8-2009

Physician as Military Officer: Conflicts in Professional Duties

Kevin Michael Bond
University of Tennessee - Knoxville

To the Graduate Council:

I am submitting herewith a dissertation written by Kevin Michael Bond entitled "Physician as Military Officer: Conflicts in Professional Duties." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

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We have read this dissertation and recommend its acceptance:

Glenn Graber, Alfred Beasley, Janice Harper

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Physician as Military Officer:
Conflicts in Professional Duties

A Dissertation
Presented for the
Doctor of Philosophy Degree
The University of Tennessee, Knoxville

Kevin M. Bond
August 2009

Dedication

This dissertation is dedicated to my mentors Staff Sergeant Harry Gilstrap, Professor Larry Magrath, and to my parents Howard and Kaye Bond. Friends all, without whom this would not be possible.

ACKNOWLEDGEMENTS

I would like to thank John Davis for starting me on this project and John Hardwig for seeing that I successfully completed it. The other members of my committee – Glenn Graber, Alfred Beasley, and Janice Harper – have all contributed to my development as a scholar, educator, and philosopher.

I would like to thank the people I work with at West Point. My interactions with them – especially COL Hannah, LTC Doty, and LTC Julum – have been invaluable to my understanding of military culture, moral psychology, and character development.

I have been fortunate for the support of my family and friends. My parents have been patient in reading my papers and helping me to clarify my views. My friends have provided me with a sounding board for my ideas. Although we collectively hold many diverse views, we can still discuss varying perspectives and continue to respect each other at the end of the day. Learning to agree to disagree, and to gracefully accept divergent views, has been a valuable lesson.

Members of Nisora Dojo deserve special thanks – Sensei England, Sempei Leh, Sempei McNeil, Kohei Henderson, and Kohei Gardner. The study of Eastern Martial Arts has opened my eyes to new ways of understanding philosophy and living "the good life."

Jim, Judi, Tom, William, and April all deserve thanks for their support. Thanks!

Finally, appreciatively and respectfully, thanks to the physicians and military personnel who shared parts of their lives with me.

Thank you all, and I hope our paths cross again in the future.

Disclaimer: The views expressed herein are those of the author and do not purport to reflect the position of the Army Center of Excellence for the Professional Military Ethic (ACPME), the United States Military Academy (USMA), the Department of Army (DA), the Department of Defense (DoD), or the Government of the United States of America.

Abstract

A “moral dilemma” is a situation in which there is more than one obligatory course of action, but to act on one choice means to not act upon the others. Moral dilemma arises when an action, or inaction, results in “wrongness” because other morally correct obligations are rendered unattainable. Sometimes prolonged exposure to moral dilemma leads to a phenomenon known as “moral distress.” Moral distress is a negative feeling or state that is experienced when a person makes moral judgments about a situation in which he or she is involved, but, due to one or more constraints, does not act upon those judgments. This inability to resolve conflicting moral judgments may be caused by a conflict of duty.

The United States Military acknowledges situations of moral dilemma when soldiers experience difficulty in determining a correct course of action because of “right versus right” conflict in duty or in values. This happens, for example, when physicians who join the military assume a dual role – that of physician and military officer. The military physician must sometimes act without being provided a satisfactory professional conceptual model of a moral working-self for adjudicating potential conflicts in duties.

A comparison of professional duties and ethics of the medical and military professions, a critique of methods of conflict resolution, and a review of issues of conflict may provide insights into instances of perceived moral dilemma. After examining these topics, I propose a moral topology of decision-making that allows military physicians the conceptual space to preserve professional and personal integrity while upholding professional standards of competence and ethical behavior embraced by both professions.

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Chapter 1: Moral Dilemmas of Military Physicians

> I don't know a soul who doesn't maintain two separate lists of doctrines—the ones that they believe that they believe; and the ones that they actually try to live by.
>
> Orson Scott Card
> *Ender's Game*

> Light and matter are both single entities, and the apparent duality arises in the limitations of our language.
>
> Werner Heisenberg

"A moral dilemma is a situation in which an agent S morally ought to do A and morally ought to do B but cannot do both, either because B is just not-doing-A or because some contingent feature of the world prevents doing both."[1] Moral dilemma most frequently arises when principles, values, or duties come into conflict. Prolonged exposure to moral dilemma sometimes results in a phenomenon known as "moral distress." Moral distress is a negative feeling or state that is experienced when a person makes moral judgments about a situation in which he or she is involved, but cannot act upon those judgments because of constraints. Constraints may be internal, such as those of conflicting values, or external, such as institutional policy or procedure that interferes with professional responsibility.

Soldiers in the United States military experience moral dilemma in what the Army calls "right versus right" conflicts. These conflicts are typically described as existing due to conflicts in duty or in values.[2] Examples of this include conflict between loyalties to squad members versus loyalty to "The Big Army" or respect to a foreigner versus loyalty to

[1] Christopher W. Gowans, *Moral Dilemmas.* New York: Oxford University Press, 1987. 3.
[2] Personal conversation with LTC Joe Doty, 10 March 09. The seven Army Values are loyalty, duty, respect, selfless service, honor, integrity, and personal courage.

soldiers in a leader's care.[3] This dissertation investigates moral dilemma as it applies to the military physician who finds a conflict arising from his professional duty as a physician and his professional duty as a military officer.

Physicians who join the military assume a dual role; that of physician and military officer. Research into moral dilemma experienced by military physicians reveals that military physicians must sometimes act without possessing a professional mental model, or moral working-self, for adjudicating potential conflicts of duties in their new dual profession. In some cases, this leads to moral distress. In other cases this leads to inefficiency and harms to patients, institutions, and the profession. Common themes of conflict are saving lives versus taking lives, personal responsibility versus following orders, serving individual clients versus serving the public, serving to foster health versus serving to foster national security, or serving an individual versus serving a group.

Chapter One is an introduction to typical reactions to the problem of moral dilemma. From these reactions, representative cases of perceived conflict in professional duties as experienced by military physicians are presented. The chapter concludes with a brief introduction of various attempts that have been used to resolve this conflict between the professional duties of a physician and a military officer, and my thesis which will provide additional conflict resolution protocols for "Train the Trainer" or "Educate the Educator" instruction.

[3] Examples are from Army Center of Excellence for the Professional Military Ethic field research, office communications, and stories collected about events currently happening in the Army.

§1: Moral Dilemma: Reactions and Phenomenology

Two broad philosophical frameworks provide the theoretical underpinning and framework for common reactions to moral dilemmas.[4] One group, rationalism, holds that moral practice is primarily a form of human rationality. Rationalism emphasizes mathematical reasoning, or a mathematical paradigm, as the highest form of human rationality. Based upon the mathematical process of reasoning, good reasoning must include a system or order, commensurability and hierarchy, abstraction, concepts, and principles. Also based upon this mathematical paradigm, moral theory seeks to discover single, universal principles. Action-guiding judgments must follow from these principles. Rationalism tends to be skeptical of experience. Reform of moral theory must come from "without," such as from naturalistic "hard" sciences, mathematics, and logical systems of reasoning.

The other group, experientialism, holds that moral practice is primarily a function of experience, particularly experiences and relationships rooted within social contexts. Reasoning is not limited to rigorous models of Platonic mathematics, but, rather, takes a non-Platonic view of mathematics where discovery of natural occurrences are combined with the creation of order, concepts, and principles. Although single, universal principles are not excluded, the nature of cognitive framing, limits of knowledge, and the creative and novel understanding of situations all contribute to the possibility of a multiplicity and incommensurability of values and principles. Experientialism holds a greater concern for the phenomenology of what it feels like to live a moral life. This group will use the naturalistic "hard" sciences, mathematics, and reason to help define the range of morality.

[4] Christopher Gowans, "Moral Theory, Moral Dilemmas, and Moral Responsibilities." N.R.

Experientialism also looks to history, biography, and literature to inform moral theory and what it means to lead a good life.

Rationalism and experientialism agree that "Moral dilemmas are standardly defined as situations in which an agent morally ought to (and can) do one thing, and morally ought to (and can) do another, but cannot do both."[5] Rationalism and experientialism disagree, however, on whether or not concern is warranted with respect to the possibility or experience of moral dilemma.

Rationalists tend to minimize concern with moral dilemma. They believe that moral dilemma may not be consistent with their overall focus on reason and rationality. Some rationalists dismiss moral dilemma by attempting to show how perceptions of moral dilemma are misguided. Other rationalists may dismiss moral dilemma because they do not consider moral dilemma to be an issue. When rationalists reason against moral dilemma they usually consider one of three approaches. First, they claim that moral dilemma conflicts with standard deontic logic. Second, they claim that a person experiencing moral dilemma is cognitively defective. Third, they take a perspective, possibly a Kantian or utilitarian perspective, and claim that ultimate principles cannot conflict, thus the problem must be in using secondary principles or a misapplication of the ultimate principles.

Experientialism explicitly denies the soundness of the first and third approach rationalism uses to reject moral dilemma. In the former case, experientialism questions the worth of standard deontic logic and of forcing a moral system to subscribe to deontic logic. In the latter case, experientialism claims that due to the multiplicity of values, the creation of

[5] Ibid. 202.

order, concepts, and values and the nature of human cognition and self-organizational schemas, moral dilemmas are both a real and legitimately experienced phenomena.

That leaves the rationalism claim that a person experiencing moral dilemma is cognitively defective. Although experientialist may acknowledge that perceptions of moral dilemma may be due to a cognitive deficiency, they claim that cognitive deficiency only explains some cases of perceived moral dilemma—not all cases. Some moral dilemmas may be conceptually reframed such that there are a minimum or no conflicts in what a moral agent ought to do. Alternatively, some agents may be able to utilize moral imagination to create novel moral solutions not previously considered. Resolving moral dilemma may involve training, education, and development of people to recognize true instances of moral dilemma and to creatively resolve moral dilemma.

Resolving moral dilemmas may also involve utilizing non-moral factors, such as regulating parameters, which will help in adjudicating how to act in the face of a true moral dilemma. However, experientialism may have to acknowledge that sometimes no solution exists for solving moral dilemma. Moreover, it may be undesirable to resolve all moral dilemmas. In some cases, such as with Nazi physicians involved with racial purity programs or with the medical personnel involved with the Tuskegee experiments, experiencing moral dilemma, and being aware of the moral dilemma confronting them might have prevented immoral and unethical actions.[6]

As will be seen in the following chapters, proponents of claims that the professional duties of a physician must conflict with the professional duties of military officers are often rationalists. Their solutions often involve claiming that no dilemma exists because (1) a

[6] See Appendix 3 and Appendix 4 for details of Nazi Medicine.

hierarchy of duties must exist and, therefore, one set of duties must take priority over the other; or (2) individuals who perceive moral dilemma or experience moral distress are simply cognitively defective, hence, they should be morally developed to recognize that one set of duties overrides the other.

§2: Moral Dilemma and the Military Physician

How do professional identity, mental models, organizational schemas, self-schemas, and scripts contribute to moral dilemma?[7]

Professional identity, mental models, organizational schemas, and self-schemas are parts of the memory that are accessed, either automatically or through conscious choice. Accessing these parts of memory often activates scripts, or semi-automatic responses, which may be prompted by a combination of environmental cues and internal processes. Scripts are dynamic, may evolve over time, may overlap, and some scripts may come to dominate a personality. Consider the following example.

When Lance walks into a classroom early in the morning he assumes the role of a teacher. As students ask him questions related to his science class, he can very quickly access scripts that prompt him to answer. When Lance first started teaching he may have had to consciously search his memory to activate the appropriate scripts, but over time they have become so ingrained in his identity that they are almost automatic.

Later that night, when Lance enters his research lab, he assumes the role of an experimental research scientist. As an experimental research scientist he may access various scripts, some that were used as a teacher, but others used as a researcher. Because Lance thinks of himself more as a teacher than a researcher, he has to exert more effort to access some parts of his memory to activate his "researcher" scripts.

When Lance leaves the lab, he is attacked in the parking lot. Lance is a martial artist. Long before teaching and research he had begun to self-identify himself as such.

[7] For a detailed account of identity, self, and schemas, see Hannah and Avolio, "Transforming Follower Moral Capacity: Toward A Holistic Developmental Model." Primers on moral psychology and professionalism are found Appendix 2 and Appendix 6 of this dissertation.

Because of his long training, and ingrained self-identity, Lance is able to automatically react according to various scripts to neutralize the threat.

Lance is a unique individual with unique memories. Environmental cues and conscious thought access different mental models, organizational schemas, and self-schemas – Lance as teacher, Lance as researcher, and Lance as martial artist. These, in turn, activate scripts that translate into actions. Now consider this for the military physician.

Physicians and military officers often have different professional mental models.[8] It is possible to identify the core professional mental models and scripts associated with each profession.[9] When reduced to core professional identities, physicians often represent socially sanctioned healers. Through medical school, ethics training, professional journals, conferences, and on-the-job training, physicians are often presented with the professional ideal to "maintain and restore human health."

