Physicians at War: The Dual-Loyalties Challenge†

Fritz Allhoff‡

1 Introduction

This project began during the 2004–2005 academic year, when I was on a research fellowship at the Institute for Ethics of the American Medical Association (AMA). Just after I began the fellowship, two articles were published in *The Lancet* by Steve Miles in which he discussed alleged violations of military medical ethics that may have transpired through physician involvement in hostile interrogations.[1,2] Then, right before the holiday break, we received notice that the *New England Journal of Medicine* would be publishing a similar essay by Gregg Bloche and Jonathan Marks, in its first issue of 2005.[3] The American Medical Association in general, and the Institute for Ethics in particular, was extremely concerned about Miles's papers and the forthcoming one by Bloche and Marks. Not only were these extremely visible publications, but many thought that the allegations they contained were of grave ethical concern. The AMA, which publishes *The Code of Medical Ethics*, takes very seriously the moral status of the medical profession and therefore was very interested in these articles. (Recently, the AMA's Council on Ethical and Judicial Affairs published an opinion on physician involvement in interrogation,[4] which represents the culmination of its thinking on these topics.)

† I thank Marcus Adams for comments on the penultimate draft of this paper.

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[1] Steven H. Miles, "Abu Ghraib: Its Legacy for Military Medicine," *The Lancet* 364.9435 (2004): 725–729.

[2] Steve H. Miles, "Military Medicine and Human Rights," *The Lancet* 364.9448 (2004): 1851–1852.

[3] M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* 352.1 (January 6, 2005): 3–6.

[4] The Council on Ethical and Judicial Affairs, CEJA Report 10, A-06, "Physician Participation in Interrogation" (American Medical Association, 2006). Reprinted in this volume, pp. 261–271.

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Allhoff_Introduction.indd 3 2/11/2008 2:49:05 PM

Having already had a background in some elements of military ethics, and the torture debate in particular,[5] my fellowship year quickly evolved to explore physician involvement in interrogations. One element of this project was to research some of the underlying moral issues, though another was to talk to those responsible for military ethics (including military medical ethics) education. This research led me to speak with those teaching military ethics at the US Military Academy at West Point, the US Naval Academy, and the US Air Force Academy, as well as those teaching military medical ethics at US Army Medical Department Center & School (Fort Sam Houston) and the University Services University of the Health Sciences (Bethesda, Maryland). After I left the AMA, I was also able to spend some time at the Australian Defence Force Academy (Canberra, Australia). In all cases, I was extremely impressed with the professionalism and commitment to ethics that was displayed at each of these training academies.

When starting the research, however, one of the first things that I noticed was how little academic work had been done in military medical ethics. The Borden Institute, an agency of the US Army Medical Department Center & School, had produced two outstanding books which were meant to be used as textbooks for the teaching of military medical ethics.[6] Steve Miles[7] and Michael Gross[8] have each written books about these topics, though these emerged, at least in part, from the previously mentioned journal articles of 2004. Finally, a symposium was held in a prestigious bioethics journal, *Cambridge Quarterly of Healthcare Ethics* (2006).[9] The point, though, is that few discussions regarding military medical ethics have been held until the past few years. As a final programmatic note, the topic of physician involvement in interrogations was afforded the plenary session at the largest biomedical ethics conference of the year, the American Society of Bioethics and the Humanities (2005). This session was somewhat unbalanced, however, insofar as all three speakers argued for exactly the same conclusion (i.e., there was no conservative or dissenting voice), though a response panel aimed to remediate this shortcoming. It was at this meeting that I met Fritz Schmuhl of Springer, who encouraged the production of this volume, particularly given the interest in the two sessions at that meeting.

In the remainder of this introduction, I would like to provide a discussion of some of the frameworks and issues that appear in this volume (§2) and then to provide a

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[5] See, for example, Fritz Allhoff, "Terrorism and Torture," *International Journal of Applied Philosophy* 17.1 (2003): 105–18. See also Fritz Allhoff, "A Defense of Torture: Separation of Cases, Ticking Time-Bombs, and Moral Justification," *International Journal of Applied Philosophy* 19.2 (2006): 243–64.

