands on specific issues such as physician involvement in interrogation and violations of medical neutrality (e.g., not providing medical care on the basis of need and urgency, which are normative values in medical ethics). To make a case for allowing military recruitment of medical students, it is essential that the core ethical values of medical neutrality in the provision of medical care and adherence to the ethical standards of the practice of medicine be met.

Students for or against active military recruitment on campus, however, may understandably bring *prudential* arguments to bear on the topic, including (1) general attitudes towards the military that stem from widespread opposition to, for example, the current war policy in Iraq and the possibility that a physician might be part of a military unit in which violation of human rights is practiced; (2) the impact of the financial incentives to accept recruitment among an economically vulnerable population of students, given the underfunded state of medical education; and (3) objection to the current administration's influence on the military's behavior on the battle field or at home, as evidenced by labeling prisoners at Guantanamo Bay as unlawful enemy combatants and limiting their human rights; and by the controversial "don't ask, don't tell" policy towards homosexual men and women serving in the military—a policy with human rights implications that has been rejected by other militaries (e.g., the United Kingdom) that allow homosexuals to serve openly [1]. Prudential concerns such as these certainly have ethical implications, but they arguably do not proscribe recruitment or physician involvement in the military on an ethical basis as long as they do not entail physician violation of established human rights and ethical mandates of the profession.

Examining Core Military Medical Ethics

At the nexus of an ethical examination of military recruitment at a medical school campus lies the question of how well military medical ethics aligns with wider professional mandates in medical ethics—that is, the possibility that physicians' obligations to the military might conflict with their obligations to the medical

profession. This is often called the problem of “dual loyalty,” and it exists in other domains of medicine outside military medicine as well [2]. There are two levels to the dual loyalty inquiry: (1) what official military ethics documents and guidelines dictate and (2) how military physicians and those in charge of them conduct themselves in the field. On core points such as medical neutrality in provision of medical care in conflict situations, official U.S. military medical ethics (according to the *Textbooks of Military Medicine, Military Medical Ethics* [3]) stand largely in line with those of the wider profession, although their guidelines are not always stated as clearly and straightforwardly as they are in nonmilitary professional manuals such as the American Medical Association’s *Code of Medical Ethics*, World Medical Association’s *Medical Ethics Manual*, and the Geneva Conventions of the United Nations.

Physicians for Human Rights (PHR) maintains a library of human rights statements related to medicine practiced in military and humanitarian group settings [4]. PHR monitors the actions of militaries and other groups around the world and government policies pertinent to human rights. A simple query of its search engine displays numerous articles and statements concerning actions that hold negative implications for human rights. Unfortunately, many of these briefs have been created in response to U.S. military, congressional, and executive branch policies. While few military physicians have been implicated in unethical medical behavior, their presence in a military where unethical treatment of people sometimes occurs should be disconcerting to anyone.

In respect to the second aspect of the dual loyalties conflict—what military physicians do in the field—recent years have brought concerns and allegations of physician and health professional participation in interrogation, torture, and prisoner force-feeding in places such as Iraq and Guantanamo Bay. To be clear, if military physicians violate entrenched ethical mandates that proscribe participation in torture and interrogation, either of their own volition or because of orders from military superiors, then medical institutions have a strong case for prohibiting military recruiting on campus. Indeed, their banning of recruiting could be construed a duty imposed by the need for change in the practice of military medicine.

Others have argued elsewhere, as have I, that physicians have a fiduciary duty to practice medical neutrality in all contexts. Conflict situations viewed as public health problems can be likened to an epidemic of disease. Physicians should conceive of conflict situations as destructive, fatal epidemics and respond accordingly [5, 6]. Medical professionalism and the ethical integrity of medicine practiced in its diverse societal domains, including military medicine, should be of the utmost concern to all physicians because the values of the profession are at stake. As Wynia et al. have explained, attitudes of the medical profession reveal much about a society’s well-being and its respect for the rights of its citizens and those of other nations [7]. Given current concerns about certain practices in the U.S. military, Amanda’s reservations are understandable. Medical institutions can play an important role in monitoring and influencing the ethical behavior of other organizations where physicians practice.

Permitting or prohibiting military recruitment on campus might be one way for the profession to make its views known.

Concluding Thoughts

Amanda's opinions about the military's presence and recruitment of medical students might arise in part from a sense of "guilt by association," given accusations of unethical behavior (e.g., force-feeding, unethical interrogation practices, and prisoner abuse) on the part of service members or military health professionals. On this view, if some military personnel violate human rights and health care standards, all military physicians are implicated due to their affiliation—and, one has to suspect, by their failure to speak out about the violations—whether or not they are directly involved. (That physicians should speak out against violations of human rights raises a separate issue that cannot be examined here [5]). The guilt-by-association allegation is, of course, unfair to many outstanding and ethical military physicians. Recently, some physicians abstained from the unethical behavior of force-feeding of prisoners at Guantanamo Bay, while others, unfortunately, reportedly participated [8, 9]. In response to Amanda's hypothetical concern, one can make the counterargument that physicians, especially those knowledgeable in the field of medical ethics, are needed more than ever in today's military and society.

Having looked at statements of military ethics and the conduct of physicians in the military separately, we can return to the question at hand: Is there an ethical argument that justifies a ban on military recruiters at medical school campuses? Based on the criteria I have laid out, the answer appears to be "no," if we are convinced that normative ethical values dictate the military physician's practice, despite any military instruction that he or she receives to the contrary. Given the military's involvement in wars that might not meet the ethical criteria of a "just war" and possible violations of human rights, there are strong prudential arguments—that perhaps gain the status of a duty—for limiting recruitment activities, even if military physicians themselves are not involved in unethical or ethically dubious situations.

Banning military recruiting from campus does not prevent students from seeking out HPSP opportunities if they choose to do so, again, on the proviso that the military satisfies universal medical ethics guidelines. There are many ways to serve U.S. citizens and others around the globe; a career of medical service to the men and women of the armed forces and civilians in combat settings is one example. Amanda, like many who are concerned with the actions of military, possibly recognizes the need to provide exceptional medical ethics education and uphold the rigorous ethical standards of professionalism. Her friend in the vignette holds the same values. In order to continue strengthening and protecting the ethical integrity of the medical profession, medical students, physicians, and the public should settle for nothing less in the military's relationship with physicians. In raising concerns and civil discussions on these issues, the values of transparency and accountability in the medical profession are more important than ever.

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Justin M. List, MAR, is a third-year student at Loyola University Chicago Stritch School of Medicine. A former fellow at the Institute of Ethics at the American Medical Association and previous editor for Yale University's Interdisciplinary Center for Bioethics, he recently wrote the chapter "Medical Neutrality and Political Activism: Physicians' Roles in Conflict Situations" in the forthcoming volume *Physicians at War: the Dual Loyalties Challenge* edited by Fritz Allhoff.

Commentary 2

by Robert J. Walter, DHCE

When an individual has more than one professional role, the potential or possibility for strain among role obligations exists. In the case of military medicine, a physician is placed at a nexus of the profession of arms and the profession of medicine. Each of these professions has an ultimate end, or *telos*, with corresponding responsibilities and obligations. In the case scenario, Amanda asserts that the ends or goals of medicine and those of the military are incompatible. To oppose that view, one must look to the theoretical constructs and practical realities of both the professions.

The *telos* of a profession provides insight into the theoretical construct that shapes and influences the practical application of its values by its members. Should a conflict between the *teloi* of two professions exist, it might be said to create an inherent or intrinsic incompatibility. Such a situation would mean that anyone who attempted to negotiate the two at any given time would be necessarily in violation of at least one set of professional obligations. On the other hand, if it could be established that the *teloi* of the two professions were, at the very least, commensurate, then theoretically an individual could practice both without necessarily violating the professional obligations of either.

Are the ends (*teloi*) of the profession of arms and the profession of medicine compatible? As described by Edmund Pellegrino, the *telos* of medicine may be broadly interpreted as “the right and good healing action taken in the interests of a particular patient” [1]. Extrapolating from the goal to its social obligations, physicians are charged with the promotion of health within society. The goal of the profession of arms, that is the profession that exists among soldiers who represent a legitimate government authority, is broadly the protection and safety of the society it serves. Both professions claim service to society as a *telos*, and both place self-sacrifice and the promotion of certain common values above personal gain and the pursuit of personal values and goals by practitioners.

Often what is called a conflict between professions is instead a conflict between professional demand and career demand within one profession rather than between professions. The prototypic professions (medicine, law, clergy, and academia) are dedicated to certain common goods and values that benefit society (i.e., health, justice, faith, and knowledge, respectively) and require that their members subordinate the pursuit of personal ends and values and adhere to certain objective standards and values. Careers, by contrast, are not necessarily governed by a set of unifying principles, values, or standards, but allow individual practitioners to pursue individual ends as long as they are within the bounds of respect for the rights of others; that is, one may not pursue personal gain indiscriminately at the expense of other individuals.

It is the pursuit of personal ends or goods versus the pursuit of a common good and the subordination of certain personal ends that distinguish professions from careers. At a theoretical level, both the profession of medicine and the military profession require members to subordinate certain personal ends and adhere to a certain set of objective standards contained within their professional code. Understood broadly, both professions’ goals—the health, safety, and protection of society—are compatible.

While an inherent conflict does not exist when the professions are considered theoretically, the reality of practice may at times present overwhelming and potentially insurmountable obstacles and frustrations that necessitate the practical divorce of two professions. Two cases illustrate this point. In the first, the role obligations of the professions may become blurred to the point that the agent is

unable to discern effectively which acts are proscribed by each profession. A physician in a noncombatant role in asymmetric warfare, for example, may not be able to tell whether it is more important to observe the immunity of an ambulance carrying opponent victims or to protect his or her troops from possible ambush by a weapon- or bomb-carrying guerilla fighter hiding in the ambulance. In the second case, role conflict may arise from the manner in which one or both of the profession is employed or embodied within specific circumstances. Many of these conflicts-of-circumstance are shared by military physicians and their civilian counterparts, e.g., whom to treat, allocation of scarce resources, complicity with actions that conflict with personal morality.

The difference for the military physician is that these conflicts take place within the context of combat and war. While few would object to the social good and necessity of a standing military for civil and national defense, there are those who might object to the means employed toward that end in particular instances. The military's means and activities might conflict with personal beliefs or moral standards. When this conflict occurs, it raises the question of how complicit that individual may be by his or her association with the military profession.

In the case of a military physician, the role is that of a noncombatant whose primary responsibility is the treatment and evacuation of wounded soldiers. The military physician plays no direct part in the aggression, though returning former patients to the fight is an indirect contribution to the war. This is an important distinction, since the intention of an agent (physician) imparts a moral character to his or her actions. The physician's intention is the restoration of health and the prevention of disease; it is not necessarily the intent of the physician that the aggression persists.

A parallel example can be found within the domain of civilian medicine. Individuals enter the profession of medicine with the intention of serving its proper goods and ends, desiring to help others and to act as instruments of health in society. Yet, for many, entry into the civilian medical profession is entry into a broken U.S. health care system that permits death and disabilities due to poor access to care. We do not, however, claim that physicians are therefore complicit with this often unethical distribution of health care simply by virtue of their participation in the profession of medicine. This example shows that material cooperation within a system—even one that conflicts with personal morality or the *telos* of the profession that it incorporates—does not necessarily invalidate or implicate the actions of individuals whose intentions are true to their profession.

Prioritizing the Conflicting Goals of Two Professions

So far I have argued that the ends of medicine and the military are not inherently incompatible, and that the practices of these professions are not necessarily incommensurate. When an individual (or group of individuals) works toward two distinct *teloi*, even commensurate *teloi*, the potential that their intermediate ends and goals will come into conflict is real. One can point to a number of conflicting intermediate examples, such as who is treated first, allied soldiers or injured hostile

combatants? What means of triage should be employed? What is the extent to which a physician is a noncombatant? Is there a role for the physician within the realm of prisoner-detainee interrogation? How might one negotiate these conflicts?

One approach to resolving the conflicts requires a hierarchical structuring of goods that may be referenced when conflict occurs among them. Simply put, is the individual a soldier first or a physician first? This is, in part, a personal consideration that must be reflected upon by all military physicians. At the same time, the axiological structuring of values is too important to be limited solely to the realm of personal reflection. It requires a broader discussion among all those who participate within this group; it should be discussed at the organizational level within the medical corps.

Another instance of conflicting intermediate goals may be useful in illustrating the point. Within the profession of medicine, we often speak of intermediate ends or goals, such as palliation of pain and suffering and the prolongation of life. These intermediary ends or goods are sought by the profession in the service of its *telos* (the right and good healing action taken in the benefit of a particular patient as the ultimate goal of the practice of medicine). There are times, however, within clinical care situations that the intermediate goals conflict, as in the case of an individual with multi-organ system failure. Here, it is possible to envision a point at which it is no longer medically feasible or personally preferable to pursue both intermediary goods, and thus the focus should be placed upon one or the other of them. Hospice might represent an example of such a transition point.