Soldiers, when reduced to their core professional identity, represent socially sanctioned killers. Through basic training, officer schools, ranger schools, sniper schools, "warrior training," and marksmanship drills, soldiers are often presented with the professional ideal to "kill men and take ground…and not to question it…follow orders."[10]

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[8] Concepts developed from personal conversations with Don Snider (Visiting Professor with Strategic Studies Institute's Research and Analysis Department, permanent U. S. Military Academy professor, former Army officer, former Director for Defense Policy with the National Security Council in the White House). (4 Feb. 09) Dr. Snider related James H. Toner's observation that military training seeks to create a core identity of soldiers based on two ideals for the modern "Warrior:" (1) to kill and prepare to kill, and (2) to die and prepare to die. Officers, however, are given the identity: (1) to kill and prepare to kill, (2) to die and prepare to die, (3) be leaders of character and (4) be a servant to the nation. Dr. Toner is a Professor Emeritus of International Relations and Military Ethics at the U.S. Air War College in Alabama.

[9] This is detailed in the next chapter.

[10] LTC Jeff Julum, Director of Education Army Center of Excellence for the Professional Military Ethic, helped me understand the enculturation of the military ethos into officers and soldiers. The quote is from Fred Downs, course notes. At a speech at West Point, Downs said to cadets "Your job is to kill the enemy and take ground." Grossman's book, *On Killing*, expresses a similar account of soldiers as killers.

The social sanction of professions includes an ideal that professionals have permission, possibly even obligations in some cases, to perform their roles to benefit their clients and society. Through training, education, and development, most physicians and soldiers begin to inculcate some professional values into their moral working-self. Physicians and soldiers have different scripts that initiate action. Various scripts and professional mental models are, to varying extent, subsumed into their personal identity and moral working-self.

What does this mean when the two professions are combined into one—that of the military physician? Military physicians are still healers, but they are exposed to a culture and climate of war. At least three areas of external socialization begin to blur the lines between physician and officer – officer schools, marksmanship training, and persistent exposure to both the history and the mythology of war and war-stories. The culture and climate of the military fosters an expectation that all uniformed members of the military should live and perform as a soldier. For the military physician, this expectation provides pressure to subsume his professional medical identity into the identity of an officer-soldier.

The military physician often retains moral schemas of a healer that are, fundamentally, in conflict with the moral schemas of a soldier. As environmental cues and internal processing presents the military physician with conflicting mental models and scripts, a military physician may find himself in a situation that might lead to moral dilemma or moral distress.

Professional literature presents the following examples of perceived conflict of duty for medical personnel in the military. These cases are influential in suggesting the need to

analyze the ethical and moral conflicts that may occur when a physician becomes a military officer.

Medical Participation: Should physicians participate in war?

During the Vietnam War, many people, including individuals in the medical profession, questioned the involvement of the United States in what they perceived as an unjust war. Liberman, Gold and Sidel document that over 300 U.S. medical students signed the following pledge in protest of the Vietnam War:

> In the name of freedom the U.S. is waging an unjustified war in Viet Nam and it is causing incalculable suffering. It is the goal of the medical profession to prevent and relieve human suffering. My effort to pursue this goal is meaningless in the context of the war. Therefore, I refuse to serve in the Armed Forces in Viet Nam; and so that I may exercise my profession with conscience and dignity, I intend to seek means to serve my country which are compatible with the preservation and enrichment of life.[11]

The medical students were concerned that given the historical dictum "first, do no harm," that military physicians could not maintain the ethical and moral values of their profession if they participated in an unjust war.

Medical Interrogation: Physicians Involved with Torture

Bloche and Marks presents this hypothetical case based on reports given by physicians involved with interrogations that employed methods that they considered to be torture:

> A physician newly deployed to 'Irakistan' must decide whether to post physician assistants and medics behind a one-way mirror during interrogations. A military police commander tells the doctor that 'the way this worked with the unit here before you was: We'd capture a guy; the

[11] R. Liberman, W Gold, and V. Sidel, V. W. "Medical Ethics and the Military," The *New Physician* 17:299-309, 1968.

> medic would screen him and ensure he was fit for interrogation. If he had questions he'd check with the supervising doctor. The medic would get his screening signed by the doc. After that, the medic would watch over the interrogation from behind the glass.[12]

Even though the physician may not be conducting the interrogations, is he not only enabling the use of torture, but also violating his responsibility to a patient in his care when he treats a prisoner being subjected to questionable interrogation techniques? Of concern to the military physician, is whether his moral responsibility is to the prisoner-patient or to the military.

Medical Research: Participating in Weapons Development[13]

Part of warfare is the continuing development of new or refined weapons to neutralize enemy targets. As Victor W. Sidel maintains, in modern warfare, the development of weapons requires medical knowledge. For example, as a military develops "green bombs" it often must consult physicians to determine the effects of the bombs on human targets. Moreover, for defensive purposes physicians are needed to evaluate treatment plans.

In general, as weapons systems gain in sophistication, medical knowledge is also needed to test their effects on biological targets. Such weapons programs include biochemical agents, nuclear weapons, sonic or light-based systems. In many cases, physician involvement may be an integral part of weapons development, testing, and

[12] M. Gregg Bloche and Jonathan H. Marks, "When Doctors Go to War," *New England Journal of Medicine* (352)(1) (2006): 4.

[13] This case is adapted from information in Victor W. Sidel's "The Roles and Ethics of Health Professionals in War." A "Green Bomb" is an environmentally friendly explosive. They are safer to handle and not as sensitive to sparks as conventional explosives.

evaluation. Of concern to military physicians, is whether or not ethical obligation to "first, do no harm" implies that physicians should refuse to participate in weapons development.

Medicine on the Battlefield: Battlefield Euthanasia

As reported by Captain Steven W. Swann, during World War II the following situation occurred:

> In the spring of 1944…elements of the 111th Indian Infantry Brigade were engaged with Japanese forces in Burma. After 17 days of constant fighting, the British units retired following their defeat. The infantry carried their wounded with them as they marched. Early in the retreat, Lieutenant Colonel John Masters, the Brigade Commander, was faced with 29 wounded deemed to be terminal by the unit's doctor. These wounded suffered from extensive head wounds and multiple amputations, and one soldier in particular had lost the lower half of his body. The unit surgeon reported that these 29 had no chance to survive, but another 30 could be saved if they could be carried by those litter bearers carrying the severely wounded. Lieutenant Colonel Masters decided to save the 30 that had a chance of survival, and at his and his surgeon's mutual reluctance, had the severely wounded soldiers killed by gunfire from his own troops so as not to allow them to fall into the hands of the Japanese.[14]

Many medical professionals must make difficult triage decisions that result in death for some patients. Some medical professionals on the battlefield consider it their duty to help mortally wounded soldiers die peacefully, providing pain relief if possible. Of concern to military physicians is whether or not, and to what extent, triage duties include participation in battlefield euthanasia. Should military necessity require a military physician to abandon his patients? In what circumstances, if any, should a military physician stand aside while wounded soldiers are killed by gunfire?

[14] Captain Steven W. Swann, Medical Corps USA, "Euthanasia on the Battlefield," Military *Medicine* n.r. (1987): 547.

Experimental Medicine: Informed Consent[15]

Randerson and Rockefeller document that experimental medicine has been used on British and U.S. troops without obtaining informed consent from individual soldiers. The following case, adapted from their findings, details the type of situation in which a military physician may find himself during a normal course of his duties.

A physician stationed at Ramstein Air Base is sometimes responsible for the administration of experimental care for novel biological and chemical agents. Recently the physician has become involved in two experimental trials.

Trial 1: Pharm-X, an upcoming pharmaceuticals company has been working on a clotting agent for use in emergency surgery. Internal studies performed by the company are optimistic. Phase-1 and phase-2 clinical trials indicate that this new clotting agent will be a success. However, unexpected financial concerns prematurely halted the studies. The pharmaceutical company arranged with the military to supply the experimental clotting agent to the military, if the military would in turn continue the testing. The physician is to oversee the administration of the new experimental clotting agent to soldiers in need of medical aid. He will provide the agent to combat medics so that they will unknowingly be using the experimental agent on uniformed soldiers, instead of the currently approved agent, in the field.

[15] This case is adapted from stories related to medical experimentation in the military. A drug, NovoSeven, was licensed in 1999 to treat hemophiliacs. England's Ministry of Defense authorized its use in battlefield trauma cases. For full story see James Randerson's article, "Experimental drug given to British troops in Iraq and Afghanistan" available on guardian.co.uk. The article was published in *The Guardian* on September 16, 2006. See also John Rockefeller's testimony before the U.S. Senate "Is Military Research Hazardous to Veterans' Health? Lessons Spanning Half a Century." A Staff Report Prepared for the Committee on Veterans' Affairs. United States Senate December 8, 1994. 103d Congress, 2d Session – Committee Print – S.Prt. 103-97.

Trial 2: Biochemical warfare has long been known to represent a danger not only to civilian populations but to soldiers in the field. As new insidious biochemical weapons are developed, it is necessary to protect people, especially those in danger of exposure.

Preventive measures, such as vaccines, are an important part of defense. Although there is an approved vaccination for subcutaneous anthrax, that vaccine has not been approved for inhalation anthrax that soldiers are likely to encounter in combat. Despite this, the physician is ordered to oversee that the new anthrax "vaccination" is given to all soldiers. This is to be administered without obtaining informed consent. The vaccination will be given as part of routine medical procedure.

As a physician it is normally considered unethical to administer trial medication to patients without the patient's informed consent. At issue is whether soldiers have given their fully informed consent to receive treatments, even experimental treatments, when they joined the military. If so, has this generalized consent relieved a military physician from the professional responsibility of providing and obtaining individual informed consent from each patient? Does a military physician who is following orders need to provide individual patients with the opportunity to refuse treatments?

Medical Education: Training Soldiers in Medicine[16]

Howard Levy, a dermatologist drafted into the U.S. Army Medical Department during the Vietnam War, was ordered to train Special Forces medical aidmen in dermatological skills. According to Levy's knowledge, this training was to serve two military functions. First, aidmen would use their medical training to care for the sick and

[16] Information in this case is from Victor W. Sidel's "The Roles and Ethics of Health Professionals in War" and Elinor Langer's "The Court-Martial of Captain Levy: Medical Ethics v. Military Law."

wounded of their unit. Second, aidmen would use their medical training as social-political tools in combat. In the latter case aidmen could (1) refuse or withdraw medical treatment in an attempt to coerce individuals, (2) use medicine as a bribe to gain information, power, or command status, and (3) use medical techniques and medicine as interrogative devices. Aidmen could abandon patients as needed to further military goals.

Levy maintained that such use of medical training was in conflict with and directly violated his medical professional code of ethics. In particular such training violated the noncombatant role of medical personnel, destroyed medical neutrality, and potentially caused harm to individuals. According to the U.S. Army, Levy was bound by the Uniform Code of Military Justice to willfully obey lawful orders.

Do military physicians have an obligation to place their interpretation of medical ethics above their military orders? Is a military physician's primary ethical duty to his medical code of ethics or, as an officer in the military, is his primary duty to his military code of ethics?

Battlefield Medicine: Care for a Civilian

Paul J. Schnearts explored the problematic situations developing in modern warfare as medical personnel find themselves in situations where they must choose how to use limited resources of personnel and materials when caring for non-military personnel:

> As a reservist with a U.S. Army Forward Surgical Team, activated as part of the Global War on Terror, I fully considered the many ethical conflicts I might face. There would likely be young men who died as a result of resource limitations. The apparent conflicting duties of a physician/soldier needed to be contemplated and justified. The Geneva Convention, which sets forth that a physician must care for both U.S. soldiers and enemy combatants using standard medical triage and practice, had to be adhered to….I had not,

> however, considered the impact societal differences would have on my perceptions of what constitutes the ethical practice of medicine….A 3-year-old boy presented to our forward surgical team 22 days after a forced emersion scald burn. The wound, which covered approximately 25% of his little body, had a pattern consistent with abuse. As anticipated, without any medical care, he had developed advanced burn wound sepsis with progression to systemic shock. Upon arrival, he was toxic and in the act of dying. Despite this, with aggressive treatment, normal physiologic parameters were restored relatively quickly. After initial stabilization, there would be the need for continued fluid resuscitation, metabolic stabilization, antibiotics, excision of the wound, nutrition, and, eventually, skin grafting. This was an overall straightforward therapeutic plan. However, although our unit is well equipped for initial stabilization and our collective knowledge base was more than adequate to care for this child, we did not have the necessary facilities to continue his therapy. A combat support hospital just 2 hours away could easily provide the needed resources.[17]

The boy had a good chance of medical recovery, and was medically eligible for treatment. But if the hospital had only limited supplies, supplies which may be needed to perform their primary mission of combat support, what should the military physicians have done to uphold their medical duties as physicians and to uphold their military duties as officers?

[17] Paul J. Schenarts, "Thee-year-old Boy with Burn Wound Sepsis: A Challenge to the Ethics of a Responsible Surgeon." *Current Surgery* 2004. n.r.

§3: Thesis

In the above cases, the military physicians experienced moral dilemma when the mental models and scripts they developed by participation in two separate professions appeared to come into conflict. Given the core professional identities that they are trying to combine – the physician as healer attempting to maintain his core identity while becoming a military officer who is (1) trained to kill and be prepared to kill, (2) trained to die and prepared to die, (3) a leader of character, and (4) a servant of the nation – it is understandable that some military physicians feel a profound sense of discord when trying to act in their dual professional role as military physician.[18]

Are there true moral dilemmas in the examples presented? Assuming there are, what solutions are typically found in the literature on dilemmas as experienced by military physicians?