[6] Office of the Surgeon General, Department of the Army, United States of America, *Military Medical Ethics,* 2 vols. (Bethesda, MD: Department of Defense, Office of the Surgeon General, US Army, Borden Institute, 2003).

[7] Steven H. Miles, *Oath Betrayed: Torture, Medical Complicity, and the War on Terror* (New York: Random House, 2006).

[8] Michael L. Gross, *Bioethics and Armed Conflict* (Cambridge, MA: MIT Press, 2006).

[9] I authored an essay in this symposium; see Fritz Allhoff, "Physician Involvement in Hostile Interrogations," *Cambridge Quarterly of Healthcare Ethics* 15 (2006): 392–402. Reprinted in this volume, pp. 91–104.

Allhoff_Introduction.indd 4 2/11/2008 2:49:06 PM

discussion of how some of these issues might be resolved (§3); the essays in the volume explore these frameworks, issues, and resolutions in greater detail.

2 The Dual-Loyalties Challenge

The motivating premise behind this volume is that, in times of armed conflict, physicians can arguably be subject to dual-loyalties. This concept has been explored in greater detail elsewhere[10] but, for present purposes, we might understand it as the existence of simultaneous obligations which might come into conflict with each other. While dual-loyalties can generalize to all sorts of contexts, our present concern is with the ones that apply to physicians during armed conflict. In these scenarios, physicians have medical obligations to those in medical need. We could ground such obligations in various ways, but the most straightforward way is to acknowledge the medical duties of beneficence and non-malfeasance, both of which have been traditional foundations of medical ethics. According to these duties, physicians are morally bound to render aid insofar as they can and not to (intentionally) make anyone medically worse off.

Such medical duties, however, might come into conflict with non-medical duties, and there are such non-medical duties that we would expect to be expressly manifest during times of war. For example, military physicians are subject to the chain of command and therefore have an obligation to obey their orders. To be sure, it might not *always* be the case that following orders from the chain of command is morally obligatory, but we can presumably suppose that, at least in the cases of just war, there is a (defeasible) reason—which we could cache out in terms of military efficiency, for example—for obeying commands and that, therefore, such commands have some sort of positive moral status. Second, the physician, in virtue of medical training, might be able to promote national security or, more nebulously, the greater good, and therefore absorb the associative moral obligations.

Of course, these non-medical obligations could precisely oppose the medical obligations previously mentioned. Consider, for example, physician participation in weapons development, which is covered in Part III of this volume. We can easily imagine cases wherein physicians are operating on the just side in a conflict against an evil regime and that their expertise could be applied to chemical or biological weapons; we could further imagine that such weapons would be effective against the enemy and lead to a quicker dissolution of the conflict. With such weapons, it could be the case that there would be fewer casualties overall—perhaps by shortening the war—or even that the existence of such weapons would be psychologically debilitating enough to the enemy that the conflict could rapidly come to an end. If this is a terrorist regime, then national security could legitimize the development of

[10] See, for example, Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty, *Dual-loyalty Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms.* Excerpts reprinted in this volume, pp. 15–38. See also the other essays in Unit I.

the weapons or, regardless, such weapons might serve the greater good—including the citizenry, present and future, which falls under the dissolved evil regime—and therefore be morally justified. But, despite the moral considerations that would count in favor of such weapons development, there are contrary considerations that would inveigh against it. In particular, the development of weapons could violate the physician obligation of non-malfeasance since those weapons would be used to harm some individuals.[11] What, then, should physicians do? Are they morally permitted to participate in weapons development?

Before moving on to a more general discussion of these challenges, let me point out some other specific contexts in which such challenges arise. Many of these are covered in this volume, but I will briefly mention them in this section. In particular, we could see the above frameworks also applying in the following: physician involvement in torture (Part II) and battlefield triage/medical neutrality (Part IV). Starting with torturous interrogations, it could easily be the case that such interrogations serve important military objectives, and that medical knowledge could make the interrogations more expedient, perhaps by conducting them in ways that invoke physical or psychological vulnerabilities of the interrogatee. Again, though, any application of medical knowledge that makes the interrogatee worse off than he/she otherwise would have been could be viewed as problematic when viewed through the lens of medical ethics.[12] Therefore, this is another instance of the dual-loyalties conundrum.