Within contemporary medical practice in the United States, the negotiation of these divergent goods is achieved by reference to the hierarchical structuring of values by the patient; that is, the patient, by reference to the values he or she holds to be important (and how they are hierarchically ranked), decides which intermediary end is to be sought. So, too, is the military physician called upon to rank hierarchically the intermediary goods of the profession of medicine and the profession of arms to resolve scenarios in which those goals conflict.

Amanda and the Military Recruiters

In the case we are presented, Amanda believes that military recruiters have no place in an academic institution devoted to healing and public safety. Her claim is most likely based in a belief that the profession of medicine and the profession of arms are either intrinsically or practically incompatible in their goals. While this may be a view of a significant minority in society, I have attempted to illustrate some of the main considerations that must be investigated in order to determine whether *teloi* and practical realities of the profession of medicine and the profession of arms are incommensurate. It has been my argument that indeed there appear to be no theoretical incompatibilities between the two professions and, while the potential exists for practical incompatibilities that necessitate reflection on the part of the individual physician and medical corps, these are not so insurmountable as to render the professions incommensurate. Rather, while the role the military physician

embodies many unique challenges that require reflection and discernment, it presents the unique opportunity to practice medicine in the important capacity of caring for individuals who willingly and selflessly place their lives in harm's way in service to their country and its ideals.

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Robert J. Walter, DHCE, is completing his fourth year at Loyola University Chicago Stritch School of Medicine. A recipient of the Armed Forces Health Professions Scholarship Program, he holds the commission of a 2nd Lieutenant in the U.S. Army Medical Service Corps and plans to pursue an Army residency in internal medicine. Robert received his doctorate in health care ethics from Duquesne University in 2004.

The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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Clinical Case

Physicians' Duties in Treating Wartime Detainees

Commentary by Wendy Orr, MD

Dr. Thompson is a military reservist deployed with a mobile medical field unit in Iraq. Several weeks into a grueling tour during which a number of American soldiers sustained serious injuries, a young Iraqi man who had been detained for questioning was brought to Dr. Thompson by the military police (MP). The MP said that the man had been found at a military checkpoint with what appeared to be a broken ankle and asked Dr. Thompson to assess the extent of the injury so that the man could be returned to the detention unit. During his examination, Dr. Thompson found that the young man had a grossly swollen orbit and bright red welts and lacerations covering his back, in addition to a fractured left ankle. Dr. Thompson strongly suspected that his patient had been beaten by a member of the unit and knew that he should notify the unit commander. Although he was well aware of international law governing prisoners of war and detainees, and although he had received comprehensive ethics training from the military regarding his duty to report signs of abuse, Dr. Thompson found himself hesitating to make a report.

Commentary

Dr. Thompson finds himself in a classic “dual loyalty” situation. The term dual loyalty was coined by the Truth and Reconciliation Commission (TRC) of South Africa, whose mandate was “painting as complete a picture as possible of the causes, nature and extent of the gross violations of human rights...including the antecedents, circumstances, factors and context of such violations, as well as the motives and perspectives of the persons responsible for the commission of the violations” [1]. In carrying out that charge, the TRC held hearings into the role of health professionals and the health sector in the perpetration or prevention of human rights abuses during the period in question (1960 to 1994). Emerging from those hearings was a set of recommendations which included “Safeguards for vulnerable health professionals” aimed at ensuring “that health professionals who work in situations in which they have *dual loyalties* are not complicit in committing human rights abuses” (emphasis added) [2].

What is a dual loyalty situation? In short, the situation arises when a health professional has “simultaneous obligations, express or implied, to the patient and to a third party, often the state” [3]. This occurs most commonly when a health professional is employed by an organization or institution, for example, the military, the prison system, police services, or mental health services, and has to treat patients who are in particularly vulnerable positions like prisoners, mentally disturbed

people, prisoners of war, or detainees. Supposedly a doctor's first obligation is to his or her patient—but what happens when serving the best interests of the patient conflicts with what the employer believes is in the best interests of national security or some “greater good”?

This is the situation in which Dr. Thompson finds himself. He is employed by the U.S. military, working under trying and traumatic circumstances in Iraq. He has seen a number of his fellow countrymen and women seriously injured as a result of Iraqi actions. The Iraqis are the enemy. He now is confronted with one of these enemies—who may well be responsible for the suffering of American soldiers. Is that why he hesitates to make a report? Does Dr. Thompson believe that the detainee deserves whatever physical punishment was meted out to him?

This might sound absolutely absurd, but while I was working as a prison doctor at the height of the South African apartheid era, I heard medical colleagues say, when confronted with beaten and tortured political detainees, “Well, he probably deserved it,” or, “They’re the ones running round the townships throwing stones and burning tyres—what do they expect?”

Perhaps Dr. Thompson hesitates because he realizes that reporting torture or abuse will be pointless anyway—the report will be filed in drawer X, and the Iraqi detainee will return to exactly the same conditions and risks of abuse whence he came. “So I may as well keep my head down and not make waves,” might be Dr. Thompson’s rationale.

Maybe Dr. Thompson’s reluctance is the result of his thinking of the patient’s best interests. It is not uncommon for detainees and prisoners who report abuse to be punished for doing so. After all, the young Iraqi man is not going home after he has been examined; he is going right back to the detention centre where his abusers have access to him and may simply beat him again for having tried to get them into trouble.

Whatever Dr. Thompson’s reasons for hesitating, he does have to decide how he will (or will not) act. He knows what he is supposed to do. The Geneva Convention states, *inter alia*:

Prisoners of war must at all times be humanely treated. Any unlawful act or omission by the Detaining Power causing death or seriously endangering the health of a prisoner of war in its custody is prohibited, and will be regarded as a serious breach of the present Convention. In particular, no prisoner of war may be subjected to physical mutilation.... Likewise, prisoners of war must at all times be protected, particularly against acts of violence or intimidation and against insults and public curiosity [4].

The same Convention goes on to say that:

Every camp shall have an adequate infirmary where prisoners of war may have the attention they require.... Prisoners of war suffering from serious disease, or whose condition necessitates special treatment, a surgical operation or hospital care, must be admitted to any military or civilian medical unit where such treatment can be given [4].

The Declaration of Tokyo states:

The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife [5].

Thus what Dr. Thompson should do firstly is ensure that his patient receives the appropriate care and medical treatment. Judging from the description of his injuries, this would necessitate admission to whatever hospital facility is available. So for a few days at least, the detainee will be safe from further assault. Dr. Thompson must carefully record the man's injuries and any report or allegations that the patient makes as to how those injuries were caused. If the man does claim assault, Dr. Thompson should document whether, in his opinion, the injuries are consistent with the history. Dr. Thompson's responsibility goes beyond simply providing immediate treatment and recording injuries; he should do whatever he can to prevent further injury to the Iraqi man, and he must report what he has recorded.

Strangely enough, while documents like the Declaration of Tokyo insist that a doctor "shall not countenance...the practice of torture or other forms of cruel, inhuman or degrading procedures" [5], commentary by human rights groups on an individual practitioner's obligation to speak out remain vague.

The WMA's 1997 declaration states that physicians have a "responsibility to honour their commitment as physicians to serve humanity and to resist any pressure to act contrary to the ethical principles governing their dedication to this task." The WMA has not, however, clarified the duty of each individual physician to speak out on behalf of victims of human rights violations. Such clarification, as well as developing means for fulfilling it, remains essential [3].

In its guidelines for military health professionals, the Physicians for Human Rights report on dual loyalty did take that next step by stating:

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.

Military health professionals should maintain their independence and report human rights violations as civilian health professionals do.... The military health professional should especially take steps to report violations of the Geneva Convention [3].

But to whom should Dr. Thompson report? Ideally, he should be able to report to his superior—but, if that person is a commanding officer and not a physician, this may not be the best thing for Dr. Thompson or for his patient. If Dr. Thompson has any doubts about his unit commander's willingness to take appropriate action against the perpetrator of the abuse and to protect the Iraqi patient, it may be advisable for him to seek alternate ways of reporting. Within the military, he might report to a more senior doctor or perhaps to a chaplain, if the former option is logistically difficult. The other option would be to go an entirely independent route and to attempt to contact an organization like Physicians for Human Rights, the International Committee of the Red Cross, or Amnesty International. This path is likely to get Dr. Thompson into trouble, and he should weigh carefully the positive and negative consequences of such action. Joint action is always easier than acting alone, and Dr. Thompson should seek support and advice from other health professionals whom he can trust, both inside and outside the military.

I would see silence from Dr. Thompson and failure to take any action as a breach of medical ethics. Others would not. At the end of the day Dr. Thompson has to answer a few simple questions in his own mind: Did I give my patient “complete loyalty” [6]? Was “the health of my patient my first consideration” [7]? Can I look at myself in the mirror and honestly say that I did the right thing?

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Wendy Orr, MD, is a consultant in change management, transformation, and diversity in Johannesburg, South Africa. She served as a commissioner on the Truth and Reconciliation Commission of South Africa, investigating the human rights violations of the apartheid era.

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Clinical Case

Maintaining Medical Neutrality in Conflict Zones

Commentary by Stephen N. Xenakis, MD, and by Yishai Ofran, MD

Asher is a fourth-year medical student doing an international elective in northern Uganda. The clinic he's stationed in serves primarily the local community, and he's seen everything from routine ear infections to advanced AIDS, encephalitis, parasitic infections, and disseminated tuberculosis.

As one of the few Westerners the villagers have ever seen, Asher has created quite a stir. Although he's starting to feel more at home in the village, he knows that his actions are watched closely by the townspeople, and he's scrupulous about his interactions with them, always respectful and deferential to local customs and values.

The organization he's working with can only staff the clinic for eight months out of the year, so when an American medical team is there, news travels fast to neighboring communities, and occasionally people come from quite a distance to seek care. One evening, Asher heard a commotion outside the clinic. Several men and women had gathered, and there was shouting. Asher asked a nurse what was causing the upset, and she explained that men thought to be affiliated with a group of rebel fighters from the north were approaching town, and some had been wounded. Asher moved to send for the local physicians and ready the procedure suites, but the nurse stopped him. "We've worked for years to establish trust among the local people here—trust that's enabled us to dramatically improve the health in these communities. It would be a grave insult if we offered care to their violent enemies, and that would surely result in a huge setback for all our hard work. We should shut down the clinic before the rebels arrive because they're not welcome here."

Commentary 1

by Stephen N. Xenakis, MD

Candidates for the Supreme Court react to hypothetical questions as if they are radioactive and creatively dodge them at confirmation hearings. But physicians use them for teaching. This case study could fall under the teaching module entitled, "How Physicians Serving in a Hostile Environment Can Make Ethical and Practical Decisions."

Asher, the medical student in northern Uganda who is in charge of the clinic for the evening, must make an urgent decision about treating potentially hostile, even dangerous, patients and does not have time to consult with others.

Let's scan the thought bubbles bursting over his head—

- First, do not harm;
- There is a duty to treat all who come to me;
- Ensure the safety of the patients and clinic staff;
- Will these men attack us—is this a ruse?
- Is there a political position that is ethical?
- What is my credibility?
- Can I explain the decision that I make to the staff and patients?
- Will the clinic staff follow my guidance?

Clearly, questions about the nature of the medical care required are simple in comparison to figuring out the effective course of action. The student confronts a dilemma with no easy answers, one that draws on lessons in both leadership and ethics. In many ways, these perspectives are interdependent: good leadership is grounded in sound ethical principles, and sound ethical principles guide good leadership. As a retired Army general and physician who imagines assisting this fourth-year medical student with his urgent decision, I can see organizing his thought bubbles with these leadership and ethics perspectives in mind.

There are innumerable theories of effective leadership. It is axiomatic that good leaders succeed not only by making the right decisions, but also by how they implement those decisions. In this case, the young medical student must take the lead, act decisively, and secure the confidence of the clinic staff to follow him as the crisis unfolds.

The scenario implies that the landscape of political alliances, personal relationships, and cultural attitudes that influence daily life in the clinic have undermined the efforts to gain the trust and confidence of the entire local population. While the scenario may appear to be one of warring factions and tribal or clan warfare, experience tells us that civil conflicts of this nature are complex and nuanced beyond imagination. More than likely, the state of affairs is more tenuous and insecure than it appears. The nurse urges closing the clinic before the injured rebels appear at the front door. Clearly, she feels that the rebels are not welcome and that treating them would set back the progress of the past several months. But Asher is not a political expert and discerning the intricate politics of the community exceeds his understanding and sensitivity to the local political and social alliances and hatreds. He is not sufficiently expert to either unravel or act on a presumed ethical political position and close the clinic in the face of this emergency.