The literature on conflicting military physician duties offers two main solutions that will collectively be referred to in this dissertation as the "either-or solution" or as "either-or solutions." These solutions follow rationalism in that proponents for either-or solutions claim that no conflict exists because either physicians' duties override officers' duties or *vice versa*. Historically we find that either-or solutions make for convenient and mostly unambiguous policy implementation that can provide satisfactory conflict resolution in some situations. Yet, as I will argue, the either-or solutions can leave moral dilemma, to some

[18] James Toner argues that every soldier shares a core professional identity to kill, to train to kill, to die, and to train to die. James H. Toner, *True Faith and Allegiance: The Burden of Military Ethics*. 22-23. Toner further quotes Boston University president, John Silber, "A person not prepared to use his skill, knowledge, techniques, and all the weapons at his disposal for the purpose of killing on behalf of the United States of America when ordered to do so has no business in the military." Ibid.

extent, unresolved or unsatisfactorily resolved for some individuals when a conflict of duty is perceived.

The unresolved or unsatisfactory resolution of moral conflict is a result of three closely related problems with the either-or solution. First, at a theoretical level, the either-or solution tends to ignore, or minimize, the subtle yet significant fact that physicians' codes of ethics and military officers' codes of ethics appear to be in conflict due to a difference in background beliefs and professional functions of the two professions.[19] That is, inadequate consideration is given to the professional identity or the moral working-self of the military physician who must combine both professional roles. Scripts continue to come into conflict because the core identity of a physician comes into conflict with the core identity of the military officer. This may heighten the chance of, or perpetuate the experience of, moral dilemma.

The second problem occurs at the clinical level. At this level are the external factors that influence moral dilemma. The either-or solutions often do not provide adequate consideration for the culture or ethical climate that persists surrounding the practice of military medicine. As with the first problem, the culture or ethical climate of the working environment of the military physician contributes to a confusion of professional identity. Scripts may come into conflict due to conflict in professional core identities. This will possibly contribute to the chance of, or experience of, moral dilemma. This dissertation presents an exploration into either-or solutions and my conceptual framework of a moral

[19] Note that this is not a problem limited to physicians serving in the military. Public health officials must also consider the possibility of the conflicting nature of rival professional duties when dealing with communicable disease. For example, public health officials may have to consider the quarantine of individual H1N1 (Swine Flu) patients against their swishes in order to protect the general public.

topology for military physician decision-making which will provide additional understanding and conflict resolution tools for individuals interested in moral dilemma.

A third problem occurs on a pragmatic level. There is a tendency among the some proponents of the either-or solutions to advocate that military codes of ethics should *always* be followed or that medical codes of ethics should *always* be followed in cases of conflict of duty. During time of war, the military proponents may have a compelling argument that military obligations and the necessity to protect the state may justify overriding a physician's medical duty to an individual. But, as indicated in Chapter Five, during times of peace, military necessity may not require a physician to choose his military duties over his medical duties. Likewise, the medical proponents may have a compelling argument that medical obligation to the individual patient should be of overriding concern during times of peace. In Chapter Five it is proposed that during times of war there is an obligation to the military and to the necessity to provide security for the state that may require a physician to follow his military duty. Extreme proponents of either of the either-or solutions tend to view duty in absolute terms that propose that a military physician should always give higher priority to either his military duties or his medical duties.

Chapter Two explores the conflict in professional codes, duties, and moral identity of physicians and officers. Understanding these views is essential to understanding why either-or solutions are embraced and why they do not always satisfactorily resolve moral dilemma for military physicians. It is by understanding the possibility of conflicting codes of ethics and by acknowledging the perspective of physician as healer and soldier as killer that either-or solutions are to some extent defensible.

Arguments for either-or solutions are presented in Chapter Three. It presents the major themes and arguments of proponents on either side of the issue. Chapter Four presents challenges to and limitations of the either-or solutions. That chapter shows how, even though the either-or solutions are consistent with the rationalist approach of resolving moral dilemma, either-or solutions may be unsatisfactory and leave the experience of moral dilemma unresolved for some individuals. It then introduces the beginning of a new, alternate way of understanding the professional role, identity, and relationship of the military physician.

Chapter Five presents a new approach to minimizing moral dilemma as experienced by some military physicians. Although it embraces the experientialism position of handling moral dilemma, it will also present a moral topology of decision-making for the military physician that should be acceptable to rationalism. The rationalist elements include re-conceptualizing the relationship between a military physician and his clients making use of parameters that can be used to regulate the rights and duties of military physicians and their clients. This presents a type of hierarchical ordering system that allows the military physician to analyze situations on a case-by-case basis so that he can make a professional judgment as to how to uphold his professional duties. The experientialism elements include understanding a new professional identity, or moral working-self, for the military physician. With proper training, education, and character development – as well as institutional support – this will help develop, modify, and inculcate new scripts for the moral working-self of the military physician.

The newly developed moral topology presented in this dissertation will allow philosophers and clinical ethicists to help some military physicians navigate instances of moral dilemma. The moral topology allows trainers, educators, and developers to assist military physicians with the development of the conceptual space needed to preserve professional and personal integrity while upholding professional standards of competence and ethical behavior.

Chapter Two: Perceived Conflict

> Happiness and moral duty are inseparably connected.
>
> George Washington

> Military medicine is a well conceived, well advised, and well established device, system, or mechanism, the mission of which is to provide the Armed Services with a quality or brand of medical coverage that is not only essential to the proper and efficient function of the military but is moreover essential to the best interests of the individual and of the national welfare.
>
> Rear Admiral Lamont Pugh, USN
> Surgeon General of the Navy, 1952

Chapter One introduces us to the concept that moral dilemma and moral distress are experienced by physicians in the military because of a conflict in duty. Classic cases illustrating moral dilemma were presented to introduce some of the issues prevalent in the literature that demonstrate the perceived conflict of duty between the professional norms of the medical professional and the military professional. To evaluate the legitimacy of this conflict, it must be understood how these norms are developed and how the norms are reinforced in the two professions.

Research into conflict of duty often lacks a theoretical understanding of the ethical codes and codes of conduct that define the moral standards of a profession. This lack of understanding may lead to a simplified view of the professional norms, roles, and commitments that lead to a perception of a conflict of duties. To avoid mischaracterizing the medical profession of the military profession, and to allow for a true understanding of the power of the psychological forces surrounding the professional identities of medical and military professionals, this chapter examines the theoretical and ethical foundations of the norms of these two professions. The chapter seeks to provide an understanding of what

drives the perception that moral dilemma, as a result of conflict between medical duties and military duties, is unavoidable within some aspects of military medicine.

This conflict of duty arises from a perception of differing professional norms that hold the belief that physicians are responsible for healing and saving lives, while soldiers are responsible for providing for the security of the state which may involve taking of life. If the different conceptualizations of the medical profession and the military profession are correct, it becomes understandable why some military physicians report experiences of dual role conflict when it is not clear which set of professional duties should be followed. When the assumptions of differing professional identities are accepted, either explicitly or implicitly, it becomes understandable how, after identifying possible areas of conflict, typical solutions more often than not attempt to adjudicate the conflicting duties by advocating the primacy of one set of professional duties over the other, either on a global scale or within a discussion of specific issues. Either-or-solutions initially appear compelling when the proponents are allowed to assume that the professional duties of a physician are, necessarily, in conflict with those of a soldier. The next chapter will explore the either-or solutions in detail. This chapter examines the conceptualizations of the two professions held by members of the professions and by society.

Sections One and Two of this chapter will present the theoretical underpinnings of how the roles of physicians and military officers and the codes of ethics used by physicians or military officers lead to the conclusion that the professions must come into conflict, especially when united into that of the military physician. This may explain how outsiders to the professions (and to some extent those inside the professions) come to the conclusion

that the roles and ethics of physicians and military officers must conflict. This conflict leads to the necessity of developing a method of resolving moral dilemma or adjudicating how to professionally manage moral dilemma.

By understanding specific aspects of the professions that come into conflict, we can better understand why some military physicians perceive and experience moral dilemma, while others remain oblivious that there may be a conflict in duties. The degree that conflicting aspects of each profession become part of an individual's self-identities, and the degree that environmental or cognitive prompts activate conflicting scripts, will regulate or explain to what degree some military physicians may experience moral dilemma. For example, individuals who whole-heartedly accept the military persona are less likely to experience a conflict when asked to perform duties that benefit their military more than their individual patients. Conversely, individuals who maintain a high degree of identity to their physician training are more likely to experience a conflict when tasked to focus on mission objectives when doing so will cause harm to their patients. Individuals who try to embrace both identities may experience moral dilemma when environmental or cognitive processes activate conflicting scripts either simultaneously or close enough in time that, at some point, they are consciously aware of a moral dilemma developing if choosing one set of duties necessitate not choosing the other.

This would explain why, from a rationalist perspective, only one set of duties should apply in any give case. This is what could lead to either-or solutions. As a method of inculcating this approach, it is possible that some rationalists would suggest that a military physician experiencing moral dilemma should simply suppress or repress one or the other

professional identities in an attempt to eliminate the conflict. To understand the specific aspects of professional identity that may come into conflict for the military physician, the next sections investigate the roles, codes of ethics, and hidden curricula that contribute to the possibility of conflicting values and conflicting professional identities.

§1: Different Roles

Why might people conclude that the central commitments of an officer are different from those of a physician? Although the claim is well summed up by exposing the kernels of their professional identities – physicians heal and soldiers kill – there is a complex network of ideals that supports and encourages the view that these two professions must come into conflict. In addition to the development of the central ethical commitments of each profession, this network includes the development of mental models of the proper role of the physician and the military officer. Training, education, and development within these professions will, to some extent, imprint the respective ethos onto professionals in that particular field.

The modern medical institution is composed of professionals and non-professionals – physicians, nurses, assistants, pharmacists, therapists, researchers, and dieticians – whose primary role is to provide the services and tools necessary to promote the health interests of individual patients. Against the role of caring for an individual is a general, and probably unavoidable, conflict between client-based service and public-based service.

The conflict between client-based service and public-based service can arise under several different situations. Conflict can develop in at least three scenarios: when a physician's patient needs resources needed by other patients, when a physician's patient engages in behavior that endangers innocent third parties, or when a physician assumes the role of both personal doctor and public health care coordinator.

Most professions have to prioritize among the needs of individual clients and between the needs of clients and the needs of society at large. Although prioritization can be

problematic, it is often of less concern when a profession can establish norms that define whether or not the professional is primarily responsible for personal or public service. An epidemiologist would serve in, *prima facie*, a public service field while a neurosurgeon would serve in, *prima facie*, a personal service field.

Traditionally, the primary agent of the medical institution is the physician who cares for individual patients. As the primary providers of health care services, physicians are charged with providing an important service to the public through the medical treatment of individuals. Physicians, like all professionals, are obligated to follow a code of conduct or some instrument of self-control, such as *The Hippocratic Oath*, *The American Medical Association Code of Ethics, The World Medical Association's Declaration of Geneva Physician's Oath*, or various internationally accepted codes. How does this compare with the ethos of the military officer?

The modern military institution is a government-controlled and -operated network of professionals and non-professionals – officers, enlisted soldiers, civilian contractors, educators, volunteers, and in some countries, draftees – whose primary role is to provide a variety of tools and services that serve the security interests of a country. More so than other professions, the military often has its role defined by an outside authority – the government it serves. For example, the U.S. Military bases its actions on needs defined by the duly elected or appointed representatives of the U.S. Government with great weight given to the policies of the President, as Commander-in-Chief, and to the Secretary of Defense. In general the government determines the national security interests and the military determines how to uphold the nation's interests as defined and prioritized by the

government. The military can advise the government about various security interests and methods of obtaining the defined goals, but the government usually determines what constitutes security interests or how to prioritize various security interests.

The focus of this dissertation is the potential conflict that can develop when service oriented toward an individual comes into conflict with service oriented toward a group, such as a military unit or a nation. For medical personnel this can be expressed as a conflict in a service oriented toward health versus service oriented toward national security. To understand the potential for conflict better, consider the professional soldier who best represents the military at a professional level equal to a physician – the military officer.

Military officers specialize in "the management of violence" with the responsibilities of "(1) [the] organizing, equipping, and training of [his military force], (2) the planning of its activities, and (3) the direction of its operation in and out of combat."[20] This is markedly different from the responsibilities of non-officers who "are specialist[s] in the application of violence not the management of violence."[21] Yet officers and soldiers share a core identity. For example, in the U.S. Army, "Every soldier…is an infantryman…every soldier is a 'trained killer.'"[22] Every soldier, and by extension, military officer, also shares a core professional identity (1) to kill, (2) to train to kill, (3) to die, and (4) to prepare to die.[23]

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[20] Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations*, (Cambridge, Massachusetts: The Balknap Press of Harvard University Press, 1957), 11.

[21] Huntington, *The Soldier and the State*, 17.

[22] James H. Toner, *True Faith and Allegiance: The Burden of Military Ethics*. 22-23. Toner further quotes Boston University president, John Silber, "A person not prepared to use his skill, knowledge, techniques, and all the weapons at his disposal for the purpose of killing on behalf of the United States of America when ordered to do so has no business in the military." Ibid.