Finally, consider some of the issues that physicians might face on the battlefield. In particular, I have battlefield triage and medical neutrality in mind. The scenario in these cases is that there are some number of individuals in need of medical attention such that the demand for such attention exceeds the supply. Some decision, then, must be made about how those resources should be allocated. Medical obligations would suggest that these decisions should be made on medical grounds alone: resources should be invested in ways to optimize (medical) outcomes. Just to take an example, imagine that there are two wounded soldiers, one of ours and one of the enemy and that there are only resources to tend to one of them. Imagine, further, that the enemy is slightly worse off, though both are very much in need. Medically, it could easily be the case that treatment should be provided to the enemy, since he is less likely to survive absent medical care. The other soldier, however, is on *our side*. Should the physician tend to the enemy, despite the fact that this could lead to the death of an allied comrade? Or, more generally, should physicians exercise (political) *neutrality* when making medical decisions? What if the injured enemy were a high-ranking officer who could be an important strategic asset? It could be the case that resuscitating such an offer could, ultimately, lead to the realization of various

[11] In my own view, this conclusion does not follow since I think that non-malfeasance should be understood in an aggregative mode: if physicians harm a few people such that more people are not harmed later—through, let's say, continued military conflict—it seems to me that such an act is not just licensed, but rather required by an appeal to non-malfeasance. This is an unpopular view that I will not develop here, but see Allhoff (2003) for related discussion.

[12] In fact, this is precisely the view taken by the AMA in its report. See pp. 261–271, this volume. For a dissent, see my essay, pp. 91–104.

Allhoff_Introduction.indd 6 2/11/2008 2:49:06 PM

military objectives; we could further stipulate that such objectives had moral significance. If the physician chooses to save the enemy officer over our private, is this *fair*? If such an officer were *less* in medical need then, despite the military advantages, then it would seem medical virtues would mandate the treatment of the private, though this could have adverse consequences for key military objectives. These questions can become even murkier when we abstract away from "micro" decisions (e.g., save this person or that one) and try to achieve some clarity about the general triage practices that should be endorsed; in any case, such situations can clearly manifest the dual-loyalties concern.

3 Addressing the Challenge

In the previous section, I introduced the notion of the dual-loyalties challenge and showed how it could be instantiated in various contexts: weapons development, torture, and battlefield triage/medical neutrality. In this section, I want to consider various ways to remediate the challenge, and I take it that there are, conceptually, four different options here. First, we could hold that medical and non-medical values are *commensurable* and that, in any given case, we just have to make adjudications about which pull more strongly. Second and third, we could hold that these values are *incommensurable*, but that one or the other set of values does not apply. One option is that non-medical obligations are patently irrelevant to medical decision making; the other is that medical obligations are inappropriate in these contexts. Fourth, we might say that the values are incommensurable, yet all apply. It is not clear to me how this fourth option is a *solution* to the challenge as it merely posits intractability. And I think, therefore, that it is simply implausible: we all believe that there are right and wrong courses of action in the scenarios mentioned in §2, and I want to suggest that we all believe this because one of the first three options listed must be correct.

The first option is the one that might seem the most straightforward: we acknowledge the existence of conflicting obligations, and then we just have to figure out which set carries more weight (while accepting the countervailing force of the contrary). So we could say, for example, that it is *prima facie* bad for physicians to develop weapons while, at the same time, allowing that complicity in weapons programs could nevertheless be justified if the stakes were high enough. As more lives hung in the balance, as the enemy regime were more evil, or as all other options had been exhausted, we might postulate increasing moral merit in physicians developing these weapons. Absent such features, though, perhaps there would not be sufficient countervailing moral weight for physician involvement in such a program given their medical obligations.