A Universal Ethical Principle

But the urgency of the situation, and the pressure on the young student to provide real leadership as well as medical expertise, calls for an ethical principle that is universal, consistent, and easily explained to all parties who come in contact with the clinic and doctor. The compelling proposition is “the healer cares for all who seek

treatment.” The principle is simple and anchors whatever actions, policies, and procedures follow. It stands up to challenges from disputing or aggressive authorities—as there is no partiality or possibility for prejudiced alliances or favors; it is unassailable. It is elegantly framed in the Geneva Conventions: “...Recognizing neither friend nor foe, they care for the wounded and sick without distinction of nationality. For charity knows no frontiers...” [1].

Imagine the heated conversations with members of either warring faction—murderers, rapists, plunderers. The physician cannot neutralize the intense emotions of the scene. But most cultures and ethnic groups recognize the special role of healing practitioners and their obligation to care for all who come to them for treatment and assistance. Societies establish a special covenant with healers and bestow privilege and authority on them. Universally, healers have social status with the understanding that they will extend their art and knowledge to everyone, regardless of political or social stripe, especially in times of emergency or crisis. In the interest of good leadership and sound ethics, the physician decides that the clinic will treat the injured and sick from the opposing faction.

But how? Now that the ethical principle has been established and reinforced, the intricacies of leadership must be put into action. Asher faces tremendously complex challenges in carrying out the decision—especially in protecting the clinic staff and other patients. The young medical student needs to organize the clinic quickly to receive the new patients and simultaneously assure the safety and protection of its staff and current patients. The decision to treat the opposition parties could backfire without adequate safeguards. He should emphasize that services are provided only under emergency conditions. In order to do that, all parties must be disarmed. Other villagers should be recruited to ensure sufficient security and crowd control. Within the clinic, treatment and waiting areas of opposing factions should be completely separated. Additional contingency plans should be made to protect patients and staff. With systematic and carefully considered triage, the treatment of the wounded will not jeopardize the safety of the others. More importantly, the troubles of the conflict would be kept separate from the work of the healers.

Often, a rational ethical decision is not judged by the logic of the underlying principles, but by the effectiveness of the leadership that executes it. The demeanor and confidence of the medical student and physicians as leaders assume overriding importance. A leader who speaks and acts with calm authority, even with some charisma, is more effective in carrying out tough decisions in complex scenarios like this one. The staff and patients who are frightened and anxious look to Asher for leadership in the crisis. For many, the final judgment about the wisdom of a decision is determined by the outcome. To say it another way, a seemingly ethical decision that contributes to large numbers of dead or critically injured staff and patients would be hard to judge favorably. Being right while causing more harm is hard to justify as ethical.

One does not have to venture into a hypothetical scenario in Uganda to see that the challenges faced by this medical student are a part of many doctors' lives. Every day, military physicians and clinics in Iraq triage and treat a host of local nationals not knowing whether they are friend or foe. They follow elaborate protocols to provide high quality care and maintain the safety and security of the patients and clinical staff as well.

In the end, the guiding principle of a physician's work is stunningly simple. The physician can only take action based on the fundamental ethical principle common to the healing profession—and that is to care for all who seek treatment. Whether detainees in Guantanamo, rebel factions in Sudan, or gang members in Los Angeles, the political situation is too complex to factor into an action plan. Ultimately, the exercise of good leadership may be the most important element in the final judgment. Sound ethical judgments and good leadership go hand in hand.

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Stephen N. Xenakis, MD, is an adjunct clinical professor at the Uniformed Services University of Health Sciences and has an active clinical and consulting practice. He is a brigadier general (retired) in the United States Army Medical Corps who served in various positions of responsibility over 28 years. He is actively engaged in developing applications of quantitative electroencephalography (qEEG) for primary care clinicians.

Commentary 2

by Yishai Ofran, MD

The first scene that comes to mind when we think of medical care in wartime is of doctors or paramedics operating on the wounded while bombshells and rockets explode all around. On the battlefield, where there is a shortage of medical staff, even moderate or mild injuries can lead to death when left untreated, so it is a fundamental moral imperative to help all people regardless of the uniforms they wear. The Geneva Convention is very strict in stating the obligation to provide medical care to all soldiers with no exceptions [1].

Asher probably pictured a scene such as this when the nurse in the case scenario above said they should close the clinic. Thinking she meant to deny care to the wounded, he would react strongly, unwilling to accept that instruction. Despite not having graduated from medical school, Asher would be committed to the

Hippocratic oath and remember that the Geneva Conventions made no exceptions to medical neutrality in armed conflicts. Upon further discussion with the nurse, Asher would most likely hear something like the following: “Don’t get me wrong, we won’t let people bleed to death. We always give first aid and perform life saving procedures, but those people can get medical aid in their villages. They only come here when your team is here because we can give better treatment. If we let those people in, war will be back in our village and people like you won’t stay here any more.”

As the nurse points out, many of the moral dilemmas that medical staff encounter during armed conflicts do not occur under fire. Modern wars do not necessarily involve large masses of troops clashing on a well-defined battlefield. Acts of hostility and violence often erupt within civilian settings. Tension and fear undermine the normalcy of civil life during conflicts. The unresolved conflict impinges on people’s simple daily decisions, even if not a single shot is fired.

The ethical dilemmas that stem from this situation are not only about treating war injuries but about treating simple diseases. Usually, throughout long-lasting conflicts people stay on their own sides. When they seek medical care they take into account the political and national affiliation of the medical facility. Yet, it may happen that they turn to a facility owned and operated by the “enemy” when the fear of disease outweighs the dread of the foe. People may actually cross the lines for what they believe is the best medical care they can get, particularly if their condition is grave and if the discrepancy in the quality of care offered on each side is substantial.

Recently, during the first days after Hamas took power in the Gaza strip, several dozen sick Palestinians who would usually have been treated at Palestinian hospitals in Gaza accumulated at the border with Israel, asking to be treated at Israeli hospitals. Those who required emergency or specific, sophisticated treatment were allowed to cross the border. When fighting subsided, patients no longer approached Israel’s border. Patients only applied for Israeli help when they were afraid that, due to the new political situation, they wouldn’t be able to get any treatment in Gaza.

There is arguably no civil domain other than medicine in which such line-crossing during armed conflict is so frequent. Thus, medical staff stand in a rare interface between enemies. What may be obvious to Asher as a foreigner is much harder for local medical personnel to see. As natives, the staff and their fellow citizens often identify with, and support the goals of, one side of the conflict. Yet Asher has correctly identified the basic mission of a doctor. Medicine is not only the act of treating patients but also the values, goals, and efforts made to prolong life, prevent disabilities, and improve quality of life. Medicine is the exact opposite of violence.

The principle of medical neutrality is such that the more armed forces respect it the more tempting is to use medical staff and facilities for military purposes. In Martin Campbell’s film *Beyond Borders*, an NGO’s (nongovernmental organization’s) medical delegation is allowed to operate within a civilian community only by

agreeing to smuggle guns for the Khmer Rouge. This violation of the principle of medical neutrality leads in the end to the destruction of the medical camp clinic and the death of some medical staff members when their secret is discovered. As the movie illustrates, the responsibility for safeguarding the principle lies squarely on the shoulders of the medical staff. Even when identifying with one side of the conflict, no one should, in his or her capacity as medical staff, participate in acts of violence. Using access to medical aid as a tool in an armed conflict violates the values that are fundamental to good care. Preselection of people entitled to medical assistance on the basis of their political party should not be used as a tool to achieve political goals. Therefore, we have to make sure medical facilities remain accessible to all, regardless of political association.

According to a recent survey, when a patient requests a legal medical intervention which the physician opposes for religious or moral reasons, it is ethically permissible in the opinion of most American physicians to explain the reason for the objection, to disclose information about the intervention, and to refer the patient to someone who will provide it [2]. One should not, however, confuse moral opposition to a specific procedure with preselection of patients on the grounds of moral or political values.

Ethical rules should balance the well-being of specific patients with the needs of the system as a whole. No medical system can be blind to financial considerations. As a result, physicians may be unable to provide care due to lack of financial means or insurance coverage. The doctor's duty is always to verify that the patient is referred to another facility where he will be able to get reasonable treatment according to local medical standards of care. It is acceptable to refer a patient to a different facility in cases where best care for this patients clashes with the needs of the system. This should not be the case, however, if the reason for referral is external to patient-doctor interaction. The line between protecting the health system (the position taken by the nurse in our story) and using health system as a weapon in the conflict (Asher's initial interpretation of her position) is very fine.

We, as medical staff, should stand for the values of medicine, especially during wartime. Seeking the help of one's enemies at such times, reflects a patient's desperation or lack of other good options of care. We should remember that a patient's decision to ask our help is a statement of trust. Thus, we should be very careful when preferring the system's needs at the cost of the patient's health. Medicine should and can open a small path to peace, and it is up to us to show the way [3].

Once the patient enters the clinic, Asher should give him the best care he can. If the patient is responsible for terror or war crimes, giving the best medical care does not conflict with Asher's duty to call authorities, which will bring the criminal to justice. Shutting down the clinic to avoid providing care to a specific patient should be prohibited. Medical staff can and should lead and influence public values especially during wartime.

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Yishai Ofran, MD, is a senior hematologist at Rambam Medical Center, a unit of the State of Israel's Ministry of Health in Haifa. He recently started a two-year research project at the Dana Farber Cancer Institute in Boston. Dr. Ofran did his residency in internal medicine at Hadassah Medical Center, Mount Scopus Hospital, Hebrew University in Jerusalem. He also serves as a military doctor in a reserve parachutist brigade in the Israel Defense Forces.

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Medical Education

Teaching Military Medical Ethics at the Uniformed Services University of the Health Sciences

Edmund G. Howe, MD, JD

Military medical personnel should adhere to the highest military and medical moral standards. This adherence is critical in all of medicine, of course, in the interest of providing optimal patient care. But it is particularly important in the military for several additional reasons. One of these is that service men and women often look to military doctors for moral guidance and view them, more generally, as role models.

At the Uniformed Services University of the Health Sciences (USUHS) all students are required to study medical ethics and have been since the first class came to USUHS more than 30 years ago. In their second year, all take a course in medical ethics that includes discussion of topics specific to the military. I have been director of this course since its inception.

Since the school began, every student has addressed many of the same core military medical issues [1, 2]: the duty to treat captured enemy soldiers as they would members of their own U.S. forces, the obligation to bring suspected ethical and legal misconduct to the attention of command, and the need to treat civilian patients in occupied territory as ends in themselves, rather than exploiting their vulnerability in the hope of winning over their “hearts and minds” in an effort to further U.S. military or political ends [3, 4].

In recent years and especially since the attacks of September 11, 2001, new topics have joined the core military ethics curriculum [5-11]: What approaches should interrogators be permitted to use during interrogations of suspected terrorists? To what extent, if any, should military care providers be involved in interrogations? What should military doctors do if and when prisoners go on a hunger strike? In discussing these new topics we remind students that military physicians must maintain the confidentiality of detainees they treat at places like Guantanamo, just as all military physicians must maintain the confidentiality of their own service persons whom they see as patients.

Each year I bring in people who have faced difficult moral decisions in the military to discuss how they responded to them. We hope that, after hearing from military doctors who have faced and made these decisions, students will appreciate more fully that they, too, can achieve the exemplary moral standards that they see modeled for them by the medical officers who come to speak.

For more than a decade now, students have heard from Gordon Livingston, MD. Dr. Livingston graduated from West Point and then went to Vietnam. While there, he experienced several military practices he viewed as unethical. These included one officer's suggestion that an enemy soldier be left to die after he had been interrogated and another's suggestion that Dr. Livingston give a prisoner succinylcholine to induce him to disclose important information, in the hope that this would result in lives saved. Succinylcholine paralyzes the respiratory muscles so that the prisoner feels as though he is suffocating. Livingston refused.

Since the present war in Iraq began, military physicians who have recently served in that region have spoken to the class. One described improving Iraqi prisoners' living conditions, telling students in detail how he expressed his ideas to his superior officer and how these were passed up the chain of command. He succeeded. Another military doctor who worked on a Navy "medical ship" explained how she and other military medical personnel explored whether enemy prisoners whom they were treating could be placed in more comfortable restraints. Again, by taking the question up the chain of command, they succeeded in this initiative.

Students have also heard from a physician who refused to serve in the military on the grounds of moral conscience and, this fall, will hear from an attorney who represents detainees at Guantanamo.

Another important area of military medical ethics relates to military doctors' treatment of their own service persons [12]. The potential problem here is "mixed loyalties" [13,14]. In some contexts military doctors may have duties to their patients and to the military that conflict or are even mutually exclusive. Such conflicts can arise, for instance, when service personnel tell military physicians that they are gay or that they recently have used marijuana.

Students learn that, in general, military doctors' two major roles are to maintain the health of each service person and to be able to give their commanders accurate information regarding the unit's health. Accordingly, in most cases, they should give priority to meeting their patients' needs, because doing so will enable them to fulfill both tasks to the greatest extent. To that end, when they have doubts as to whether they are acting primarily in their role as physicians or as military officers, they can take the initiative to clarify this ambiguity by explaining their dual role to their patients and telling them specifically which role will have priority before they begin to treat them. This approach best furthers their service patients' autonomy, and, thus, most respects them as persons [15].