[23] Ibid. 23. Due to this core identity, unless a distinction is warranted I will use military officer rather with soldier because it seems to be this particular focus that leads to the perception of conflict for the military physician.

As providers of security services, officers are charged with providing an important and essential service to the public. To achieve their mission goals, officers must ideally focus less on self-serving interests and more on orientation towards community interests, specifically the interests of the country the military serves. That is to say, they should not be purely self-serving. Officers, like other professionals, are expected to follow a code of conduct and exercise some measure of self-control as set forth in various codes of conduct such as *The Officer's Commission and Oath, The Code of Conduct, The Laws of War, The Soldier's Creed*, or various international laws.

Given this understanding of the role of the military officer, and the understanding previously given regarding the role of the physician, what does this suggest about the role of the military physician?

When military and medical roles are hybridized into a physician who is a military officer, there might appear to be a non-controversial role – providing for the security of the state and healing those clients under the professional's care. In reality, attempts to combine medical roles with military roles sometimes result in situations in which it is impossible to satisfy the duties required of one or the other profession. The different roles and duties of physicians and military officers create the potential for moral dilemma, because in choosing to act on one set of duties, it is claimed, the other set of duties must be abandoned or compromised. When one abandons or compromises one's duty, one is not fulfilling one's professional code of ethics and an individual's self-identity may become confused or conflicted.

§2: Codes of Ethics and the Hidden Curricula

Like all professionals, physicians and military officers are obligated to follow a code of conduct or some instrument of self-control. Although codes of ethics can be legally binding, or even required under certain circumstances, they are ultimately a *prima facie* indication of an individual and a society subscribing to a prescribed set of moral duties. This can be at the individual level, when an individual "professes" or publically takes an oath to follow a code. It may also be at a social level where a society provides legal sanctions for a profession to engage in certain activities provided members agree to be bound to some level of ethical conduct—conduct usually sanctioned or publicized through professional codes of ethics.

Codes of ethics and professional oaths perform several functions. Oaths provide a declaration of belief, a structure of judging merit or demerit, and an instantiation of self-binding duties or conduct. They also provide a framework for a professional mental model or mental schema of a professional. In light of this, what do physicians' codes of ethics communicate about the ideals of physicians; and what do physicians' codes of ethics reveal about the mental schema or self-identity that may develop within a physician?

Consider several common codes subscribed to by the medical profession: The *Hippocratic Oath, The American Medical Association Code of Ethics Preamble,* and the *World Medical Association's Declaration of Physician Responsibility*.

A translation of the original form, *The Oath of Hippocrates* states:

> I SWEAR by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation - to reckon him who taught me this Art equally dear to me as my parents, to share my substance

> with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot![24]

Problems could arise for modern physicians trying to use this version of the medical oath. To resolve these problems, updated versions of the *Hippocratic Oath* change various aspects of the oath, e.g., eliminating pagan references, allowing for surgery, and promoting the idea to protect and help patients. In addition to modified versions of the *Hippocratic Oath*, other physician codes have become common.

Physicians who join the American Medical Association (AMA) are expected to follow the AMA's code of ethics. The basics of the AMA's code can be found in *The American Medical Association Code of Ethics Preamble*:

[24] Hippocrates, "The Oath," translated by Francis Adams, http://etext.library.adelaide.edu.au/mirror/classics.mit.edu/Hippocrates/hippooath.html

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. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

A physician shall support access to medical care for all people.[25]

[25] American Medical Association, "AMA Principles of Medical Ethics (2001)," http://www.cirp.org/library/statements/ama/

As a final example of what kind of conduct is expected from physicians, consider *The World Medical Association Declaration of Geneva (1948) Physician's Oath*:

> At the time of being admitted as a member of the medical profession: I solemnly pledge myself to consecrate my life to the service of humanity; I will give to my teachers the respect and gratitude which is their due; I will practice my profession with conscience and dignity; the health of my patient will be my first consideration; I will maintain by all the means in my power, the honor and the noble traditions of the medical profession; my colleagues will be my brothers; I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient; I will maintain the utmost respect for human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity; I make these promises solemnly, freely and upon my honor.[26]

How do these codes compare to the codes followed by military officers?

Some scholars claim that unlike physicians or lawyers, "Military professionals have never had a formal code of professional ethics akin to the Hippocratic Oath or the American Bar Association's Code of Professional Responsibilities."[27] These scholars imply that within military tradition there is not a common code of conduct whereby officers can trace their ethical origins. While military officers may not have a single historical statement, such as the *Hippocratic Oath*, upon which the ethical origins of the military code of conduct are based, modern efforts are underway to nonetheless codify a common professional military ethic. Until a common professional military ethic is established, contemporary officers' codes of ethics are derived from both formal documents and informal elements.

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[26] *Declaration of Geneva* (1948). Adopted by the General Assembly of World Medical Association at Geneva Switzerland, September 1948.

[27] James H. McGrath and Gustaf E. Anderson III, "Recent Work on the American Professional Military Ethic: An Introduction and Survey," American *Philosophy Quarterly* 30, no. 3 (July 1993): 190.

Within the United States, the formal documents include: *The Officer's Commission and Oath, The Constitution of the United States of America, The Laws of War* (composed of the Constitution, treaties, and the army's 'law of the land'), *Federal law* (*U.S. Code* and *Uniform Code of Military Justice*), *The Code of Conduct* (a non-punitive ethical guide), *The Soldier's Creed, Service Regulations, Officer Guide, Training Documents,* and *Handbooks*. Excerpts from these documents will help in understanding the ideal "professional atmosphere," or culture and climate, surrounding the military officer.

The Enlistment Oath and *Officer's Commission and Oath*:

> I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; and that I will obey the orders of the President of the United States and the orders of the officers appointed over me, according to regulations and the Uniform Code of Military Justice. So help me God.[28]
>
> I, _____ (SSAN), having been appointed an officer in the Army of the United States, as indicated above in the grade of _____ do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign or domestic, that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservations or purpose of evasion; and that I will well and faithfully discharge the duties of the office upon which I am about to enter. So help me God.[29]

The first oath establishes that a person agrees to enter into the public service of the United States and to obey the legal orders of those in authority. It specifically references the authority of the President of the United States, other officers of higher rank, and military regulations and law. Depending upon a complex arrangement of orders and laws, authority

[28] Title 10, US Code; Act of 5 May 1960 replacing the wording first adopted in 1789, with amendment effective 5 October 1962. This is the oath taken upon enlistment in the US Army.
[29] DA Form 71, 1 August 1959, for officers. This is the oath taken upon accepting a commission as an officer in the US Army.

might also be granted to international law or foreign officials. The second oath establishes that the person is voluntarily entering into a professional status with all the rights, responsibilities, and duties as established within the military structure. Once again, the same authority structures apply.

To find more specific guidelines of conduct we can examine excerpts from the formal code referenced in the enlistment oath, *The Uniform Code of Military Justice*:

> Any commissioned officer of the armed forces who, after tender of his resignation and before notice of its acceptance, quits his post or proper duties without leave and with intent to remain away therefrom permanently is guilty of desertion. Any person found guilty of desertion or attempt to desert shall be punished, if the offense is committed in time of war, by death or such other punishment as a court-martial may direct, but if the desertion or attempt to desert occurs at any other time, by such punishment, other than death, as a court-martial may direct. [30]

> Any commissioned officer who uses contemptuous words against the President, the Vice President, Congress, the Secretary of Defense, the Secretary of a military department, the Secretary of Homeland Security, or the Governor or legislature of any State, Territory, Commonwealth, or possession in which he is on duty or present shall be punished as a court-martial may direct.[31]

> Any person subject to this chapter who – **(1)** violates or fails to obey any lawful general order or regulation; **(2)** having knowledge of any other lawful order issued by a member of the armed forces, which it is his duty to obey, fails to obey the order; or **(3)** is derelict in the performance of his duties; shall be punished as a court-martial may direct.[32]

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[30] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 885, Art. 85, Desertion. I have not discovered any similar "death penalty" for civilian physicians who abandon their duties, although there are liability issues, e.g., for negligence in some cases.

[31] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 888, Art. 88, Contempt towards officials. As with desertion, I have not discovered similar speech sanctions to which physicians are bound. However, it is not uncommon to find clauses in employment contracts that regulate against inflammatory remarks directed towards the institution of service.

[32] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 892, Art. 92, Failure to obey order or regulation. I have witnessed this, although not at the level of a court-martial. The soldier tried to leave a meeting to "cool off" as tempers were flaring. An officer ordered him to stay, but he continued to walk out. Although he was not court-martialed, I was made to understand that the soldier could be given an "Article-15," punishment which would result in the soldier having to quit the Army. It could possibly have led to a court-martial and a dishonorable discharge. Unless negligence is a factor, it is

Any person subject to this chapter who is guilty of cruelty toward, or oppression or maltreatment of, any person subject to his orders shall be punished as a court-martial may direct.[33]

Any member of the armed forces who before or in the presence of the enemy – (**1)** runs away; **(2)** shamefully abandons, surrenders, or delivers up any command, unit, place, or military property which it is his duty to defend; **(3)** through disobedience, neglect, or intentional misconduct endangers the safety of any such command, unit, place, or military property; **(4)** casts away his arms or ammunition; **(5)** is guilty of cowardly conduct; **(6)** quits his place of duty to plunder or pillage; **(7)** causes false alarms in any command, unit, or place under control of the armed forces; **(8)** willfully fails to do his utmost to encounter, engage, capture, or destroy any enemy troops, combatants, vessels, aircraft, or any other thing, which it is his duty so to encounter, engage, capture, or destroy; or **(9)** does not afford all practicable relief and assistance to any troops, combatants, vessels, or aircraft of the armed forces belonging to the United States or their allies when engaged in battle; shall be punished by death or such other punishment as a court-martial may direct.[34]

Any person subject to this chapter who, without justification or excuse, unlawfully kills a human being, when he – (**1)** has a premeditated design to kill; **(2)** intends to kill or inflict great bodily harm; **(3)** is engaged in an act which is inherently dangerous to another and evinces a wanton disregard of human life; or **(4)** is engaged in the perpetration or attempted perpetration of burglary, sodomy, rape, robbery, or aggravated arson; is guilty of murder, and shall suffer such punishment as a court-martial may direct, except that if found guilty under clause (1) or (4), he shall suffer death or imprisonment for life as a court-martial may direct.[35]

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doubtful a physician would be punished for similar activity – certainly not for leaving an administrative meeting.

[33] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 893, Art. 93, Cruelty and maltreatment. Of the listed codes here, this one most closely appears applicable to physician conduct, although it would seem to fall under negligence.

[34] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 899, Art. 99, Misbehavior before the enemy. Physicians, not in the military, are not under such restrictions. In fact, civilian physicians frequently do violate many of these conditions with respect to confronting enemy troops.

[35] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 918, Art. 118, Murder. Except in special circumstances, physicians may not legally participate in the killing of another human being.

> Any commissioned officer, cadet, or midshipman who is convicted of conduct unbecoming an officer and a gentleman shall be punished as a court-martial may direct.[36]

These excerpts provide insight into differences between professional expectations of military officers as compared to professional expectations of physicians. They highlight the voluntary nature of serving as an officer, the legalization of morally appropriate actions (attitudes of speech, conduct in public, and treatment of others), inappropriateness of unlawfully killing human beings, and the explicit warnings that violating certain rules of military conduct may result in death. Overall, the articles provide legal sanctions for activity, especially in the case of *Article 133*, conduct unbecoming an officer and a gentleman, which contains elements often thought to exist solely under moral purview.

Though it may not have the clearly defined legal force as *The Uniform Code of Military Justice*, *The Military Code of Conduct* is an example of another kind of document guiding the conduct of military personnel:

> I am an American, fighting in the forces which guard my country and our way of life. I am prepared to give my life in their defense. I will never surrender of my own free will. If in command, I will never surrender the members of my command while they still have the means to resist. If I am captured I will continue to resist by all means available. I will make every effort to escape and to aid others to escape. I will accept neither parole nor special favors from the enemy. If I become a prisoner of war, I will keep faith with my fellow prisoners. I will give no information or take part in any action which might be harmful to my comrades. If I am senior, I will take command. If not, I will obey the lawful orders of those appointed over me and will back them up in every way. When questioned, should I become a

[36] United States Code, Title 10, Subtitle A, Part ii, Chapter 47, Subchapter 10, Section 933, Art. 133, Conduct unbecoming an officer and a gentleman. Examples of conduct unbecoming an officer: making false or misleading statements, failure to pay dept, public drunkenness, associating with a prostitute, failure to support family, etcetera. Many of these seem to have a "public" clause built-in. To my knowledge, physicians do not have "gentleman" clauses in their codes of conduct, although the *Hippocratic Oath* may have clauses so interpretable. Employment contracts may also contain such clauses for physicians.