This line is not without problems, both epistemic and metaphysical. Regarding the epistemic ones, we simply do now *know* how many lives might be at stake, or what the consequences will be of us having (or not having) chemical or biological weapons. Metaphysically, we might meaningfully ask how many lives are *worth* a single transgression against non-malfeasance, and thence beckons the specter of incommensurability. The epistemic worries, though, are just that, epistemic: whether we *know* the

relevant stakes, it hardly follows that there does not *exist* some proper course of action, and we then have to do the best we can to determine what it is. The commensurability problem is a difficult one as well, and people choosing this approach to resolving the challenge will surely owe us an account of their thinking in this regard.

Let me also point out another answer that might present itself here, which is more empirical than conceptual. In setting up the above challenges (in §2), I made various suppositions, and people might simply deny that any of these is reasonable. For example, in the torturous interrogation case, I asked that we consider an interrogation that advanced the greater good, despite its transgression of medical virtues. It is certainly an open possibility here to deny that such an interrogation is *possible*, perhaps by denying the plausibility of any sort of utility forecast that would justify the interrogation. In the torture debate more generally, this is a common line,[13] though I think that there are responses.[14] This approach, then, admits of the commensurability of the conflicting obligations while, at the same time, denying that there will ever be much pull coming from one of the directions; a quick look at the literature would suggest that the non-medical obligations are more commonly thought to be the impotent ones. Regardless, I think that this is the approach that it most intuitive, though there is some work to be done regarding how the commensurability would be understood.

Second, we could resolve the challenge by saying that one of the two directions (necessarily, as opposed to contingently) exerts no pull. The more common direction that this would take is to deny that extra-medical considerations can have any import on medical considerations. This strategy is one that we might appropriate, in a different context, to Michael Walzer.[15] Walzer has postulated "spheres of justice" exist such that we can only make distributions of resources within some sphere based on considerations internal to it, rather than to some distributive logic that would be motivated from some other sphere. In applying that structure to our context, it would therefore be inappropriate to make decisions regarding *medicine* by appeal to *extra-medical* considerations: medicine occupies its own sphere of justice and, therefore, medical decisions must be based on medical considerations alone. Note, then, that this view is patently is one of incommensurability: it does not *matter*, for example, whether there are tremendous extra-medical benefits to be gained through some action that violates tenets of medical justice since the former are inadmissible regarding considerations of the latter. On this view, there is no dual-loyalties challenge since there are no *dual* loyalties in the first place: physicians must make medical decisions based *solely* on medical considerations and chains of command, national security,

[13] See, for example, Jean Maria Arrigo, **"A** Utilitarian Argument against Torture," *Science and Engineering Ethics* 10.3 (2004):1–30. See also Matthew Wynia, "Consequentialism and Harsh Interrogations," *American Journal of Bioethics* 5. I (2005): 4–6.

[14] See, for example, Fritz Allhoff, "A Defense of Torture: Separation of Cases, Ticking Time-Bombs, and Moral Justification," *International Journal of Applied Philosophy* 19.2 (2006): 243–64.

[15] Michael Walzer, *Spheres of Justice* (New York: Basic Books, 1983).

Allhoff_Introduction.indd 8 2/11/2008 2:49:06 PM

and the greater good are impotent against such considerations. While Walzer did not explicitly apply his framework to this present context, such an application is nevertheless fairly straightforward.