Members of the military are often viewed as a likely group for participating as "subjects" in military medical research, so students are taught that it is absolutely critical to protect service personnel from coercion, real or implied, to participate in research. This protection is particularly important because people in the service may

perceive that they have a duty to participate in military medical research and, as a result, might not feel free to decline.

In general, the primary goals of the medical ethics course (and of many other ethical discussions students have during their four years at USUHS), are to help them identify ethical problems, recognize their personal value biases, and understand the most basic ethical factors, values, and arguments on “both sides” of present and emerging major military medical ethical issues. It is anticipated that, as a result of this knowledge, USUHS students will make better ethical decisions throughout their military careers.

It is important for students to understand the difference between situations in which they may exercise their discretion in making moral choices and situations in which they may not, as in the cases that Dr. Livingston describes each year. They must treat enemy prisoners/patients as they would treat their own and not do such things as give prisoners succinylcholine or any other drug (e.g., intravenous sodium amytal or “truth serum”) for a purpose other than beneficial medical care. These decisions are not matters of personal discretion. But when they are in doubt or in situations for which military medical ethics has not prepared them, they should follow their moral conscience and refuse to do anything that they believe is unethical or illegal. This, they are told, is, in addition, what military law requires.

To highlight and emphasize the importance of the last point, we have invited an historian from the Holocaust Museum in Washington, D.C., to present the final lecture in this course for the past several years. She presents a film that shows some of the horrors perpetrated by Nazi doctors during and right before World War II [16-18]. The point of this presentation is that the doctors who committed these atrocities had other choices; they didn’t have to do what they did.

This historical example is intended to make USUHS students aware that, like all other present and future physicians, they now are and always will be at risk for acting in ways that are morally suboptimal and even unconscionable. They are urged to consider, therefore, how their best protection against behaving in these ways may, indeed, be themselves.

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Edmund G. Howe, MD, JD, is a professor of psychiatry at the F. Edward Hebert School of Medicine of the Uniformed Services University of Health Sciences (USUHS) in Bethesda, Maryland, and is director of the Programs in Ethics. He is a senior scientist at the Center for the Study of Traumatic Stress, USUHS, and the founding editor-in-chief of the *Journal of Clinical Ethics*.

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Journal Discussion

Physician Obligations to Help Document the Atrocities of War

David Boren, MA

Yamada S, Fawzi MC, Maskarinec GG, Farmer PE. Casualties: narrative and images of the war on Iraq. *Int J Health Serv.* 2006;36(2):401-415.

No one seems to dispute the claim that patients should not be filmed in clinical settings without consent. The American Medical Association's *Code of Medical Ethics* holds consent for filming to as high a standard as consent for normal medical procedures [1]. The code does not forbid the filming of patients who give consent before the filming takes place. In the context of full war, one can find countless patients who consent outside hospital settings to being photographed or filmed to illustrate the carnage of which they are victims. In an article in the *British Medical Journal* that condemns the filming of patients without their permission, Jerome Singh acknowledges that there can sometimes be a need to inform the public of atrocities [2]. But Singh argues that the need to inform the public should take a distant second place to protection of patient privacy [2].

By contrast, Seiji Yamada et al. highlight the role of images and narrative in informing the public about the atrocities of war. Their article "Casualties: Narratives and Images of the War on Iraq" further suggests that health care professionals, in particular, have a responsibility to "seek out such accounts and images" [3]. The authors approach the casualties of war from a public health perspective. They call upon physicians to view the death tolls of war as a problem within their professional purview and to respond by acting to alleviate the suffering.

The Case for Physician Activism

The thesis of the article seems reasonable. Article VII of the AMA Principles of Medical Ethics states that physicians should work to improve the public health [4]. War casualties constitute a public health disaster worthy of attention because of the number of people who die or suffer as a consequence. Victims of war suffer a distinctive form of public illness in that they are harmed by the actions of other human beings. The fact that people can be prevented from inflicting harm on others is all the more reason to draw attention to war as a public health problem.

The argument of Yamada et al. in favor of using imagery is appealing, given our tendency to view lives of "the enemy" as disposable. Respect for human life is a value held by nearly all world religions, and it is a principle articulated in Article I of the AMA's Principles of Medical Ethics [5]. Policy makers and their electorate must

be sensitized to every lost life, whether it be military or civilian, and every lost life must be taken into account when decisions about whether to escalate war or to withdraw from it are made. Images—perhaps even more than words—can foster the necessary sensitivity.

In supporting the case for illustrative imagery and narratives, the authors give an historical account of past efforts to sanitize the costs of war by censoring what the American people saw. They discuss the effects imagery had on public opinion of the Vietnam War and make a convincing case that the government acknowledged this effect by limiting media coverage of the two Gulf Wars. This provides context for judging the role images play in public acceptance of war. The authors offer evidence that suppression of stunning visuals perpetuates the ever-rising death toll of wars by encouraging public acceptance and giving politicians the green light to continue. [6] In short, Yamada and colleagues claim, someone needs to stand up against suppression of “evidence,” and they clearly believe that physicians should be among the first to do so. The authors’ expose of the government’s alleged tactics gives activists a concrete way to make a difference by ensuring that the ugly face of war is shown and seen.

A Much Bigger Message

But Yamada et al. want to talk about much more than images. In fact, their title is somewhat misleading. They *really* want to tell doctors and other health professionals *not* that they should document the war in pictures and narrative but that they have a duty to respond to the suffering caused by war specifically and international policy in general. At this point their article shifts from an argument about the power of narrative and photos to a critique of U.S. policy in Iraq, including the 12 years of sanctions that fundamentally damaged the Iraqi infrastructure and caused much loss of life. This narrative-rich section refers to Susan Sontag’s defense of haunting photojournalistic images—those who don’t recognize that suffering occurs have not reached psychological maturity, Sontag says [7]. Our authors add to her judgment by asking rhetorically, ...“might those in public health and medicine...have some additional responsibility to react and act” [8]?

The concluding section suggests three possible responses by health workers—charity, development aid, and social justice. Only the last of these is the “right” response, according to Yamada et al. because offering charity or dismissing a war-ravaged country as a “developing nation” does not place sufficient blame on social injustice as the cause of the catastrophic conditions.

Conclusion

While the approach taken by Yamada et al. may subordinate the article’s argument for the persuasive power of narrative and images to a plea for physician social activism, it raises several issues that are important to contemporary biomedical ethics. Pictures can provide much information if they come from different sources, that is, points of view. Furthermore, physicians are undoubtedly in a position to make a difference—even if their exact role vis-a-vis the narrative and images they

hear and see has yet to be comprehensively defined. As military technology becomes more advanced and the threat of terrorism continues to make headlines, our leaders and electorate may face difficult decisions, including where, when, and whether to go to war. Every time we decide to go to battle, we must have a full account of the carnage. If we make a wrong decision, full information will help us to right the wrong. The essential starting point is a factual picture of the situation. As custodians of society's health, physicians should be the first people to demand it.

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David Boren, MA, is a medical student at University of Illinois College of Medicine, Chicago. He was a summer intern at American Medical Association's Council on Ethical and Judicial Affairs in 2007.

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Clinical Pearl

A New Focus on Caring for Survivors of Extreme Violence

Richard F. Mollica, MD, MAR

Major depression and post-traumatic stress disorder (PTSD) are two of the most common psychiatric disorders associated with life experiences of violent conflict [1]. Extensive research has demonstrated a high prevalence of these disorders in combat veterans, survivors of torture, and civilian populations traumatized by mass violence. These diagnoses are well known, and their signs and symptoms are clearly defined in the *Diagnostic and Statistical Manual, 4th Edition (DSM-IV)* [2]. Yet despite the availability of explicit diagnostic criteria, persons who have experienced extreme violence are often poorly diagnosed and treated. Based on 25 years of clinical experience caring for patients traumatized by extreme violence, I believe the reasons for most poor care are related to three problems in clinical diagnosis and treatment: neglecting the trauma story, misuse of the psychiatric diagnosis, and overlooking the patient's natural resiliency.

Problem One: Neglecting the Trauma Story

It took me two decades to learn that obtaining the trauma story should have top priority in caring for patients affected by extreme violence [3]. Unfortunately, this principle is often neglected by the health professional who is afraid to listen to the suffering of the patient in detail, especially if he or she has no treatment plan or experience caring for these patients.

The trauma story is easier to obtain than most clinicians imagine. They simply need to ask the patients what traumatic events have occurred in their lives. If a trusting relationship has been established with the patient, he or she will readily respond with the story. It is unusual for patients to be overcome with grief and pain; they almost always retain emotional control. Many clinicians feel they cannot ask about the patient's traumatic life history because they only have a few minutes with their patients. Patients appreciate time limitations and titrate their stories to fit within the allotted time. Clinicians should thank their patients for their revelation of painful life events and pick up the story where the patient left off during the next visit. (Good record-keeping will facilitate this process.) In our clinic, this slow process is called "a little, a lot, over a long period of time." The clinician should not rush. In fact, some stories are so emotionally disturbing that revealing them over time is less traumatizing and more therapeutic. In almost every case, the patient is extremely grateful that the clinician has listened to the story.

Problem Two: The Misuse of Psychiatric Diagnoses

The trauma story sets the clinical stage for the patients' medical and psychiatric diagnoses and treatment. But the diagnosis of PTSD in, for example, an Iraqi civilian or an American soldier fighting in Iraq tells the clinician little about the psychological, social, spiritual, or medical problems related to violent events. The diagnoses of PTSD and depression can obscure the specific symptoms that are contributing to the patient's suffering. Most patients do not have the full PTSD diagnostic profile, nor do they meet all diagnostic criteria—but they are still suffering, and their psychological and physical pain are most likely affecting job performance and social relationships. So the next step is to discover each patient's specific symptoms.

We seek to identify the presence of nightmares and insomnia and treat these disorders in addition to the major symptoms of depression, intrusive thoughts and memories, and hyperarousal associated with PTSD. In our experience, the symptom clusters associated with the major diagnoses need to be individually evaluated and then treated if necessary. Rarely does a single medication or counseling approach relieve the pain caused by extreme violence. The trauma story, then, points the clinician in the direction of the psychological, social, and spiritual dimension of the trauma-related illnesses that need to be addressed. This approach also allows for the cultural aspects of symptom expression and health-seeking behavior to be entered into the therapeutic equation [4].

Problem Three: Overlooking Patient Resiliency

The recently published treatment approach for traumatized persons (see suggested reading) focuses on reinforcing the patient's resiliency and existing coping strategies and the enormous self-healing capacity of survivors of extreme violence [5]. It has been scientifically demonstrated that, at the time violence strikes, a biological, psychological, social, and spiritual self-healing response is activated that often leads to recovery without the help of health professionals. For some, partial relief from suffering leads to care-seeking within the health care system. Unfortunately, many clinicians do not appreciate the effort that patients have already put into their rehabilitation and recovery. In the days before modern medicine, self-healing was a major therapeutic force in the care of sick human beings. Ancient physicians knew how to work with the natural healing forces that begin after an injury or an illness, which they described with the term, *vis medicatrix naturae*.

Building on the care that has taken place between trauma survivors and healers, a clinical reform that relies upon scientific and culture-based evidence is now well advanced. Four simple questions summarize this therapeutic reform and provide a guide to the healing process. The patients' answers reveal what is being done and what still needs to be done in the recovery process. The questions are:

1. What traumatic events have happened?
2. How are your body and mind repairing the injuries sustained from those events?

3. What have you done in your daily life to help yourself recover?
4. What justice do you require from society to support your personal healing?

Mental health professionals, and indeed all health professionals, should use these questions in their treatment of traumatized persons. The fourth question often surprises clinicians because they have failed to appreciate the deep injustices associated with traumatic life experiences, especially during times of conflict. Justice is a major concern for victims of manmade violence and needs to be addressed clinically, even if the therapist is in no position to right a wrong or punish an aggressor.

After a quarter of a century addressing the identification and treatment of survivors of extreme violence, I am sure that we can confidently tell our patients who feel hopeless and full of despair at the beginning of treatment that they can and will recover. This prognosis is more than an opinion; it is based upon scientific evidence.

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Suggested Reading

Mollica RF. *Healing Invisible Wounds: Paths to Hope and Recovery in a Violent World*. Orlando, FL: Harcourt; 2006.

Richard F. Mollica, MD, MAR, is a professor of psychiatry at Harvard Medical School in Boston, and director of the Harvard Program in Refugee Trauma.