> prisoner of war, I am required to give name, rank, service number, and date of birth. I will evade answering further questions to the utmost of my ability. I will make no oral or written statements disloyal to my country and its allies or harmful to their cause. I will never forget that I am an American, fighting for freedom, responsible for my actions, and dedicated to the principles which made my country free. I will trust in my God and in the United States of America.[37]

Army leaders are encouraged to promulgate *The Soldier's Creed* as both the "Warrior Ethos" and *the essence of professionalism exhibited by all soldiers*:

> I am an American Soldier.
> I am a Warrior and a member of a team. I serve the people of the United States and live the Army Values.
> I will always place the mission first.
> I will never accept defeat.
> I will never quit.
> I will never leave a fallen comrade.
> I am disciplined, physically and mentally tough, trained and proficient in my Warrior tasks and drills.
> I will always maintain my arms, my equipment, and myself.
> I am an expert and I am a professional.
> I stand ready to deploy, engage, and destroy the enemies of the United States in close combat.
> I am a guardian of freedom and the American way of life.
> I am an American Soldier.[38]

There can be no doubt that a key element in professional development is formal education, both in gaining knowledge of the technical aspects of a profession and in gaining an understanding of the moral expectations of the professionals within a given field. In the education of physicians, instructors acknowledge that "When teaching students our core values, we must consider the real world in which they will work and relax. The concept of

37 These are the main points extracted from *Army Pamphlet 360-512*. This Code of Conduct is somewhat controversial in that the code is itself challenged as causing psychological, and sometimes physical, harm to prisoners of war.

38 Army Field Manual 6-22, "Army Leadership: Competent, Confident, and Agile," Headquarters, Department of the Army, Washington, DC, Oct 2006, 4-10.

'teaching' must include…conversations held in the hallway, jokes told in the cafeteria, and stories exchanged about a 'great case' on our way to the parking lot."[39] This type of teaching, the informal element, has also been a standard within military training.

The application of the hidden curriculum is often not contained within formal education. In the military the hidden curriculum includes the informal elements of the officers' code of ethics. The informal elements of the officers' code of ethics are attitudes, expectations, and experiences which officers are expected to perceive and incorporate into their own lives. These elements include developing military virtues of courage, loyalty, obedience, selflessness, truthfulness, candor, discipline, technical competence, and integrity. They also include the discussion of problems experienced within the military life of less than free and informed consent, moral aspects of the legal plea of *respondeat superior,* and combat obedience. The informal elements also include discussions of duties when orders are conflicting, i.e., discussions include the nature of permissible versus obligatory duties with respect to obedience and disobedience when there is a conflict of orders.

The informal education of physicians and soldiers is important because interpretation of and internalization of aspects of codes of ethics, and appropriate role behavior, are strengthened or weakened through informal elements of training, education, and development.

[39] David T. Stein and Maxine Papadakis, "The Developing Physician – Becoming a Professional," *New England Journal of Medicine* 2006; 355 (17): 1794.

§3: Conflicting Values, Conflicting Identities

Given this background of the roles of physicians and military officers, as well as the professional codes of ethics that help shape their professional identities, it is possible to extract some of the underlying professional values or differences that *appear* to come into conflict between physicians and soldiers.

Physicians are typically concerned with individuals in need of health care. Central values held by physicians include: care and compassion towards those individuals in their charge, respect for human dignity and rights, concern for moral law, working towards the best interests of their patients, safeguarding patient confidentiality, advancing medical knowledge, and in some cases contributing to community development and public health. Priority is often placed on individual patient care except in the most extreme circumstances, e.g., when a patient directly presents a potential harm to an innocent third party.

Military officers are typically concerned with group interests related to mission goals in service of an entire country. Although they will have to deal with individuals, their focus is on the good of the group. Central values of military officers include: service, obedience, and self-sacrifice for the greater good of their country. Other values include courage, loyalty, obedience, selflessness, truthfulness, candor, discipline, technical competence, and integrity.

A possible professional conflict is experienced by some military physicians through internalizing, in different conceptual schemas, the mental models of two separate professions. A medical professional should prioritize responsibilities towards individual patient care, while the military professional should prioritize professional responsibilities

towards the common good and focus on overall group welfare. When accessing different schema, or when given the time to reflect upon different schema or their associated scripting patterns, this may develop into an experience of moral dilemma. Three examples emphasize this dichotomy.

When dealing with clients, physicians ought to give full, honest, and open disclosure towards their patients regarding their condition and options of treatment plans. There does not appear to be present in the physicians' codes, provisions for giving incomplete or dishonest disclosure towards their patients. Military officers and military leaders in general, are often charged with being honest. Yet, they claim that there are instances where military necessity requires them to be restrictive or misleading towards those they represent or command in order to successfully maintain mission goals.

For example, a squad leader was told by his platoon leader that he (the squad leader) should lie to a fellow squad member so that the squad member would not be distracted during an upcoming mission.[40] A military physician may be conflicted in whether to maintain confidentiality of her patients when ordered by her commanding officer to report why patients are seeking her services. Likewise, when the Department of Defense orders military physicians to participate in "man-break" tests by misleading a soldier into participating in experimental hallucinatory drug research or bio-chemical tests, the military physician may feel professional conflict[41]

[40] Personal communication, Army Center of Excellence for the Professional Military Ethic interview at Ft. Hood, 18 Nov 09. The fear is that the soldier's problems could become a distraction or dangerous and might directly contribute to the harm of other squad members.

[41] John D. Rockefeller IV, et el. "Is Military Research Hazardous to Veterans' Health? Lessons Spanning Half a Century." Staff Report Prepared for the Committee on Veterans' Affairs. United States Senate, December 8, 1994.

A second type of example shows the possible dichotomy in professional values. While both physicians and military officers may desire to preserve the confidentiality and privacy of patients and soldiers, concerns for group welfare can override this desire. In the case of physicians, dangers to the public, such as communicable diseases or threatened injury to others, can be grounds to override patient confidentiality and privacy.

Even in these cases, physicians should not exploit patient weaknesses. However, at times, military officers may have grounds to override and exploit confidentiality and privacy for mission goals. For example, Judge Advocate General officers can offer immunity to material witnesses for testimony in criminal investigations. Yet, it is acceptable for them to act like civilian "defense lawyers" to obtain a confession "confidentially and privately" then report the criminal activity to others.[42] Military intelligence officers may attempt to exploit character weaknesses in soldiers to test them for security risks. This may include using information that would normally be considered private or confidential such as patient records of psychological counseling sessions.

As a third example of the possible dichotomy of values, consider that both physicians and military officers are legally protected from accidentally causing death when they are following professional standards of competency. These same professional

[42] An example related in an interview of a Military Police soldier (MP). In a private conversation a Commanding Officer is talking to a Private about how the Private is doing. The Commanding Officer learns that the Private is feeling depressed and lonely. He has no girlfriend, no children, and the only thing he has is a fierce loyalty to the U.S. Time passes. The Commanding Officer is planning a mission where someone is needed as "bait," possibly being sent to die, so that others can accomplish the mission. Knowing that the Private is fiercely loyal to the U.S., and has no family to mourn if he dies, the Commanding Officer tells the Private that he has a critical mission for the Private. He needs the Private to infiltrate an enemy base and steal some documents. Although he lets the Private "volunteer" for the mission, the Commanding Officer does not tell the Private that military intelligence expects the Private will be killed in the attempt. Moreover, the Commanding Officer does not tell the Private that he is being used as a distraction for another more important mission. 19 March 09.

standards of competency also regulate the purposeful involvement in death. While military officers may be required to make decisions that result in the loss of life in the performance of their duties, physicians are rarely granted legal sanction to end life.

In general, physician codes of ethics and institutional training focus on protecting and caring for individual patients. Officer codes of ethics and training focus on protecting and obeying for the perceived good of the state. For physicians there is a strong socialization component of adopting a professional identity of healer; while for the military officer there is a strong socialization component of adopting the professional identity of someone who kills and prepares to kill.

From these examples, and a survey of the roles, codes of ethics, and informal elements of professional development, it is possible to draw some generalized conclusions comparing physicians with military officers.

From a physician's perspective there may exist obligations derived from their role as a physician, codes of ethics, and professional norms. These obligations include duties of nonmalfeasance and beneficence, allowing for patient autonomy, respecting confidentiality, maintaining truthfulness, and providing compassionate care. From a different perspective, military officers also have obligations derived from their role as soldiers, codes of ethics, and professional norms. These include duties of self-sacrifice, protecting noncombatants, serving military goals, and obeying lawful and moral orders. As we have seen, each set of professional ideals includes different professional duties.

The military physician is, in a sense, a dual professional. He is a professional in his role as a physician and a professional in his role as an officer. Yet, acting in the capacity of

either profession requires accessing different self-schemas or activating different scripts. Hopefully this includes activating normatively appropriate scripts. Taken individually, each professional moral schema may represent a single, unified moral working professional identity. Yet, taken together, it is possible that the professional moral schemas may come into conflict under certain circumstances.

The degree that conflicting aspects of the medical profession and the military profession become part of an individual's self-identities, and the degree that environmental or cognitive prompts activate conflicting scripts, will regulate or explain to what degree some military physicians may experience moral dilemma. For example, individuals who whole-heartedly accept the military persona are less likely to experience a conflict when asked to perform duties that benefit their military more than their individual patients.

Conversely, individuals who maintain a high degree of identity to their physician training are more likely to experience a conflict when tasked to focus on mission objectives when doing so will cause harm to their patients. Individuals who try to embrace both identities may experience moral dilemma when environmental or cognitive processes activate conflicting scripts either simultaneously or close enough in time that, at some point, they are consciously aware of a moral dilemma developing if choosing one set of duties necessitate not choosing the other.

When these core identities come into conflict, the military physician confronts the possibility of, and experience of, moral dilemma. The next chapter investigates the either-or approach to resolving moral dilemma.

Chapter Three: The "Either-Or" Solution

> To save the country is paramount to all other considerations.
>
> General Order No. 100, Art. 5.

> The physician's highest calling, his only calling, is to make sick people healthy—to heal, as it is termed.
>
> Samuel Hahnemann

Assuming that physician duties can come into direct conflict with officer duties, what conflict resolutions are available? Following a rationalist tradition, the two most common responses are: (1) officer duties should override physician duties, or (2) physician duties should override officer duties. Two additional hypotheses of conflict resolution between officer duties and physician duties seek to resolve any conflict by suggesting that: (3) officer duties and physician duties are related much like Ross characterized *prima facie* deontological duties, that is, in any given dilemma an individual weighs the duties based on the situation and carries out the ones given higher priority. Finally, it is not uncommon to see appeals made that: (4) as a member of the moral community there are non-professional duties above and beyond professional ones; thus non-professional duties may regulate the dilemma.[43]

In my interviews with military and medical personnel, and implied in much of the professional literature relating to military physicians, I find that often either (1) or (2) is taken as obviously true, with the opposing position taken as obviously false. Less often both (1) and (2) are taken as obviously false, in which case people choose either (3) or (4). However, upon scrutiny we find that in this latter case there is often still an underlying bias

[43] There are a few more options available, e.g., if we move to mapping logical systems onto duty systems. Those types of options go beyond the scope of this project. The four positions given are derived from rationalism and experientialism positions.

favoring solution (1) or (2). This chapter provides a literature review of proponents for (1) and (2). Section One will provide accounts from proponents of the view that military officer duties should outweigh physician duties. Section Two will provide accounts from proponents of the view that physician duties should outweigh military officer duties. The next chapter, Chapter Four, presents an analysis and evaluation of this literature.

§1: The Needs of the Many & Military Necessity

There are two basic approaches utilized by those defending the either-or solution that military officer duties should outweigh physician duties; what I will call the general and the specific approaches. General approaches do not specifically deal with physicians or other medical personnel in the military; they deal with general duties that *everyone or anyone* may have in a military context when military needs conflict with their own interests, duties, or liberties. The general approaches establish the foundation upon which the specific approaches are based. Specific approaches specifically target physicians or medical personnel in their arguments. They emphasize duties that *physicians* may have in a military context when military needs conflict with their professional interests, duties, or liberties.

Proponents of the either-or solution that military duties outweigh physician duties base their arguments on the assumption that a state's collective interests override an individual's interests. Thus, individuals are sometimes required to sacrifice some personal liberties or interests in order to ensure the survival of the state. The military is a necessary component of the state providing for the security and defense of state interests. Civilian and military duties are derivatives from serving the state.

Sometimes duties require individuals to serve in some capacity of service to the state, e.g., taxpayer, juror, or military conscript. Serving the state can require giving up or limiting certain individual rights to benefit the group such as when politicians are forced to give up expectations of privacy and soldiers are restricted in their freedom of speech. Through trial and error, the state and military have adopted what is essentially a rule-utilitarian approach to duty within the military – duties are derived from group benefit over

time. Consequently, it is assumed, military duties override medical duties because in the long-run the benefits of following this plan outweigh the harms of either not following the plan or outweigh any short-term harms caused by the plan.

There are several more assumptions necessary for these approaches to work appropriately. It is critical that the military faithfully discharge its responsibility pursuant to national interests. This, in turn, depends on professional soldiers faithfully discharging their individual duties. Historically we know that not all militaries or individuals in the military have faithfully discharged their duties. States, aware of the potential for abuse, usually try to enact laws or procedures to protect themselves from militaries or soldiers who do not faithfully discharge their responsibilities. For example, in the United States, the military is nominally under the civilian government's control and the military is required, expected, and obligated to follow the laws and policies of the United States. Failure to comply with executive and legislative mandates, laws, and regulations and/or policies is often met with harsh penalties.