This view is not without problems, though many people will nevertheless find it compelling. As far as I can tell, the most pressing objection would have to do with how we individuate different spheres. As I laid it out in the previous paragraph, the medical sphere was conveniently insulated from the non-medical realm, and this insulation provided a solution to the dual-loyalties challenge. However, this structure could receive pressure in either of two directions. First, we might wonder whether this medical sphere is *too small*. In fact, the reason it offers a solution to the dual-loyalties challenge is that it is precisely of the scope that would do so and, therefore, might be thought to be idiosyncratic or *ad hoc*. What is so special about medicine such that it gets its own sphere of justice? The postulation of such a sphere almost seems to be question-begging against "greater good" considerations, since it eliminates those considerations out of hand (e.g., by asserting a sphere which they cannot penetrate). We could certainly carve up the spheres differently, and maybe "greater good" could be some such sphere, of which medicine were a proper part. Regardless, it would seem that the postulation of some sphere needs to be *motivated* in some way, and it is not clear to me what the motivation for a medical sphere would be.[16] Conversely, maybe the medical sphere is *too big* (as opposed to too small). If there is a medical sphere, there could very well be sub-medical spheres: just as some features set off the medical sphere from others, features within it might be used to set off facets of it from itself. The problem would then be that this conception of spheres could lead to a sufficiently high number of them such that they would not be useful in particular cases. Regardless, the proponents of spheres will have to say something about *why* there is a sphere of medicine and why it does not either get subsumed under a bigger sphere or fracture into multiple smaller ones; only such a compelling story here would preserve the merits of this answer.

Finally, we could resolve the dual-loyalties challenge in the third way, which is again to deny that there are dual loyalties at all. While the spheres of justice approach negates the relevance of extra-medical obligations, a converse approach holds that *only* extra-medical obligations are admissible and that medical obligations do not apply. Again, this line would deny that there is a dual-loyalties *challenge* since there would not be competing obligations at all. This is undoubtedly the least popular of all the options and, as far as I can tell, I am the only person who defends it.[17] The idea here is that medical obligations apply only to *physicians* and that there is conceptual space for medically-trained military functionaries who are nonetheless not physicians.[18] Physicians are members of the medical *profession*, and this carries with it various moral features. For example, they have taken an oath

[16] In the book (and in subsequent literature), this topic is explored, though I take it to continue to be one that assails the position.

[17] See Allhoff(2006), pp. 395–400. Reprinted in this volume, pp. 96–104 [section entitled "Are Medically Trained Interrogators *Physicians*?"].

[18] I acknowledge that, despite this contention, the title of this volume nevertheless invokes 'physicians'. I do this most proximately for ease of use, but also in recognition of the consensus view on this issue.

to abide by various features of that profession, including providing care for those in need. But we could easily imagine medically trained personnel who are not members of this profession: they may never have taken the oath nor ever planned to provide positive medical services. Rather, they could use their medical training in an adversarial way, such as through the development of weapons or through participation in hostile interrogations.

I want to suggest that medical obligations do not apply to these people, whom I take to be something other than physicians. The contrary view would have to hold that, *regardless* of these people's non-participation in the medical profession, the obligations nevertheless attach to them. I think that this line is problematic for various reasons, and provide those arguments later in this volume. A second critique of this position—which came out as a response to my paper and is therefore not considered within it—is that the people that I would otherwise exempt from medical obligations are, *in fact*, physicians: they *have* taken the associative oaths and *are* members of the medical profession. I do not disagree with this claim, but it does nothing to erode the conceptual space that I aim to delimit. Rather, it seems completely possible to me that military physicians could *opt out* of the profession, and that some of their obligations would thereafter dissolve. (Some, however, would not, such as the obligation to preserve confidences obtained through participation in the profession.) Furthermore, there is no reason that these personnel had to take whatever oaths would ground medical obligations: we could easily imagine a medically-trained force that completely rejects these values altogether.

In this introduction, I have discussed briefly the issues that motivate and constitute the volume. In §2, I introduced the notion of the dual-loyalties challenge, which is further discussed in Part I. I also introduced some particular issues in which this challenge is manifest: physicians and torture (Part II); physicians and weapons development (Part III); and physicians on the battlefield (Part IV). Each of these parts comprises papers which explore the associative dimensions in greater detail, and display a range of different perspectives thereof. In §3, I discussed various options to resolve the dual-loyalties challenge; these are also variously considered throughout the following essays. At the end of the volume, I have included three appendices, which are statements published by the World Health Organization and the American Medical Association regarding physician involvement in armed conflict.

Thank you for your interest in this project; I hope that you find the following essays engaging and provocative!

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Allhoff_Introduction.indd 10 2/11/2008 2:49:06 PM

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