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October Contributors

Brian S. Carter, MD, is a professor of pediatrics (neonatology) at Vanderbilt University and co-director of the pediatric advance comfort team at Vanderbilt Children's Hospital, both in Nashville, Tennessee. He is a former U.S. Army lieutenant colonel and served as a brigade surgeon in the first Gulf War. He has written on medical ethics generally and is co-author of a chapter entitled "Physician-Soldier: A Moral Profession," in *Military Medical Ethics*, an Army textbook.

Michael L. Gross, PhD, is chair of the Department of International Relations at the University of Haifa in Israel. His recent publications include *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* (MIT Press, 2006).

Edmund G. Howe, MD, JD, is a professor of psychiatry at the F. Edward Hebert School of Medicine of the Uniformed Services University of Health Sciences (USUHS) in Bethesda, Maryland, and is director of the Programs in Ethics. He is a senior scientist at the Center for the Study of Traumatic Stress, USUHS, and the founding editor-in-chief of the *Journal of Clinical Ethics*.

Mark A. Levine, MD, is an associate professor of medicine at the University of Colorado in Boulder and active in its Center for Bioethics and Humanities. He is the Centers for Medicare and Medicaid Services' Region VIII chief medical officer. Dr. Levine is a member of the oversight body of the American Medical Association's Ethical Force Program, was elected to the Council on Ethical and Judicial Affairs in 2001, and is the current chair of that council.

Justin M. List, MAR, is a third-year student at Loyola University Chicago Stritch School of Medicine. A former fellow at the Institute of Ethics at the American Medical Association and previous editor for Yale University's Interdisciplinary Center for Bioethics, he recently wrote the chapter "Medical Neutrality and Political Activism: Physicians' Roles in Conflict Situations" in the forthcoming volume *Physicians at War: the Dual Loyalties Challenge*, edited by Fritz Allhoff.

Richard F. Mollica, MD, MAR, is a professor of psychiatry at the Harvard Medical School in Boston, and director of the Harvard Program in Refugee Trauma at Massachusetts General Hospital.

Yishai Ofran, MD, is a senior hematologist at Rambam Medical Center, a unit of the State of Israel's Ministry of Health in Haifa. He recently started a two-year research project at the Dana Farber Cancer Institute in Boston. Dr. Ofran did his

residency in internal medicine at Hadassah Medical Center, Mount Scopus Hospital, Hebrew University in Jerusalem. He also serves as a military doctor in a reserve parachutist brigade in the Israel Defense Forces.

Wendy Orr, MD, is a consultant in change management, transformation, and diversity in Johannesburg, South Africa. She served as a commissioner on the Truth and Reconciliation Commission of South Africa, investigating the human rights violations of the apartheid era.

Hernan Reyes, MD, is medical coordinator of the Health in Detention program for the International Red Cross in Geneva, Switzerland. His specialty is obstetrics and gynecology. For more than 20 years he has been involved with prison health issues and has written extensively on the subject.

Gary Schwartz, MD, is a second-year surgery resident at St. Luke's-Roosevelt Hospital Center in New York, New York. His areas of interest include minimally invasive gastrointestinal surgery and surgical oncology.

Stephen N. Xenakis, MD, is an adjunct clinical professor at the Uniformed Services University of Health Sciences and has an active clinical and consulting practice. He is a brigadier general (retired) in the United States Army Medical Corps who served in various positions of responsibility over 28 years. He is actively engaged in developing applications of quantitative electroencephalography (qEEG) for primary care clinicians.

Robert J. Walter, DHCE, is completing his fourth year at Loyola University Chicago Stritch School of Medicine. A recipient of the Armed Forces Health Professions Scholarship Program, he holds the commission of a 2nd Lieutenant in the U.S. Army Medical Service Corps and plans to pursue an Army residency in internal medicine. Robert received his doctorate in health care ethics from Duquesne University in 2004.

Staff Contributors

Lee Black, LLM, is a senior research associate for the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago. Prior to joining the AMA, he was a staff attorney with the Legislative Reference Bureau in Springfield, where he drafted legislation for the Illinois General Assembly.

David Boren, MA, is a medical student at University of Illinois College of Medicine, Chicago. He was a summer intern at American Medical Association's Council on Ethical and Judicial Affairs in 2007.

Theme Issue Editor

Lhasa Ray is a fourth-year medical student at Albert Einstein College of Medicine in New York City, and a second-year master's student in Einstein's Clinical Research Training Program. She is a recipient of the American Federation for Aging Research Summer Fellowship, and has conducted research in under- and overtreatment of the elderly, palliative care, and metabolic causes of cognitive change. She is applying for internal medicine residency programs, and intends to specialize in critical care.

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Health Law

Informed Consent in the Military: The Anthrax Vaccination Case

Lee Black, LLM

I understand that many laws, regulations, and military customs will govern my conduct and require me to do things under this agreement that a civilian does not have to do [1].

The legal doctrine of informed consent stems primarily from the right to protect the sanctity of one's body from the intrusion of others. It means that patients must be told of risks and benefits of medical treatment and must give their consent prior to receiving treatment. The idea of consent to treatment, virtually nonexistent a century ago, has become entrenched to the point that consent is now mandatory in most circumstances. During this time, experience has shown how essential consent is, especially in medical research. Today, printed consent forms are common, and patients have recourse to the courts when informed consent procedures are not followed.

Life in the military operates under a somewhat different set of rules. Understandably, demands made of the military exceed those made of civilians, and the requirement to protect the sanctity of a soldier's body is not equivalent to the requirement to protect that of a civilian; at least, that is the presumption espoused by the armed forces' enlistment document quoted in the headnote to this article. Along with increased duties and heightened risks, members of the military face lowered requirements for informed consent to medical treatment.

The Anthrax Vaccine

The original statement of the military's anthrax vaccination program (Anthrax Vaccine Immunization Program or AVIP) mandated (i.e., no consent was required or requested) inoculation using a vaccine that had been approved by the Food and Drug Administration (FDA) roughly three decades before this program began. Following the establishment of the program by a memo from the Secretary of Defense in 1997, questions arose about the proper use of vaccinations and whether service men and women were placed at undue risk without their informed consent.

According to the FDA, the anthrax vaccine's efficacy was established in a 1950s study of animal hide workers, having been developed to protect them from cutaneous anthrax—contracted through skin exposure. The licensing of the vaccine was based on this form of the disease [2]. The vaccine was estimated to be nearly 93 percent effective [3].

But the military sought to protect its soldiers against anthrax contracted through inhalation (not skin exposure), a more potent form of the bacterium [4]. Although the original study of the vaccine indicated that it afforded protection to both forms of anthrax, the limitations of that study had been acknowledged (there were only five cases of inhalation anthrax in the study, versus 21 cases of cutaneous) [3].

Soon after the AVIP was initiated, soldiers began complaining of side effects, many of which were debilitating to the point that some were unable to perform their duties. Some refused the vaccination and were sanctioned or threatened with discharge or other punishment that could negatively affect their careers. Those who complained of side effects also faced discipline, leading one soldier to sue the military for a violation of free speech rights [5].

Following complaints at Dover Air Force Base (DAFB), Colonel Felix Grieder suspended the vaccination program and later said that the vaccines provided at DAFB contained squalene, a substance known to cause the side effects experienced by soldiers at Dover. Squalene was used to increase the effectiveness of vaccines [6]. A survey completed by members of one unit at DAFB who had been vaccinated showed a much higher-than-average incidence of more serious side effects (32 percent), such as severe joint pain, memory loss, and arthritis, than those experienced at other military installations.

Due to myriad problems cited by those vaccinated, and the military's continued insistence that the vaccine was safe, the United States General Accounting Office (GAO) performed its own survey of National Guard and Army Reserve members [7]. The results of the GAO survey were consistent with the survey performed at DAFB: the rate of adverse events was significantly higher than what was stated in the vaccine product insert [7].

In addition to this higher rate of adverse events, the GAO survey found that a large percentage of members were dissatisfied with or did not believe the information provided them concerning AVIP. It is probable that the morale of the guard and reserve units was more greatly impacted because their consent was not sought. The GAO survey circumstantially indicated, however, that had consent to the vaccination been required, most unit members would not have been vaccinated, thereby defeating the stated purpose of the AVIP.

Due to the large number of adverse reactions, the response of the military to complaints, and medical problems leading to inability to perform duties, the judicial system eventually became involved.

Suing the Military

It is, in general, difficult to sue any government entity, including the military. The government limits its liability through the doctrine of sovereign immunity, which prevents citizens from suing the government without its consent. One of the few

paths for grievances is through the Federal Tort Claims Act, a limited exception to immunity. Court decisions have further restricted the liability of the military. A number of lawsuits have been filed, however, seeking to protect the rights of service members. Since informed consent is not required for service members when treatment is approved by the FDA, the primary argument was that the use of anthrax vaccination was experimental. This legal theory also had the effect of bypassing limitations on the ability to sue the government.

The military is constrained by law when seeking to require members to participate in experimental treatment or use of a drug “unapproved for its applied use.” Notice must be provided containing certain information about the treatment [8], and consent must be obtained in accordance with the federal Food, Drug, and Cosmetic Act [9]. After more than three decades of use, the vaccine itself was not experimental. But the vaccination used by the military had been approved by the FDA for cutaneous exposure to the disease, whereas AVIP was intended to protect the troops from inhalation anthrax, and many raised the question of whether the vaccine was effective against that form and whether the military could mandate inoculation.

Six service members sued the Secretary of Defense, Secretary of Health and Human Services, and the Commissioner of the FDA under the theory that the anthrax vaccine was experimental when used to protect against inhalation anthrax. A federal court agreed and suspended the vaccinations unless informed consent was obtained or the president waived the consent requirement (which he never did).

Very quickly after that order, the FDA announced a final rule classifying the vaccine as “safe and effective ‘independent of the route of exposure’” [10]. The plaintiffs again challenged the vaccination program, arguing that the FDA had failed to obtain public comments prior to approving the vaccination to protect against inhalation anthrax. Had the FDA permitted time for public comments, the plaintiffs noted, they and others would have offered additional studies and other evidence that the vaccine should not be approved for inhalation anthrax.

The federal district court again agreed with the service members—the FDA’s previous practice for final rules dictated a public comment period, especially since it had been 18 years since it last solicited comments on this matter. The court enjoined involuntary inoculations:

...unless and until FDA follows the correct procedures to certify AVA [anthrax vaccine absorbed] as a safe and effective drug for its intended use, defendant DoD may no longer subject military personnel to involuntary anthrax vaccinations absent informed consent or a Presidential waiver [11].

The court also applied the injunction to all members of the military, not just the six plaintiffs in the case.

The court's order in *Doe v. Rumsfeld* established a public record about the vaccine and its history. The vaccine that the Department of Defense was attempting to require through its AVIP was "intended solely for immunization of high-risk of exposure industrial populations such as individuals who contract imported animal hides, furs, bone meal, wool, hair...and bristles" along with "laboratory investigators handling the organism" [12]. This vaccination was meant solely for a limited high-risk population, not the widespread inoculation envisioned by the AVIP.

AVIP Today

Although the AVIP was enjoined in 2004, that court order did not mark the end of the program. In 2005, the injunction was modified at the request of the government [13]. The FDA had not yet approved the vaccine for its intended use, but a law was enacted in 2004 that permitted "Emergency Use Authorization," which allows unapproved use of a drug by the military based on a determination of a military emergency involving a heightened risk of attack with a biological agent.

Today, the AVIP is mandatory for service members serving in certain areas and voluntary (and encouraged) for others. The military's AVIP web site provides information on the vaccine as well as on the threat of biological attack. It maintains that the vaccine is "safe and effective," and links to studies and other educational resources [14].

The modification of the injunction against mandatory inoculation did not settle challenges to vaccine uses that were based upon its experimental nature and the legality of emergency use authorizations. The lawsuit of *Doe v. Rumsfeld* is ongoing.

Informed Consent in the Military

If a soldier refuses a mandated anthrax vaccination, he or she may be demoted, discharged, or even imprisoned for disobeying an order. In the military, there are valid arguments for providing certain treatments without consent, where either the health of the individual or of the whole is at stake. And while it is true that the armed forces are exempt from many rules that govern the conduct of private citizens, to require treatment known to have a relatively high incidence of side effects tests the limits of these arguments. Is there a point at which the risk to a person is so great that informed consent can never be waived? This question may be answered if and when *Doe v. Rumsfeld* is decided.

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Lee Black, LLM, is a senior research associate for the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago. Prior to joining the AMA, he was a staff attorney with the Legislative Reference Bureau in Springfield, where he drafted legislation for the Illinois General Assembly.

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Policy Forum

Force-Feeding and Coercion: No Physician Complicity

Hernan Reyes, MD

In the past 24 months, the issue of hunger strikes has discreetly yet persistently made headlines and stirred up discussions among ethicists and medical doctors alike [1]. The World Medical Association (WMA), which was created after the Second World War to ensure the independence of all physicians and to promote and achieve the highest possible standards of ethical behaviour and care, saw fit to re-examine and update its 1991 Declaration of Malta on Hunger Strikers in October 2006 [2]. There were several reasons for this review, some related to the evolving nature of hunger strikes, and others related to the way they were being managed by medical staff in certain situations. Many publications have dealt with one or another aspect of these issues. This paper will attempt to explain to physicians not overly familiar with the issue of hunger strikes how and why the WMA chose to revise and upgrade its declaration. The return to force-feeding was one of the main reasons for the WMA's taking a second look at the ethical principles that apply to voluntary fasting.