Despite these precautions, there are failures in the system. Individuals can act in dishonorable, unscrupulous, or immoral ways. Failures can also occur when the civilian government: (1) does not give the military clear goals and mission objectives, (2) does not give clear guidance in the handling of enemy combatants, noncombatants, and terrorists, (3) fails to provide the military with just cause in their operations, or (4) fails to act ethically or morally. Included in these failures are concerns about the confusion generated by the use of privatized military firms in hostile regions, concerns with the confusion caused by changing the rules of engagement, and concerns about the confusion generated by changing policy

concerning conformity to international law. Yet, proponents of advocating the general approach of the primacy of military duties can always return to a common, rule-utilitarian defense: yes, there are occasional problems that arise in the system, yet over time following this approach results in a better society.

Given these background assumptions, how do the general and specific approaches differ? The *first approach* is a *generalized* defense that military duties, in the service of state interests, should have priority over non-military duties or over an individual's interests. For example, some countries mandate military service in such a way that individual citizens of that country must serve at the expense of their personal interests – modern Israel's mandatory military service, pre-1973 U.S. military drafts, or Romania's mandatory military service. When serving in the military individuals are expected to act to benefit the larger group, even at the expense of their own interests. This means that they are expected, if required, to participate in dangerous missions, risk their lives, or otherwise sacrifice individual liberties for the overall good. From the generalized defense, proponents for the priority of military duties can infer that military physicians must likewise give up certain rights related to their medical obligations while assuming certain duties to the state because state interests override their personal and professional liberties and duties.

The *second approach* is much more *specific*, or direct, by claiming that when military officer duties conflict with physician duties, the military duties have priority over physician duties.[44] This approach draws on much of the foundation of the general approach, especially the idea that state interests override an individual's interests. However, this

[44] Thus, physicians are ordered to act as physicians in some circumstances, but ordered to act as soldiers in other circumstances. This does, however, leave unanswered which orders are legal or not.

approach goes farther and claims that although military physicians may hold ideals contrary to what military duty requires of them, as military personnel they are still required to serve the military interests of the state. As members of the military, military physicians continue to perform the tasks of their medical professions by caring for the health of individuals, but in instances where their professional ethics conflict with their military duty, military duty assumes priority.

In particular, it is claimed that military physicians, like all soldiers, are expected to follow legal orders, even when those orders conflict with personal beliefs or physician norms of conduct. Military physicians may be expected to participate in weapons development, interrogations, and experiments on non-informed soldiers. Military physicians may be expected to help maintain the fighting strength of the military even if it means sacrificing the health or welfare of an individual patient.

In this section, I examine four authors who maintain that the state's interests override an individual's interests. I have chosen these authors because their views often reflect those of the military personnel I have interviewed. These authors provide insights as to why the claim that military duties override physician duties is not entirely unwarranted. In general, these authors propose that state interests should override individual interests. According to these authors, when military duties serve the state's interests, military physicians will find that their physician duties may become subordinate to their military duties. Huntington and London are used to illustrate the general defense, while Colbach and Gross are used to illustrate the specific defense.

§1.1: Huntington

Huntington is a strong advocate for strengthening military security and weakening individual liberalism.[45] In his work *The Soldier and the State: The Theory and Politics of Civil-Military Relations,* Huntington writes about developing a theoretical framework for civil-military relations and for developing "officership" as a profession. Although Huntington mentions physicians in the military, their role is not his focus. However, selective passages from his larger work apply to military physicians. This section will indicate how his *general* approach to civil-military relations and of "officership" as a profession leads to the claim that, during instances of professional conflicts, military duties should override physician duties.

The argument extractable from Huntington is that in order for individuals to flourish they need protection from outside forces; protection that only a state can provide. *The overriding concern for a nation must be military security*. Military security depends upon two key elements: a military actively working for the interests of the state and the actions of professional soldiers. Professional soldiers cannot be effective in their duties unless they obey orders and act for the collective interests of the military and the nation they serve.

This type of argument contends that although physicians lack command authority in the military, they are nonetheless members of the military organization. As members of the military organization, physicians are obligated to act for the interests of the military and,

[45] "Liberalism" is the term Huntington often uses to refer to a political theory that places great weight on individual liberties such as freedom of speech, association, and religion. He often also associates with this a rejection of authoritarian government and service to the state. Thus, liberalism is closely associated with, if not identical to a classical view of "liberties." Firsties (students who are Seniors at the United States Military Academy), are required to study Huntington's works. His thoughts continue to have a large impact on officer development.

hence, for the interests of the nation. As soldiers, physicians cannot be effective in their duties unless they obey orders. Given that physicians are supposed to act for the collective interests of the military, and they are supposed to obey orders, during times of conflicting duties it is necessary for a military physician's military duties to override his medical duties.

Consider some details surrounding Huntington's analysis of "officership" as professionalism and his theoretical framework for civil-military relations. According to Huntington, professionals work in a social context such that "the professional man can no longer practice if he refuses to accept his social responsibility."[46] As professionals, individuals must accept social responsibility and work, in some sense, toward the social good. In the case of military officers, they accept the social responsibility of providing for the security of the state. Historically, this responsibility translated into specializing in the management of violence: "The duties of the officer include: (1) the organization, equipping, and training of [the military] force; (2) the planning of its activities; and (3) the direction of its operation in and out of combat."[47]

Serving the state through the management of violence engenders several values: cooperation, organization, and discipline.[48] According to Huntington, these values downplay the importance of the individual such that for a military man to carry out his duty it is necessary that he "emphasizes the importance of the group as against the individual."[49] Huntington takes a strong stance for the importance of the group and claims, "Success in

[46] Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations* (Cambridge, MA.: The Belknap Press of Harvard University Press, 1957), 9.
[47] Ibid. 11.
[48] Ibid. 63.
[49] Ibid. 63. Under this type of ranking, the squad is more important than the individual, the platoon is more important than the squad, etc.

any [military] activity requires the subordination of the will of the individual to the will of the group."[50] It appears that this subordination of the will is not a minor, or weak, subordination. Rather, Huntington seems to suggest that in many cases the individual should, essentially, lose himself into the group. We can see this in Huntington's treatment of soldiers who are following orders.

> The military profession exists to serve the state….the profession has to be organized into a hierarchy of obedience. For the profession to perform its function, each level within it must be able to command the instantaneous and loyal obedience of subordinate levels. Without these relationships military professionalism is impossible. Consequently, loyalty and obedience are the highest military virtues.[51]

Perhaps remembering the events from the Nuremberg Trials, Huntington qualifies this by adding a "legal" description for when it is appropriate to follow orders. "When the military man receives a *legal* order from an authorized superior, he does not argue, he does not hesitate, he does not substitute his own views; he obeys instantly." [52] Then Huntington seems to relapse into a pre-Nuremburg mentality by abrogating personal responsibility from those who follow orders as he says, "He is judged not by the policies he implements, but rather by the promptness and efficiency with which he carries them out. His goal is to perfect an instrument of obedience; the uses to which that instrument is put are beyond his responsibility. His highest virtue is instrumental not ultimate."[53] However, Huntington acknowledges that there may be limits to following orders.

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[50] Ibid. 63.
[51] Ibid. 73.
[52] Ibid. 73. Emphasis added.
[53] Ibid. 73. On 7 August 08 two Army officers discussed historical military activity. During a conversation about LTC Oliver North they both expressed anger at how LTC North was portrayed by the media. They both insisted that he was a great officer who was doing his job as given to him by the military's political leaders. Revealing a common sentiment accepting this role in the Army, one of the majors said "What we want to do doesn't matter, we are just tools. Tools for other people."

Huntington considers two separate tensions when dealing with the limits of obeying orders. "The first concerns the relation between military obedience and professional competence, the moral and intellectual virtues of the officer. The second concerns the conflict between the military value of obedience and nonmilitary values."[54] In military operations, a person may disobey only if (1) following orders results in military disaster or (2) mission success can only be achieved by disobeying the orders.

This creates a possible confusion as this apparently goes against Huntington's previous claim that soldiers do not argue, hesitate, or substitute their own views when given an order. Huntington states that soldiers are supposed to obey instantly. He then claims that in non-operational issues, professional competence must be the criteria. The professional must ask, "Does disobeying promote more good to the profession than disrupting the chain of command?" Though Huntington's statement still gives priority to the military, the conclusions are somewhat confusing, as this claim seems at odds with Huntington's previous claims that professionals must act for the good of military security or national interests, not for the good of their professional or personal values.

An additional confusion may arise as we try to understand how Huntington deals with conflicts between military obedience and personal morality. He simultaneously claims that officers must follow the orders given to them when the giver of the order has legal authority to give it, yet:

> The soldier cannot surrender….his right to make ultimate moral judgments. He cannot deny himself as a moral individual….As a soldier he owes obedience; as a man, he owed disobedience. Except in the most extreme instances it is reasonable to expect that he will adhere to the professional ethic and obey. Only rarely will the military man be justified in following the

[54] Ibid. 74.

> dictates of private conscience against the dual demand of military obedience and state welfare.[55]

Huntington's view could be interpreted as coming very close to expressing a "case-by-case" approach to solving moral dilemma. Will this allow physicians enough conceptual space to allow their physician duties to take priority over military duties? Although this may seem initially plausible, it is nonetheless inconsistent with Huntington's overall thesis.

Consider Huntington's claim that professionals must have some type of social responsibility. As an example of this, he says, "a physician ceases to be a physician if he uses his skills for antisocial purposes."[56] Nevertheless, this is where the controversy arises. What is considered antisocial purposes when it comes to physicians serving in the military? Huntington's position implies that as long as physicians are working for the purposes of the military, and as long as the military is effectively working for the interests of the state, then physicians are engaged in legitimate social purposes.

Part of Huntington's position must be that the soldier does not judge what the interests of the state are. However, notice that it may not be clear. Is detaining people indefinitely without charges (Guantanamo) in the interests of the U.S. or not? It may make us appear to be more secure, but the cost of this practice may be excessively high to our moral standing and the added security may be temporary. Even if we restrict the scope of "national interest" to military security, it is not clear whether this practice makes us more secure (isolating would-be terrorists) or more vulnerable to terrorist attack (being more widely viewed as worthy of such an attack). The national interest here is clearly debatable. Similar concerns may arise for abusive interrogation techniques in Iraq.

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[55] Ibid. 78.
[56] Ibid. 9.

Huntington does not appear to allow for such instances where what the military is assigned to accomplish may be perceived by many to not promote the best interests of the state. Moreover, he seems to hold to the view that to effectively work for the military, physicians will have to act as though military duties override physician duties when they come into conflict.

This may not be obvious when first considering what Huntington says of physicians in the military. Recall that officers are responsible for the management of violence. Given this characterization, and given that physicians in the military are officers, yet do not specialize in violence management, Huntington notes that "Individuals, such as doctors….are normally distinguished by special titles and insignia and are excluded from position of military command. They belong to the officer corps in its capacity as an administrative organization of the state, not in its capacity as a professional body."[57] Thus, although they are officers, physicians in the military are not fully in the chain of command. They receive and give orders within the administrative duties of medical services. During combat situations, they can receive orders from enlisted personnel if no officers are present, but they cannot give orders to soldiers concerning combat operations.

Another point, which makes the duties of physicians in the military obscure, is Huntington's observation that, "While the primary responsibility of the physician is to his patient, the lawyer to his client, the principle responsibility of the military officer is to the state."[58] An officer is loyal to an institution, not a person. Yet a physician should be loyal to his patients, not just to an institution. Although it may sound as though Huntington would

[57] Ibid. 12.
[58] Ibid. 16. The modern U.S. Army echoes this sentiment when the motto of the medical services is to "preserve the fighting strength."

allow physician duties to override military duties, it may be more accurate to conclude that he would favor the opposite.

Huntington does not address directly the conflicting role of a professional physician assuming the duties of a professional soldier. Rather, he is dealing with a theoretical account of a military officer as a professional and the relationship between civil and military affairs. Although Huntington mentions physicians in various capacities, when trying to reconcile his account of physicians with his account of professional soldiers we do not reach a clear understanding of their respective duties.

Huntington's writings are used extensively in the training, development, and education of officers. His views help define current military culture and ethical climate, particularly the culture and mores of the military officer. This military culture has a profound impact on physicians as they assume the dual role of the military physician that combines the medical profession with the military profession. According to Huntington, as soldiers, physicians are expected to follow orders. Moreover, as officers "The officer submerges his own personal interests and desires to what is necessary for the good of the service."[59] Repeatedly Huntington places emphasis on the following two assertions: "The military security of the state comes first. Moral aims and ideological ends should not be pursued at the expense of security."[60] Moreover, "The military profession serves the ends of the state."[61] Huntington indicates that physicians serving in the military should be concerned, primarily, with fostering the security of the state, even at the expense of

[59] Ibid. 63.
[60] Ibid. 68.
[61] Ibid. 72.

physician related duties, personal interests, and desires relating to patient care and responsibility.

§1.2: London

Perry London's general framework offers a slightly different account of the proper resolution of conflicting duties experienced by the military physician. Rather than mandating that officer duties should always outweigh physician duties, London's position is that physicians should not be criticized for following military duties. At the very least, a doctor should be excused for following his military duty. London argues for this in his analysis of the following case:

> Fear of Flying: A twenty-six-year-old staff sergeant AC-47 gunner with seven months' active duty in Vietnam presented with frank admission of fear of flying. He had flown over one hundred missions, and loss of several crews who were well known to the patient, precipitated his visit. He stated he would give up flight pay, promotion, medals, etc., just to stop flying. Psychiatric consultation to USAF Hospital, Cam Ranh Bay, resulted in thirty-six days' hospitalization with use of psychotherapy and tranquilizers. Diagnosis was Gross Stress Reaction, manifested by anxiety, tenseness, a fear of death expressed in the form of rationalizations, and inability to function. His problem was 'worked through' and insight to his problem was gained to the extent that he was returned to full flying duty in less than six weeks. This is a fine tribute to the psychiatrists at Cam Ranh Bay. (633 Combat Spt Gp Dispensary, Pleiku AB.)[62]

This case was presented in the Hastings Center Report with the following question: In a military conflict, does the doctor serve the soldier or the state? London claims that not only were the doctors showing technical ability but they were also acting morally in serving the state to the possible detriment of their patients. London seems to base this conclusion on

[62] Perry London, "Fear of Flying: The Psychiatrist's Role in War," *Hastings Center Report* 1976; 6, no. 1: 20. This case is reprinted from the Air Force's PACAF Surgeon's Newsletter, December 1966.

a type of cultural relativism claiming that a social endorsement of military action implies that all soldiers, including medical personnel, should let military duty set their "moral compass."

To reach this conclusion London first distinguishes between what he calls "the old conventional morality" and "the new conventional morality." In the former, "A soldier's duty was to uniform, mission, or country via chain of authorized command."[63] This seems to imply that not only are soldiers expected to sacrifice themselves, if necessary, for the good of the state, but that military physicians must also do their part in supporting the greater good. Against this, the new conventional morality "implies that soldier-doctors should themselves define where their duty truly lies." [64] London disagrees with the new conventional morality. "To argue that most people can, or should be, routine arbiters of their own morality, I believe, slaps harshly in the face of reality."[65] By embracing the old conventional morality we can infer that London's position is one in which military physicians should perform duties that conform to the chain of command.

London's denial of the new conventional morality is based on two ideas. First, the reality to which he refers is that "Individual morality is built on the bedrock of social norms, and is sustained by reinforcements in social custom. It perishes slowly but surely when social norms change and the rewards and penalties for erstwhile good and bad behavior are changed to meet new rules."[66] From this we can interpret, that if social norms allow military duties to override medical duties, that is where individual morality should lie.

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[63] Ibid. 20.
[64] Ibid. 20.
[65] Ibid. 20.
[66] Ibid. 20.

The second idea London draws upon is that "most of humankind, most of the time, are too busy trying to manage the routines of daily living to spend much energy on moral calculations. Most morals get borrowed from the neighbors, the organization, or the big shot of other-directed society."[67] London believes that physicians, especially in combat situations, may not have the time to make moral calculations. In such circumstances, they have to follow the rules or policies that they are given. We see that London's position has an interesting difference from Huntington's in that for London, it does not matter if a war is perceived by some as being contrary to the interests of the military and/or the U.S. For Huntington it does matter.

Social norms and policy could mean that physician duties override military duties, but London does not create that impression. He seems to acknowledge that military duties should override physician duties because London claims that "a decent society makes the individual the last arbiter of morality, not the first one….In 1975, it is unseemly, if not immoral, to retrospectively condemn the doctors of last decade's war for doing what then looked like their duty in a cause which they probably supported."[68] The implication is that military interests are legitimate, overriding considerations, concerning a military physician's duties.

Now that two proponents of the general defense of the either-or solution claiming that military duties should have priority over physician duties have been reviewed, it is possible to extract some similar themes in their positions. First, the defenses share a belief in the overriding importance of state security through military power. Second, the defenses

[67] Ibid. 20.
[68] Ibid. 21.

emphasize state interests over individual interests, and are usually willing to sacrifice liberal freedoms in favor of state security. Finally, the defenses contain implications that physicians in the military should allow military duties to override physician duties when they come into conflict. Some of these implications might be considered subtle, yet they provide common reasoning as to why people accept this general position.

Now consider two examples of the either-or proponents that utilize the specific approach to address the claim that officer duties should override physician duties when there is a conflict underlying professional ethics or codes of conduct. First, will be a study of Colbach's position on combat psychiatry. From there consideration will be given to Gross's account of physicians in the military.

§1.3: Colbach

Edward Colbach takes no position concerning moral dilemmas of military physicians in non-combat situations. Colbach's specific account of combat psychiatry reiterates many of the themes of the medical-military dilemma and serves as a reminder of the issues that are involved. Soldiers experience many of the same medical problems that civilians experience, although the number of incidents and intensity of problems can be significantly higher in combat situations. In addition to physical injuries, combat duty produces higher rates of mental problems such as stress, paranoia, delusions of grandeur, and post-traumatic stress disorder. According to Colbach, these problems are acerbated when soldiers are treated to benefit the military organization rather than treated to benefit the individual soldier. Yet, Colbach claims that ultimately his duty, and the duty of all combat psychiatrists, is to the

military as an organization and not to the soldiers as individual patients. How does Colbach articulate the dilemma and how does he reach his conclusion that during times of combat, broadly construed, military duties outweigh physician duties?

Colbach first notes an interesting dichotomy between civilians in peacetime situations and soldiers in combat situations. In civilian life, it is considered abnormal for someone to constantly experience fear and anger. When someone has these symptoms, they are advised to seek medical attention or otherwise make changes in their life that will reduce, and remove when appropriate, the fear and anger.

Once the decision is made to seek medical help for constant feelings of fear and anger, or other medical problems, the patient can be reasonably assured that under most circumstances the physician is primarily responsible to the patient. As Colbach says, "In medical school I had been taught that my primary responsibility was to my patient. There were always some exceptions to this . . . when I had to consider my responsibility to society as well."[69] Unless the patient represents a clear and present danger to himself or others, the physician's primary concern, *qua physician,* is to treat the patient in order to resolve his individual medical issues without third party involvement.[70] Some of the more common treatments for fear and anger include having the patient avoid stress "triggers," giving the patient drugs to help minimize physiological stress, and helping the patient develop stress

[69] Edward M. Colbach, "Ethical Issues in Combat Psychiatry," *Military Medicine* (150) (1985), 257.

[70] This is the ideal and assumes (1) the physician is paid for his services (unless he is volunteering his time), (2) the physician has the proper resources for treatment (such as time, medications, equipment), and (3) the patient is cooperative in his treatment plan. Moreover, in countries without state-funded healthcare, insurance considerations may play a significant role in determining the health care of a patient. Yet, physicians often do make choices to act *as physicians* and "game the system" to benefit their patients.

management skills. In all cases, the focus is on enabling the patient to develop greater health and autonomy.

Compare the civilian situation with that of the combat soldier. "Fear and anger were present in most of the military personnel I met."[71] For Colbach this comparison precipitates a revaluation of values—whereas continuing fear and anger are considered abnormal in civilian life, they are revalued as the norms of experience and expectation within a combat military life.

This affects the therapeutic situation in several ways. First, military leaders are less likely to acknowledge that a medical problem exists because nothing is out of the ordinary. "People fighting a war were expected to be unhappy and anxious and depressed."[72] This means that unless a soldier is so fearful or angry that it causes problems within the military structure or mission, the soldier is unlikely to be sent to medical help for treatment.

Second, when a soldier visits a doctor, the doctor's treatment of the soldier is different from treatment typical in civilian practice. As a civilian psychiatrist, Colbach had a professional duty to treat his patients and help them cope with their normal reactions of fear and anger. As a combat psychiatrist, Colbach had a professional duty to consider the goals of the military. "The role of the military psychiatrist was to help soldiers cope with these feelings *for the greater good*."[73] This was reflected in the motto of the Army Medical Corps, which Colbach felt he had to adopt, to "Conserve the Fighting Strength" and

[71] Colbach, "Ethical Issues in Combat Psychiatry," 257.
[72] Ibid. 257.
[73] Ibid. Emphasis added.

consequently to adopt an ideal that "A successful Army needed *relatively healthy* soldiers to shoot guns and drive trucks and cook food."[74]

For Colbach, "relatively healthy" refers to non-optimal care from the individual's perspective when "the purpose of Army medical personnel was to keep sufficient numbers of soldiers capable of doing their jobs. The particular needs or wishes of the individual were to be considered secondary to the needs of the unit."[75] According to Colbach, treating the patient-soldier can involve misleading the patient, breaching confidentiality, and medicating the soldier in ways that may benefit the Army but not necessarily the soldier. Proponents of military duties overriding medical duties could extend this to say that this type of treatment can occur at any time in which the Army will be benefited during combat or even during peace times. Opponents to this position could point out that treating the patient in this manner would not normally be considered acceptable professional physician care in civilian life.

What about soldiers who willingly sacrifice themselves for the good of the military? Are they in some sense being mistreated when they voluntarily seek medical care with the express purpose of getting the minimal healthcare necessary to return to duty? If there is informed choice there is probably not a problem. In civilian life, similar situations occur with firefighters, rescue personnel, or police who are hurt or wounded and often want to return to their job before they are completely healthy. Executives in private business, who experience physical side-effects of stress but want to get back to the job, are in similar

[74] Ibid. 257.
[75] Ibid. 257.

circumstances. As long as these people are making informed choices, there is a sense of professional obligation to respect their wishes.

However, an interesting Catch-22 situation sometimes arises in the military. In some cases, seeking help for mental stress can actually be counter-productive for the individual seeking treatment. A psychiatrist can either (1) conclude that the soldier is experiencing normal combat reactions, in which case he is either not treated or given minimal care to return to duty, or (2) indicate that the soldier is unfit for duty. This is especially a problem for personnel who wish to perform better in the field, seek medical help for psychological problems, but are then removed from active duty.[76]

Through Colbach's writings, it becomes apparent that for Colbach there was a conflict in roles and in duties between Colbach *as physician* and Colbach *as combat psychiatrist*. The experience of this moral dilemma expressed itself as tension. This tension was not only about how Colbach treated patient-soldiers, but also about how he viewed himself. "The degree of emphasis on the group over the individual in the military, however, was certainly hard for me to accept . . . . But I did want to survive. And I quickly realized that, if I was to survive in the military, I would have to adapt to the mores of that society."[77] Thus, one reason Colbach made the decision to allow his military duties to override his medical duties was a psychological desire to survive his military experience. Yet the decision was difficult to embrace as Colbach saw the solution as a delicate balancing act. "I

[76] See: Frontline, "The Soldier's Heart." Posted online on March 4, 2005; CBS Evening News, "The Military's Showdown Over PTSD." Posted on April 17, 2008; CBS News, "Key Obstacle To Soldier Counseling Removed." Posted on May 1, 2008. NPR, Daniel Zwerdling "Soldiers Face Obstacles to Mental Health Services" and "Soldiers Say Army Ignores, Punishes Mental Anguish." *Morning Edition*, December 4, 2006.

[77] Colbach, "Ethical Issues in Combat Psychiatry," 257.

began to see it as a real challenge to operate on that thin edge where I could somehow accommodate both the individual and the unit."[78]

As a physician and a psychiatrist, Colbach's moral dilemma occurred when his training to help and care for the individual patient conflicted with his obligations as a military officer to support military goals and objectives. By choosing military duties over medical duties, Colbach experienced an inability to balance individual patient needs with those of the military unit. His failure to adequately combine his dual role as a military physician produced moral distress:

> I had schooled myself to shut out individual needs and desires and suffering…I dealt with a population of limited young men who needed all of the help they could get. I was a physician and a psychiatrist trained to help others. Yet, because of all the circumstances, in many ways I was a failure in actually reaching out to those fellows and touching them and alleviating their suffering. That simply wasn't my job, at least the way I interpreted it….And once having acquiesced to my role as a military psychiatrist, I then had to accept that my obligation to my individual patient was far superseded by my obligation to the military and, eventually, to my country. This focus is the main ethics of military psychiatry.[79]

For Colbach, it was not that military security was a priority, nor was it the case that society should determine the ethics of combat situations. Neither was it the case that some type of utilitarianism prevailed. Rather, the conditions of active war constrained his options in providing medical care to an extent that Colbach perceived that military duties should override physician duties because the ethical culture and climate of military medicine fostered actions that supported the belief that professional military ethics and duty should override professional medical ethics and duty.

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[78] Ibid. 260.
[79] Ibid. 260. Chapter Five will contain a case study of Colbach's moral dilemma.

§1.4: Gross

One of the more recent *specific* approaches for defending the mandate that military duties override physician duties comes from Michael Gross. Whereas Colbach focuses on situations during active combat operations, Gross argues that during times of war we should apply principles of medical ethics differently than we do during times of peace. He claims that because modern bioethics rarely acknowledges this difference, it is inadequate to satisfactorily deal with moral dilemmas encountered when principles of bioethics conflict with principles of warfare. Gross's solution is to re-evaluate the relationship between the foundational principles shared by bioethics and warfare. Through this re-evaluation, Gross advocates the legitimacy of military necessity. This newfound legitimacy dictates that, when a military physician perceives conflicts of duty, he should forgo his physician duties in favor of his officer duties.