Hunger strikes, more correctly termed “voluntary protest fasting,” made headlines several times in the last two decades of the 20th century. The first time, closely watched by the media, involved prisoners in Belfast, Northern Ireland. Bobby Sands, a militant of the Irish Republican Army, and nine other Irish prisoners, all members of republican paramilitary or political organizations, starved themselves to death in 1981, to protest the nonrecognition of their status by the government of the United Kingdom. At the time, the medical staff of Northern Ireland prisons had only the WMA 1975 Declaration of Tokyo for ethical guidance. That declaration aimed principally at forbidding physician participation in torture, but contained a proviso on hunger strikes. The declaration stated that, “Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially...” [3, 4]. The wording “artificially” here was meant to refer to the use of force in feeding a hunger striker via nasogastric tubing or intravenous administration of nutrients. The use of “artificially” instead of “forcibly” was due to imprecise word choice and did not convey clearly enough that feeding applied forcibly was what was proscribed. It further confused the issue by making it seem that any form of artificial feeding was forbidden.

Hunger strikes in Africa and Asia in the years following the 1981 Belfast strikes raised the need for more guidance for physicians. Because the Declaration of Tokyo mainly dealt with physician (non-) participation in torture, it was obvious that a new

declaration had to be drawn up exclusively on voluntary fasting outside of torture-related contexts. This process led ultimately to the Declaration of Malta.

There were other issues at stake as well. Following the Belfast hunger strikes, during which the prisoners only ingested bottled water and no nutrients whatsoever, comparison was inevitably made with politically motivated fasting among prisoners in other contexts, notably in the Middle East and Latin America. In those contexts, the fasting was very often not “total,” and “cheating” (i.e., eating on the side and “on the sly”) was a rampant phenomenon. Those bouts of fasting were often “food refusals,” rather than “voluntary total fasting,” in the sense that those who declared themselves openly “on hunger strike” had not the slightest real intention of hurting themselves in any way, counting instead on the prison doctors to take care of them [5]. Other cases involved determined fasting, but not in a very convincing way, and certainly not with the intention of “going all the way.” In all these cases, there were usually no problems for physicians, as the different types of “fasting” never went on long enough to provoke clinical concerns, let alone any ethical dilemma related to force-feeding or any other forced medical intervention.

Another major clarification was needed to differentiate hunger strikes from suicide. The Irish hunger strikers certainly did not want to die; they wanted to obtain recognition for and solutions to their demands, and they were willing to sacrifice their lives to that purpose if need be. Hunger strikers are not suicidal—as a matter of fact, detainees who are depressive or who have suicidal tendencies should be handled as medical cases and not considered to be hunger strikers [6].

From the late 1990s through 2002, hunger strikes in Turkey made headlines and added a new twist to “fasting for politically motivated reasons” [7]. The Turkish hunger strikers, it quickly became evident, did take some nourishment “on the side,” but this was only to prolong their time for negotiation. As it turned out, they died anyway, because their demands were not met, but they died from prolonged non-total fasting. Thus, fasting did not necessarily have to be total to be fatal, and the difference between those who, since Bobby Sands, were considered as “real hunger strikers” and those who engaged in “phony fasting” was no longer valid.

Whether the fasting was truly voluntary did however become an issue. The hunger strikes in Turkey were often collective, and it was not always clear whether those who were fasting were indeed volunteers, or if they were somehow “volunteered” by whatever internal prisoner hierarchy was in place.

The 1991 version of the Declaration of Malta had taken all these factors into account, notably stressing the fact that physicians should ascertain that each hunger striker was fasting voluntarily and not being coerced by other prisoners or indeed any outside party, including family. Malta did not, however, explicitly forbid force-feeding, since, at that time, force-feeding had not emerged as a major issue. In fact, after an unfortunate mishap in the Middle East in the early 1980s, which resulted in the death of two prisoners who were forcibly fed liquid nutrients unintentionally into

the trachea rather than the esophagus, force-feeding had practically disappeared from the political scene. Resuscitation of a patient was considered, whereby the physician could intervene and “feed artificially” [8] a hunger striker who was lapsing into a semicomatose state, if the physician was convinced that the hunger striker did not, in fact, want to die. In such a case, this would obviously constitute “artificial” and not “force-” feeding, as active resistance by the hunger striker was ruled out by his or her noncompetent, or unconscious, state.

The advent of force-feeding in the new century, in the context of hunger strikes that, although clearly politicized, just as clearly involved a situation of conflict and protest, made it necessary to clarify and revise the whole concept of artificial feeding and force-feeding. Inasmuch as force-feeding obviously involved coercion, and since the situations of those hunger strikers to be force-fed was already one of constraint and coercion—in some cases even of torture—the concept of force-feeding understandably came under close scrutiny and criticism from many angles. Those in charge in different countries who decided to force-feed, often justified their action by calling it “artificial feeding” and implying or outright declaring, that the prisoners in fact tacitly agreed to be fed enterally by nasogastric tubing.

A working group was constituted at the request of the WMA that elaborated a new version of Malta in 2006, explicitly forbidding force-feeding. The principle of respect for patient autonomy was found to overrule, in this case, the principle of beneficence. Hunger strikes are a “last resort” way of expressing protest or dissent in situations of coercion, and it was felt that respect for patient autonomy in such cases overruled mere beneficence. Hunger strikers should not be force-fed. The revised declaration clearly forbade the use of force-feeding, assimilating it to “inhuman and degrading treatment,” that is “never ethically acceptable,” but at the same time allowing leeway for the physician to resuscitate an individual who might have lapsed into unconsciousness. The declaration stressed, however, that artificial feeding, usually meaning intravenous fluids, (but could arguably also mean feeding by nasogastric tubing) when freely accepted by the hunger striker, was indeed a way to gain time and thus to save lives while respecting the dignity and rights of the hunger strikers involved.

The problem remains that even the new 2006 version of the Declaration of Malta is just that—a declaration, and thus part of what is called “soft law.” Although most states respect such guidance from the World Medical Association, some states refuse to abide by it on the grounds that it is not part of any “treaty” their government has signed, let alone ratified. This, of course, is beside the point. WMA declarations are not treaties; they are internationally recognized guidance on ethical principles by a respected organization with a track record dating back to the worldwide rejection of the grave violations of medical ethics during World War II. The medical associations of more than 80 countries have adhered to the World Medical Association’s guidance—including those of many of the countries whose nonmedical authorities do not accept WMA guidance on issues such as hunger strikes. It takes a strong and active national medical association to challenge such unethical behaviour and

support those physicians caught in a situation of dual loyalties—on the one hand, wanting to follow WMA recommendations; on the other, being instructed by their government to do otherwise. This in itself is very serious. Force-feeding ordered by a higher authority will, of necessity, need the participation of physicians.

The Declaration of Malta does not forbid resuscitation, which can be fully justified in certain situations. It envisages the saving of a hunger striker's life when there is doubt as to his proclaimed intentions to fast "until the end." There have been recent, highly politicized cases of hunger strikers, who, while loudly and vehemently claiming they wanted to keep fasting "to the bitter end" if necessary, had not the slightest intention of dying and were merely in a complex relationship of manipulation and a sort of "blackmail" situation. The clinical physicians taking care of these "hunger strikers" were fully convinced they did not in fact want to die, and in each case they were prepared to resuscitate if and when there was medical necessity for such treatment. In several cases, the hunger strikers simply stopped fasting once their demands had been met.

Physician participation in the actual repeated and regular force-feeding of hunger strikers who clearly refuse any nourishment as their way of protesting, be it against their living conditions or against the way they are treated, is a violation of the guidance stipulated in Malta. This could be construed as medical complicity in what Malta calls "inhuman and degrading treatment." The resort to hunger strikes has been portrayed in the media as a form of asymmetrical warfare or as "blackmail," which is not to be allowed [9]. In situations where protest fasting is clearly a detainee's way of remonstrating against mistreatment of prisoners, it raises the question of whether Tokyo rather than Malta should be applied. In Tokyo, artificial feeding was specifically prohibited so that prisoners who were being ill-treated or tortured, and protesting with the only means at hand—the hunger strike—would not be restored and reinvigorated by artificial feeding only to be sent back to their situation of torture [10]. Many states declare they do not practice torture and that, therefore, the suggestion that Tokyo applies rather than Malta is not valid. Whatever the situation, force-feeding qualifies as a form of inhuman and degrading treatment, according to the World Medical Association, and is just as illegal as torture in international law. The 2006 version of Malta also clearly states: "It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will" [2].

In the overwhelming majority of hunger strikes (voluntary protest fasting), the strikers do not want to die but are using the only means of protest they feel they have left to them. It could be argued that there are some hunger strikers who do want to die, seeing their situation as hopeless and wanting to make the most of their protest. It can equally be argued that submitting such strikers to weeks, or even months, of force-feeding may well be part of the overall hopeless situation they see themselves in. In such cases force-feeding is indeed a form of inhuman and degrading treatment and fuels their desperation. Physicians should not be involved in coercive procedures, as it makes them complicit in the overall situation of torture or other ill-

treatment. Inhuman and degrading treatment is, in international law, as “illegal” as torture is. There is no place for physicians in force-feeding.

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Hernan Reyes, MD, is medical coordinator of the Health in Detention program for the International Red Cross in Geneva, Switzerland. His specialty is obstetrics and gynecology. For more than 20 years he has been involved with prison health issues and has written extensively on the subject.

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Policy Forum

Role of Physicians in Wartime Interrogations

Mark A. Levine, MD

In the debates by individuals and professional organizations about the role of physicians in wartime interrogations, the argument is often made that interrogations are going to take place and abuse is likely to occur. Given those facts, the argument goes, isn't it better that physicians be present to serve in a watchdog role? The *AMA Code of Medical Ethics* says no, and prohibits this role [1]. Let us explore the rationale for the prohibition, starting with the AMA's Principles of Medical Ethics.

The preamble to those principles states,

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self [2].

Clearly then, a physician has recognized responsibilities to the patient and to society. Does honoring the societal responsibility allow a physician to participate in interrogation and, if so, to what extent?

The first of the nine AMA Principles of Medical Ethics speaks to the primary duty mentioned in the preamble by stating, "A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" [2]. This clearly places the physician in the role of patient protector. Why doesn't this justify a protector role for physicians during an interrogation? Some have argued that physician monitoring may prevent harm by identifying an interrogation's humane limit. The answer is that the physician serving in this role would be violating another essential component of the profession's role—that of trust.

Physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups and to advocate for their patients' welfare are essential to development of the trust that is the foundation of the patient-physician relationship [3]. Patients must have trust that their physicians will hold their best interests foremost. A physician who is present during the interrogation is there to represent the state (or other authorities) in their carrying out of the interrogation. How can a patient's trust be maintained under this circumstance? The person being interrogated would certainly be reluctant to share potentially relevant

clinical information with the physician for fear that it would be used against him. Thus, whatever potential benefit might have accrued would have come at the expense of patient trust and potentially at the expense of that interrogee's health and well-being. For this reason alone, the physician should not take part in any way as an agent of the interrogators. The physician must understand that being present during interrogation undermines his or her commitment to put the patients' best interest above all else and, recognizing this, must not be present.

But, some would say, cannot the physician's presence prevent abuse because interrogators know they will be reported if they cross the line? Certainly that would be in an interrogee's best interest, right?

In fact, the opposite appears to be true. Some literature suggests that subjects are more likely to inflict greater harm under supervision [4]. And besides, this places the physician-monitor in the role of allowing or—at the least—appearing to allow the interrogators to continue the abuse if the limit has not yet been reached. Is this primarily for the benefit of the patient? Is it demonstrating a responsibility to the patient first and foremost? And is this competent medical care provided with compassion and respect for human dignity and rights?

The AMA's *Code of Ethics* is very clear in outlining the appropriate duties of a physician in interrogation settings [1]. These are:

1. Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.
2. Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
3. Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
4. Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.
5. When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.

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Mark A. Levine, MD, is an associate professor of medicine at the University of Colorado in Boulder, and active in its Center for Bioethics and Humanities. He is the Centers for Medicare and Medicaid Services' Region VIII chief medical officer. Dr. Levine is a member of the oversight body of the American Medical Association's Ethical Force Program, was elected to the Council on Ethical and Judicial Affairs in 2001, and is the current chair of that council.

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Medicine and Society

The Physician as Healer, Citizen, and Soldier

Brian S. Carter, MD

Physicians have long been acknowledged, recognized, and sought after not only for their skills and knowledge as healers, but also for their contribution as involved citizens and advocates for social justice, order, and the public good. In many societies, physicians hold esteemed leadership roles and political offices. Examples from abroad include numerous physician leaders in Asia, Africa, and the Middle East, as well as the former Prime Minister of Norway, Dr. Gro Harlem Brundtland, who served in that capacity for over a decade and thereafter became the World Health Organization's director-general. In the United States, where one of the signatories to the Declaration of Independence was physician, soldier and statesman Benjamin Rush, relatively few physicians are seen in the most prominent levels of government or political leadership today. Although there were 17 physicians in the 109th Congress, one can question their effectiveness, as most downplayed their medical backgrounds [1]. Two prominent exceptions are Howard Dean, MD, former governor of Vermont and current chairman of the Democratic National Committee, and William Frist, MD, the former Republican U.S. Senator from Tennessee.

While the history behind the apparent division of personal, professional, and public lives and their respective loyalties is beyond the scope of this paper, it is important to note that many physicians are conscientious citizens who function in broader circles than those of health care. Many have served in some governmental capacities — whether in the uniformed services (U.S. Public Health Service or military branches), the Indian Health Service, in appointed office, and, less often, in elected office. That physicians might find themselves advocating for a good greater than that of their individual patient's well-being should not come as a surprise, since they are educated and equipped to study diseases and other threats to public health. These same physicians, in academia, industry, and government have the collective wisdom to offer public policymakers and politicians solutions aimed at disease prevention and control and disaster relief. Many real world experiences that have contributed to the advance of this wisdom come in times of national conflict and war.

Physicians who serve their country in the uniformed services are frequently asked how they can justify being in an organization—the military—that uses lethal force. Does the use or the threat of violence to meet the military's professional responsibilities pose an absolute moral barrier for physicians? No. Force may be employed by individuals engaged in self-defense or criminal activity, or used more broadly by societies for protection as well as offense (police and military forces). I

would argue that all use of force is not immoral. Furthermore, military physicians and the uniformed health care workers under their command are referred to by the Geneva Conventions as “noncombatants.” As such, they may not become involved in offensive military actions, although they may act to defend themselves and their patients in circumstances of attack.

The profession of medicine and the military profession provide society with essential services: health care and security. While they have different ends and utilize different means, their ends are compatible and mutually supportive—especially in times of national defense or armed conflict [2]. Without security, neither individual citizens nor society can benefit from the profession of medicine and the healing arts. This can be seen in present-day Iraq where many in medical training have left the country because they cannot practice amid the constant duress of political turmoil, civil unrest, and a lack of security. The physician in uniform in time of war is simply meeting his or her responsibility to protect society and its values with special (and greatly needed) expertise.

Nor are the potential role conflicts unique to military physician. Civilian doctors face conflicts between the interests of individual patients and those of society. The reporting to state authorities of infectious diseases that threaten the public welfare is but one example of the dual responsibility physicians have to individual patient welfare and the public good. Another example occurs when, in the course of managing a psychiatric patient, the physician learns that the patient threatens harm to self or others. This knowledge compels the physician to breach otherwise strict adherence to patient confidentiality. For military physicians, obvious conflicts occur between the duty to keep patient information confidential and the safety of others.

While serving as a medical company commander and brigade surgeon in wartime, I was asked by a military commander to estimate the dates on which some female soldiers who were being redeployed to the United States had become pregnant. Their pregnancies warranted their leaving the combat theater of operations, but the specific knowledge of when and where they had become pregnant was not essential to the administrative action. My taking a stand to preserve the female soldiers’ confidentiality was ultimately respected by the commanders, though it did cause some friction and required education on ethical conduct for all concerned.

Like his civilian counterpart in these cases of perceived and real conflict, a military physician must balance responsibility to the patient with responsibility to the greater good—be that the general public health or the health of the military unit and the people affected by it. While it may not be the military physician’s prerogative to derive an operational mission plan or to set policy based upon political alignment, it is his or her responsibility to point out where plans and policies encroach on humane treatment of persons and patients in an area of military operation. Military physicians in administrative, command, or advisory capacities can contribute to the avoidance of injury, human maltreatment, and unnecessary force and so effect a principle of conservation in respecting, preserving, and protecting human resources.

This is a basic principle of military action, the conservation of force. It serves as a justification for joining the professions of medicine and the military together in wartime. It is a model for explaining the necessary value of physicians serving in the military. Soldiers are both resources to accomplish an assigned mission and human beings, sons and daughters, mothers and fathers, husbands and wives of the society that has sent them to war. If we do not act to conserve them, we may lose the society that sent them into harm's way [2].

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Brian S. Carter, MD, is a professor of pediatrics (neonatology) at Vanderbilt University and co-director of the pediatric advance comfort team at Vanderbilt Children's Hospital, both in Nashville, Tennessee. He is a former U.S. Army lieutenant colonel and served as a brigade surgeon in the first Gulf War.

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Medicine and Society

Physician-Soldier

Gary Schwartz, MD

The seasoned and effective soldier and doctor are similar in one respect—they share a keen sense of intuition honed by years of experience. The professional who succeeds on the battlefield and in the wards applies insight that is not teachable even in the best of training facilities, only learnable by rigorous life experience.

But these professional roles differ from each other in many ways, so much so that some have questioned whether serving in both professions at the same time is ethically possible. Might doing so even be reproachable? Are physicians, given their duty to preserve and restore physical and mental health, obligated to attempt to banish war and warriors from the earth? As defenders of health and human life, ought physicians be held responsible for promoting—if not guaranteeing—the prevention of injury? If so, this should exclude their participation in or support of war in any form.

Intuitively, this argument appears sound. The physician's professionally imposed obligation to heal entails a duty to prevent injury when possible, a duty obviously violated during times of war. The principle of prevention of harm can be seen either as an extension of the obligation of beneficence included in the Hippocratic Oath or as a separate and superior obligation—in fact, the modified Hippocratic Oath taken by the majority of physicians in this country includes the clause “I will prevent disease whenever I can, for prevention is preferable to cure” [1].

But this argument assumes that the ethical obligation to heal (do good) necessarily entails an obligation to prevent harm, an obvious example of which is war. In reality, doing good (beneficence) and preventing harm (maleficence) are not always compatible ends, and conflict with each other at times.

The tension between the principles of beneficence and nonmaleficence is not always obvious in the one-on-one clinical encounter. Proposed treatments for a given patient can usually be predicted to either benefit the patient or do harm. Even here, though, there are instances in which an intervention may cause both good and harm and the benefits and risks must be weighed before a treatment decision is made. When more than one individual is involved, the balancing and decisionmaking become more complicated. The principle of promoting the *greater* good clashes with the intent to prevent *individual* harm. In general, the former, utilitarian approach is deemed the more practical, since qualitative “good” is quantified by considering the number of

individuals affected, and the action that benefits most often becomes the ethically endorsed action.

In the case of war, individual rights are frequently violated in the interest of the greater good. Examples here range from the restrictions on individual rights that soldiers accept upon joining the military, to the deprivation suffered by families of dead soldiers, and restrictions placed on supplies available to civilians. While unjustifiable militant action is obviously morally reprehensible, these infringements of individual rights for the potential benefit of many may be justifiable and even warranted.

The distinction between the good of the individual and the good of the many applies to the question of the physician's role in denouncing war. If no war is justifiable, the physician is obligated to condemn all acts of war. But if military action can prevent more widespread morbidity or mortality, then not only should it not be condemned, it should be supported by the international community of health care professionals. Such an extreme movement existed during the conflict in Kosovo in the late 1990s, when the international organization Physicians for Human Rights called upon President Clinton to intervene with ground forces to prevent the massacre of innocent victims [2]. Judgments about the justness of and "need" for war are extremely value-laden and tied to the perspective of the decisionmaker. Those who undertake the calculus of how much wrongdoing justifies war, with the infringement of individual rights and bloodshed that come with it, venture into moral minefields. They must have knowledge from many sources and the support of many before committing lives to this "least bad" course of action.

The dual role of the military physician is demanding. Physicians must fulfill their obligation to heal and ease the suffering of all parties involved, while acting ethically in the conflict situation. Despite supporting a military intervention against an oppressive regime, physicians on the battlefield are obligated to treat even those soldiers who commit inhumane actions; not doing so would breach the fundamental humanitarian duty of the physician [3]. This obligation is based on the World Medical Association's *International Code of Medical Ethics*, adopted in 1949, stating that the physician must not allow ethnic origin, nationality, or political affiliation to intervene between his duty and his patient [4]. On the battlefield, the physician's clinical responsibility is the patient, irrespective of the actions that got him or her there and the utilitarian goals of the war.

There are social needs without which civilization would crumble. One of these is the promise of protection and security without which people would be unable to go about their pursuit of society's goods. Protection and security are fostered through the rule of law, through politics and diplomacy, and sometimes through war, when the utilitarian goals of such action can be justified for the sake of society. Yet, even in wartime, the ideals of humanity must be considered by the medical community as superior to all others [5], which in practice translates to a policy of providing medical care for both friend and foe.

It is the physician's responsibility to recognize that *tutti fratelli*, they are all our brothers [6]. The physician is obligated to provide comfort to the suffering and healing to the injured, while leaving the politics to diplomats.

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6. In June, 1859, a Genevan tourist named Jean-Henri Dunant observed a battle between the armies of France and Austria in Castiglione, Italy. At the war's end, Italian doctors and nurses cared for the injured soldiers of both sides, saying "tutti fratelli," they are all our brothers. Koch T. Weaponising medicine: "Tutti fratelli," no more. *J Med Ethics*. 2006;32(5):249-252.

Gary Schwartz, MD, is a second-year surgery resident at St. Luke's-Roosevelt Hospital Center in New York City. His areas of interest include minimally invasive gastrointestinal surgery and surgical oncology.

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History of Medicine

From Medical Neutrality to Medical Immunity

Michael L. Gross, PhD

To what extent are physicians neutral in war? After all, the job of any army medical corps is to maintain the fitness of the armed forces and to return the wounded to duty so they can fight again. Military surgeons, medics, and nurses support armies in the most fundamental way and insure their fighting capability. In what way, then, are they neutral?

Answering this question depends upon whether we understand neutrality to mean “impartiality” or “immunity.” These are very different meanings, and only the second speaks to the neutrality of medical personnel as we know it today. “Impartiality” means “objective” and reflects the imperative to provide medical care without preference for one side or another. At one time, this was true. Medical workers who took the field as civilian volunteers in the early days of the Red Cross or Quakers who volunteered for the British Army in World War I tended to the wounded of both sides without distinguishing between them. This is not true, however, of modern-day military medicine. Here medical personnel augment military capabilities. This point is often lost on pacifists who agree to military service on condition that they be assigned to medical duties. Manuals for conscientious objectors, therefore, find it necessary to warn against such naivete:

...some men are actually inducted into the medical service thinking that medics are instruments of mercy apart from the Army and its primary objectives. This erroneous conclusion can lead to serious personal difficulties. True, the medics save lives and ease suffering, sometimes in a manner which takes real heroism. But the medic is a soldier, and the ultimate objective of medics is to win battles [1].

Nevertheless, medical personnel are different from other battlefield actors. Although they are not neutral in the sense of being impartial, medical workers do retain a large measure of immunity or protection. Their immunity from harm is one of the most enduring conventions of modern war. In the early modern period, there were several ad hoc agreements to protect medical personnel and to repatriate them if captured. But quality medical care did not become a feature of modern war until the mid-19th century [2]. Prior to this time, the wounded often found themselves abandoned when the fighting ended. Those who made it to an aid station received abysmal care, and the mortally wounded were shunted aside to die alone and unattended. These were the horrors that Henry Dunant witnessed at the battle of Solferino, Italy, that brought

him to lead an international effort to found the Red Cross in 1859. Red Cross volunteer nurses were not soldiers, but civilians. They were not beholden to any army or nation, and were neutral by definition. As such, they could not enter the battlefield without a guarantee of protection from the warring parties. This volunteer nursing effort was the basis for the First Geneva Conference in 1863 [3].

By 1868, the Geneva accords had firmly established the conventions of medical neutrality. Nonmilitary medical personnel required immunity because they were, in fact, neutral, unarmed, and incidental to the war. Their immunity stemmed from their prior, objective neutrality, not from the medical task they performed. Nuns tending religious needs enjoyed the same protection as nurses caring for the wounded. The fact that some served a medical function did not, in and of itself, accord protection. Yet as volunteer medical personnel continued to work closely with, and under the direction of, “official medical personnel,” that is, military surgeons, the two required and eventually came to enjoy identical protection. Neutrality passed seamlessly from nursing volunteers to military surgeons. As a result, the latter acquired a measure of objective neutrality, and we began to think of military medical workers as somehow incidental to war and “above the fray.” By the 20th century, volunteer medical personnel largely disappeared as modern armies expanded their medical corps significantly. The volunteers were gone, but the principle of medical neutrality they initiated remained behind and intact.

Immunity, a Matter of Convention

From this brief history, it is important to see that immunity is a matter of convention or agreement; it is not a moral imperative linked to the practice of medicine or religion. That is, there is nothing about the practice of medicine that morally compels anyone to protect surgeons and nurses on the battlefield. As a military asset, they are vulnerable to death and injury. There is no compelling moral reason to distinguish between a doctor and a tank driver except for the fact that the sides *agree* to protect medical personnel. They do so out of mutual self-interest in the same way they agree not to harm one another’s political leaders. In the latter instance, large armies fear anarchy should their top political echelon suddenly be wiped out. Anarchy would devastate the ability of either side to wage war, and, because both sides are equally vulnerable to its threat, it is mutually advantageous to protect one another’s leaders. The same is true for medical care. Modern military organizations fear that, without their medical corps, they would not be able to maintain their fighting force. Since either side can easily respond in kind should the other target medical personnel, there are good reasons to protect them.

This arrangement holds up well (and has held up well) until one side withdraws from the agreement. But if medical neutrality is grounded in agreement, there is nothing morally wrong with attacking military surgeons if the sides agree otherwise or if one side refuses to sign on. This may occur when there is no longer an incentive to protect one another’s medical personnel. This problem is acute in asymmetrical warfare in the Middle East. Following a vicious wave of terror attacks against

Israelis in February 2002, for example, the Israeli Defense Forces systematically entered Palestinian cities to destroy terrorist infrastructures.

The fighting in some areas was fierce, and troops sometimes fired on ambulances and killed medical personnel. In response to charges of violating medical neutrality, Israel drew attention to guerrilla practices of booby-trapping the wounded, using ambulances to transport terrorists and war materiel, and taking refuge in hospitals. Two arguments characterize the debate. One reaches to the conventional and reciprocal nature of medical immunity and suggests that, once one side violates the convention, the other side is no longer bound to respect it. The other argument accepts the overwhelming importance of medical immunity but argues that military necessity may override medical neutrality in those exceptional cases when innocent civilians are threatened by terror attacks.

These are relatively new arguments because each side now weighs the costs and benefits of violating immunity in a way that conventional adversaries could not. In conventional war, the risk of violating medical immunity was great, as were the benefits of respecting it. In asymmetrical warfare, this is not necessarily the case. Guerrillas will complain when ambulances are stopped and hospitals searched for suspected terrorists, but the benefits of using an ambulance or hospital for military purposes often outweigh the cost. Equally, the stronger power has nothing to fear from attacking medical installations except, perhaps, the condemnation of the international community. But violations of neutrality by guerrilla fighters, often for the purpose of conducting terrorist attacks, blunt public opinion. Many will see the logic, for example, of stopping, searching, and even attacking ambulances. Once one ambulance is used to transport arms or terrorists, what are the chances another will be used in the same way? Human rights activists call on Israel to show restraint because the probability is not high. In fact, most ambulances *are* utilized for their intended purpose. Israeli responses echo rational choice: under uncertainty, the odds of abuse are even. And, if the odds are even and the potential harm to a single patient in an ambulance pales beside the potential harm posed by terrorism, then utility demands stopping each and every one. Palestinians complain that harm accumulates to their detriment; Israelis fear that the next ambulance may be a car bomb.

In this environment, civilians and wounded suffer as medical care is disrupted in precisely the way the Red Cross hoped to prevent. Here we see how clear, traditional guidelines are upended by insurgency warfare, creating acute dilemmas for commanders in the field and international law. Whether and how the international community will deal with the problem remains to be seen. The rules of warfare are changing rapidly as asymmetrical, guerrilla war replaces conventional warfare between nation-states. Time-honored conventions that include the protection of medical personnel, torture-free interrogation, the ban on assassination, and the prohibition of chemical weapons are all facing difficult challenges.

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Michael L. Gross, PhD, is chair of the Department of International Relations at the University of Haifa in Israel. His recent publications include *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* (MIT Press, 2006).

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Op-Ed

A Moral Obligation for Military Medical Service in the United States

Dominick A. Rascona, MD

As an active duty military medical officer who has been deployed several times, I wish to infuse the debate over the dual role of military physicians with a sense of the military physician's ethical responsibility to society as a whole. To do so, I summarize the concept of dual agency and raise the topic of duty. Then I develop an argument for what I consider an ethically superior, but seldom discussed, moral position: the obligation of physicians to perform military medical service in the United States. In advancing this concept, I am aware of the contradiction inherent in the notion of mandatory service in a free society. I am also aware that the American military itself generally disagrees with this opinion.

Dual Agency

Dual, or mixed, agency refers to the conflicts and potential for unethical breaches of the fiduciary relationship between a provider of services and a consumer of those services. Although I believe the relationship between a physician and a patient is special (perhaps even sacred), I find the fiduciary aspect of that relationship no more unusual or distinctive than that of any other professional faced with decisions that weigh the benefits and risks of his or her client (usually an individual) against the purported benefits for an organization or society.

Indeed, dual agency concerns can be found in almost any human interaction where fiduciary relationships exist—in law, finance, real estate, medicine, guardianship, commerce, education, and essentially every other endeavor that is considered a profession. Whenever someone represents another and agrees to consider that person's interests paramount, a fiduciary relationship is created and, with it, some potential for moral discord should a claim arise that conflicts with the client's interests.

In military medicine, dual agency is addressed conceptually and in many real-world scenarios by Edmund Howe in the *Textbooks of Military Medicine*. His chapter on mixed agency in military medicine convincingly discusses and provides an ethical framework for an analysis that will produce the best results over time [1].

There is a concept, however, that I believe supersedes and overarches concerns about mixed agency, a concept by virtue of which mixed agency conflicts occur. That concept is duty. When one assumes more than one professional duty, the moral dilemma of dual agency arises, and those who are willing to bear this mantle of

responsibility must be well prepared if they are to avoid moral pitfalls. It would be difficult to defend the argument that it is morally better to avoid the responsibilities that engender potential dual agency than to accept those responsibilities and prepare oneself to deal with ethical conflicts should they arise.

Duty

What is a duty, then, and how can medical service to the military be considered one? The definition of duty available in an online dictionary of philosophical terms derives from philosophers Immanuel Kant and W. D. Ross. A duty is “what we ought to do; an action that people are required to perform; the practical content of a moral obligation” [2].

The “definition” I tend to favor, though, is one that hangs in the gymnasium of the U.S. Naval Academy: “If not you, who? If not now, when?” I like this rendering of the definition because it implies the self-evident truth that, when there is something that *needs* to be done for the benefit of all, if every individual were to leave this duty to someone else, it would go undone. I believe most people fail either to understand or to accept this truism when it comes to military service in general and military medical service in particular. Indeed, I believe a pervasive and severe misunderstanding about the nature of service in the United States threatens most efforts at improving our society and perhaps even the persistence of our nation.

Importantly, the degree and manner in which military force is used as an instrument of foreign policy should not be confused with the moral weight and clarity of the concept of military defense. In this regard, I remind readers that the United States recognized just this distinction after World War II when it reorganized the Departments of War and the Navy into the newly named Department of Defense. The need for a system of collective defense seems to be an unfortunate, indeed tragic, part of human existence. From antiquity through today, it appears self-evident that “those who wish for peace must prepare for war” [3].

One argument that questions the morality of military service in general (including medical military service) suggests that somehow, by maintaining military force, one invites attack. Another argument implies that the fiduciary relationship between doctor and patient is sacrosanct and therefore precludes any assumption of dual agency. Other arguments are raised and countered in the *Textbooks of Military Medicine*.

In my view, whatever the argument, an eschewing of military service boils down to a willingness to allow others to take on a duty that is necessary to the maintenance of the infrastructure of civil society.

Duty is not discussed much in modern Western culture, having been supplanted by more palatable arguments for and dissertations on individual rights. Even when rights are discussed in terms of concomitant responsibilities, the responsibilities part of the equation is generally mild, if not passive, in nature: pay taxes, vote.

Discussion of the morality of military medicine and the consequent moral dilemmas faced by military medical service providers should be an essential part of the dialogue about duty and service in the United States. Mandatory service should fall under the definition of duty, and duty should be of relevance in the wider realm of ethics in general: “If not you, who? If not now, when?”

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Dominick A. Rascona, MD, is a captain in the U.S. Naval Medical Corps and practices at the Naval Medical Center in Portsmouth, Virginia. His area of specialty is adult pulmonary medicine and critical care.

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About the Contributors

Theme Issue Editor

Lhasa Ray is a fourth-year medical student at Albert Einstein College of Medicine in New York City, and a second-year master's student in Einstein's Clinical Research Training Program. She is applying for internal medicine residency programs and intends to specialize in critical care.

Contributors

Lee Black, LLM, is a senior research associate for the Council on Ethical and Judicial Affairs at the American Medical Association in Chicago. Prior to joining the AMA, he was a staff attorney with the Legislative Reference Bureau in Springfield, where he drafted legislation for the Illinois General Assembly.

David Boren, MA, is a medical student at University of Illinois, College of Medicine, Chicago. He was a summer intern at American Medical Association's Council on Ethical and Judicial Affairs in 2007.

Brian S. Carter, MD, is a professor of pediatrics (neonatology) at Vanderbilt University and co-director of the pediatric advance comfort team at Vanderbilt Children's Hospital, both in Nashville, Tennessee. He is a former U.S. Army lieutenant colonel and served as a brigade surgeon in the first Gulf War.

Michael L. Gross, PhD, is chair of the Department of International Relations at the University of Haifa in Israel. His recent publications include *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* (MIT Press, 2006).

Edmund G. Howe, MD, JD, is a professor of psychiatry at the F. Edward Hebert School of Medicine of the Uniformed Services University of Health Sciences (USUHS) in Bethesda, Maryland, and is director of the Programs in Ethics. He is a senior scientist at the Center for the Study of Traumatic Stress, USUHS, and the founding editor-in-chief of the *Journal of Clinical Ethics*.

Mark A. Levine, MD, is an associate professor of medicine at the University of Colorado in Boulder, and active in its Center for Bioethics and Humanities. He is the Centers for Medicare and Medicaid Services' Region VIII chief medical officer. Dr. Levine is a member of the oversight body of the American Medical Association's

Ethical Force Program, was elected to the Council on Ethical and Judicial Affairs in 2001, and is the current chair of that council.

Justin M. List, MAR, is a third-year student at Loyola University Chicago Stritch School of Medicine. A former fellow at the Institute of Ethics at the American Medical Association and previous editor for Yale University's Interdisciplinary Center for Bioethics, he recently wrote the chapter "Medical Neutrality and Political Activism: Physicians' Roles in Conflict Situations" in the forthcoming volume *Physicians at War: the Dual Loyalties Challenge* edited by Fritz Allhoff.

Richard F. Mollica, MD, MAR, is a professor of psychiatry at Harvard Medical School in Boston, and director of the Harvard Program in Refugee Trauma.

Yishai Ofran, MD, is a senior hematologist at Rambam Medical Center, a unit of the State of Israel's Ministry of Health in Haifa. He recently started a two-year research project at the Dana Farber Cancer Institute in Boston. Dr. Ofran did his residency in internal medicine at Hadassah Medical Center, Mount Scopus Hospital, Hebrew University in Jerusalem. He also serves as a military doctor in a reserve parachutist brigade in the Israel Defense Forces.

Wendy Orr, MD, is a consultant in change management, transformation, and diversity in Johannesburg, South Africa. She served as a commissioner on the Truth and Reconciliation Commission of South Africa, investigating the human rights violations of the apartheid era.

Dominick A. Rascona, MD, is a captain in the U.S. Naval Medical Corps and practices at the Naval Medical Center in Portsmouth, Virginia. His area of specialty is adult pulmonary medicine and critical care.

Hernan Reyes, MD, is medical coordinator of the Health in Detention program for the International Red Cross in Geneva, Switzerland. His specialty is obstetrics and gynecology. For more than 20 years he has been involved with prison health issues and has written extensively on the subject.

Gary Schwartz, MD, is a second-year surgery resident at St. Luke's-Roosevelt Hospital Center in New York City. His areas of interest include minimally invasive gastrointestinal surgery and surgical oncology.

Robert J. Walter, DHCE, is completing his fourth year at Loyola University Chicago Stritch School of Medicine. A recipient of the Armed Forces Health Professions Scholarship Program, he holds the commission of a 2nd Lieutenant in the U.S. Army Medical Service Corps and plans to pursue an Army residency in internal medicine. Robert received his doctorate in health care ethics from Duquesne University in 2004.

Stephen N. Xenakis, MD, is an adjunct clinical professor at the Uniformed Services University of Health Sciences and has an active clinical and consulting practice. He is a brigadier general (retired) in the United States Army Medical Corps who served in various positions of responsibility over 28 years. He is actively engaged in developing applications of quantitative electroencephalography (qEEG) for primary care clinicians.

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