Gross establishes the foundation of his ideas by first arguing that the ethics of war are not in conflict with the ethics of medicine because both of these areas rest on similar philosophical foundations. The first part of the foundation consists of values arising out of the Enlightenment, which proposes that it is "the state's duty to protect an individual's right to life, the paramount place of autonomy, self-determination, and human dignity, and the dictates of utility that constrain the duty to protect life or dignity at any cost."[80]

[80] Michael Gross, *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War,* (Cambridge, MA.: The MIT Press, 2006) *28*. Notice that this probably will not justify many wars – not Korea, not Vietnam, not Iraq. Maybe this is where Martz comes in. The soldier's duty is to fight and win even wars that are not justified by appeal to these values.

The second part of the foundation consists of shared principles: the right to life, respect for autonomy, human dignity, and utility.[81] According to Gross, it is in the shared values where medical-military dilemmas originate – that of state duties coming into conflict with an individual's rights. Resolution of these dilemmas is adjudicated through an appeal to the shared principles.

Normally there is no conflict between state interests and individual rights because "in nearly all cases imaginable, bioethical norms should prevail in the conduct of medicine: physicians should respect confidentiality and patient autonomy, medical personnel should remain neutral, and patients should receive care solely subject to medical need. But during war, military necessity may override these duties."[82]

In times of war, however, the state must sometimes "set aside many of the principles that prohibit intentional harm to others and accept the need to take life and wreak destruction, either to save ourselves, save others, protect cultural artifacts and traditions, or avenge a wounded sense of pride and honor . . . the conditions necessary for human existence and for making our lives worth living."[83]

As Gross claims, whether or not ethics shift during times of war is often dichotomized into either a "realist" position or an "idealist" position. According to the realist view, at the national level, morality follows only one rule – survival. In the fight for survival, ethics may be minimized or eliminated whenever state interests are jeopardized. Against this view, Gross continues, are idealists who think that the state is a tool to help people attain the ethical life. A classically liberal state ensures the conditions necessary for

[81] Ibid. 28.
[82] Ibid. 62.
[83] Ibid. 324.

liberty and happiness, but must be regulated or it risks destroying the very ideals it is trying to protect.

During war, according to Gross, one of two things happens. Either the ethical focus shifts to survival, in which anything necessary for survival is allowed, or certain ethical principles are subordinated in order to ensure that the state survives in order to protect individuals' liberty and happiness. In the former case, the government may determine that certain rights of privacy are counter-productive to national security and institute a secret national phone-tapping system. The idealist position, on the other hand, might advocate a slight loosening of privacy rights, but still mandate that privacy be respected by maintaining the requirements of showing probable cause and respecting legal procedures to ensure that privacy is not violated. Whether the realist or idealist position is taken, Gross maintains, there is a shift from ethics that are appropriate in times of peace, to ethics that are appropriate in times of war.

Medical ethics is included in this shift. Military necessity becomes an overriding concern when state interests are significantly threatened, such as when the state is no longer able to provide for the conditions necessary for liberty or happiness of its citizens.[84] Priorities, including appropriate forms of medical care, are shifted to maintain combat readiness and facilitate the goals of the military. In particular, the focus of medicine is no longer on individual patients, but on preserving force strength. This influences the right to life, self-determination, and patient welfare because, "claim rights vary from patient to patient as a function of medical need and identity."[85]

[84] Unfortunately, Gross does not elaborate on what conditions justify "military necessity."
[85] Gross, *Bioethics and Armed Conflict,* 327.

Gross supports his claim that medical ethics in times of peace is different from medical ethics in times of war by arguing first, "the hallmark principles that drive bioethical decision-making in ordinary clinical settings are largely absent. Military personnel do not enjoy a right to life, personal autonomy, or a right to self-determination to any degree approaching that of ordinary patients."[86] Second, "the principles of contemporary just war may simply override many bioethical concerns. Military necessity grants paramount authority to reason of state, proportionality limits but does not eliminate excessive harm, and the doctrine of double effect permits unintentional harm to noncombatants."[87] Gross also challenges the presumption that physicians, especially military physicians, have a duty to provide care and that patients have a right to receive it.

Ultimately, Gross maintains that the realities of combat limit what would normally be thought of as absolute rights, such as peacetime respect for autonomy and its derivative emphasis on informed consent, respect for privacy, and confidentiality. That is, the realities of war dictate that military necessity severely curtails informed consent, privacy, and confidentiality. Thus, Gross maintains that military officer duties ought to override physician duties.

[86] Ibid. 15.
[87] Ibid. 15.

§2: The Patient Comes First

For most members of the medical community, the inclination to follow the ideals of the medical profession is strong. This often follows from both personal convictions and from training. Physicians are trained to perceive that the patient comes first and that a physician has license to exercise their own professional judgments regarding patient care. This is evident in the *World Medical Association International Code of Medical Ethics*. According to the WMA, general duties of a physician include:

> A physician shall…always exercise his/her independent professional judgment and maintain the highest standards of professional conduct…respect a competent patient's right to accept or refuse treatment…be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity…deal honestly with patients and colleagues…respect the local and national codes of ethics.[88]

Specific duties to patients include:

> A physician shall…act in the patient's best interest when providing medical care…respect the patient's right to confidentiality…in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.[89]

On the basis of the spirit of this code, the belief that in most instances the patient's needs take priority over other duties, leads to the claim that physician duties should override officer duties. For some, the code identifies potential areas of conflict between the physician's medical duties and his duties as a military officer. The WMA code states that physicians should exercise independent professional judgment in the medical care of their patients, they should respect the patient's choice of accepting or refusing treatment, they

[88] "World Medical Association International Code of Medical Ethics." October 2006, online resource: http://www.wma.net/e/policy/c8.htm
[89] Ibid.

should maintain full professional and moral independence concerning their patients, and they should deal honestly with their patients.[90]

Proponents of this view often take one of two approaches. From an extreme position, proponents argue that physicians are unable to act morally when forced to abandon, alter, or subvert their physician duties towards individual patients in favor of other concerns. At a less extreme position, it is claimed that more harm than good occurs when physicians are not allowed to exercise their physician values and duties. Harms may be to the patient, the physician, or the society.

According to the World Medical Association, and modern medical traditions, there is an assumption that all things being equal, the patient comes first. Exceptions to this rule seem to apply to two specific situations. One, when the patient may cause harm to others, the physician has permission to protect the third party, including breaking confidentiality, medically confining his patient, or reporting a patient to the proper authorities. Two, when the physician is acting for a third party, in which case the patient should have full knowledge of that situation and consent to the treatment under the criteria established by the third party.

The potential for conflict of duties arises in understanding how that second situation applies to a military physician. The previous section illustrated how some scholars claim that military physicians should let their military duties override their medical duties. In contrast, the scholars in this section will claim that even when working for a third party, such as the military, there are some ethical duties that cannot be abdicated. Their claim is that a good physician, a moral physician, first attends to the care of his patients and then considers other obligations and duties.

[90] Pearl S. Buck's story, "The Enemy," highlights the deep-seated commitment a physician has to patient care.

The claim that physician duties should override military duties is usually formed by utilizing one of two different arguments. One argument focuses on a specific issue and uses the issue as a justification to claim that in this area physician duties clearly override other duties, such as military duties. This approach argues for physician duties overriding military duties in a certain type of situation or conflict. The general argument of these scholars would be: A physician may never purposefully use medicine or medical knowledge to cause harm to another individual, therefore physicians may never participate in combat roles (or, some may argue, any military role). Moreover, whenever someone has a medical need, and the physician is in a position to help, that physician should address that person's medical need. The argument concludes that there are some things physicians do not do, such as purposely or directly using their medical skills to cause harm to individuals. The "specific duty" argument claims that if physicians do not override other duties there is a potential of violating the dictate that patients come first which risks causing harm not only to the patient, but also to the physician and possibly the institution of service.

The second type of argument used by scholars, seeks to establish that generally physician duties override other duties. This is done by extending the focus of the argument to many issues and then extrapolating to all situations. Again, an appeal is made that it is wrong for physicians to use their medical knowledge in ways that cause harm. The scholars then illustrate how allowing military duties to override physician duties causes harm. Harms include not only harms to individual patients, but also harms to physicians or even to the institutions of service. For example, certain activities may subvert a physician's role as a healer, or risk psychologically harming the physician. Scholars using this type of argument

claim that ultimately, for various reasons, unless military physicians are able to practice as physicians unbound from other duties, they are unable to act as moral agents.

§2.1: Sidel

Sidel contrasts nicely with both Huntington and Colbach. Huntington represents an extreme where military duties override physician duties; Sidel represents an extreme position where physician duties override military duties. Colbach represents a position claiming that in combat situations it is necessary for personal survival to forsake or substitute the professional ethics of a physician. Sidel claims that there is no conflict between military and medical obligations because "It is morally unacceptable for a physician to serve as both a physician and a soldier in the United States military forces, and probably in other military forces as well."[91] The overriding ethical principles of medicine are "concern for the welfare of the patient" and "primarily do no harm;" while the overriding ethical principles of military service are "concern for the effective function of the fighting force" and "obedience to the command structure."[92] Because these principles conflict, according to Sidel:

> The ethical principles of medicine make medical practice under military control fundamentally dysfunctional and unethical. Medical practice under these conditions of military control may be harmful to the personnel being cared for, to the overall mission of the armed forces, and to the practice of medicine—not only in the military service but in other settings as well.[93]

[91] Victor W. Sidel and Barry S. Levy, "Physician-Soldier: A Moral Dilemma," in *Military Ethics*, vol. 1. ed. T.E. Beam and L.R. Sparacino, Textbooks of Military Medicine (Washington, DC: Borden, 2003) , 312.
[92] Ibid. 295.
[93] Ibid. 296.

Sidel explores five ethical dilemmas where, he claims, these principles significantly conflict with each other.

First, according to Sidel, by adopting the motto "To preserve the fighting strength," military physicians are guilty of subordinating the best interests of their patients. Sidel identifies four areas in which military interests override patient wishes or fail to attend to a patient's best interests: triage, medical research, violations of confidentiality, and a failure to keep adequate medical records.

According to Sidel, military triage does not follow medical standards of care in that patients are not treated in order of severity of condition. Rather, soldier-patients are treated in order to expedite the return of soldiers to the ranks regardless of long-term medical consequences. Sidel identifies the practice of dividing military casualties into at least two groups. The first group is labeled "expectant" in that they are expected to die because their injuries require extensive treatment that exceeds the medical resources available in the field. It is not that there are unavailable resources, either in the field or in some "safe" zone, but medical resources are saved for casualties in the second group. The second group is the "walking wounded." Their wounds are dressed quickly so that they can have weapons issued to them and continue fighting. Sidel does not identify any other classifications of the wounded. Triage is based not on the medical needs of the individual soldier, but on the military needs of getting troops back in the field. One of Sidel's objections with this practice is that extended care is neither provided nor expected for wounded soldiers.[94]

[94] Gross's account of the history of medicine in the military confirms that there is historical precedent in which nations do not provide medical care for soldiers. See "Medical Care for the Wounded," and "Wartime Triage" in Gross's *Bioethics and Armed Conflict*. See also John Rockefeller's testimony before the U.S. Senate "Is Military Research Hazardous to Veterans' Health? Lessons Spanning Half a Century. A Staff

Sidel also claims that medical research, such as nuclear or biochemical testing, is conducted on soldiers without informed consent.[95] Medical research in the military is not bound by typical safety protocols. In 1990, the Food and Drug Administration provided the Department of Defense with a waiver authorizing the use of investigational drugs and vaccines. The FDA justified this ruling for a number of reasons. First, there is an appeal that trying "something" is better than "doing nothing." Second, there is an appeal that "extraordinary circumstances" warrant extreme measures to attempt to save lives. Third, there is an appeal that people who lack capacity to make decisions in life-threatening conditions would want medical personnel to attempt to try to save their lives.[96]

According to Sidel, violations of confidentiality are generally accepted in the military; unless it pertains to military or national security, there are no secrets in the military. According to my interviews, commanding officers can order disclosure of any medical knowledge of a soldier under their command that may be relevant to military performance. Officers decide what is relevant.

Finally, Sidel proposes that there is a general failure in the military to keep adequate medical records. This failure, he claims, impacts long-term healthcare for soldiers, as it is difficult, if not impossible, to track or treat long-term injuries or ailments.

Report Prepared for the Committee on Veterans' Affairs," United States Senate December 8, 1994. 103d Congress, 2d Session – Committee Print – S.Prt. 103-97.

[95] In cases where soldiers have the option to refuse medical testing, some do not feel free to do so. Sometimes soldiers are not informed of medical testing. The typical reasons for not informing soldiers of testing are that when large groups of soldiers refuse testing, the testing results are no longer reliable. Also, reasons of "national security" are often invoked to insure secrecy. See Gross's "Patient Rights for Soldiers" in *Bioethics and Armed Conflict*, Randerson's "Experimental drug given to British troops in Iraq and Afghanistan," and John Rockefeller's testimony "Is Military Research Hazardous to Veterans' Health?"

[96] Sidel and Levy, "Physician-Soldier," 297.

The second set of ethical problems confronting military physicians concern Sidel's claim that military physicians are guilty of overriding patient wishes in at least three areas: medical immunizations, management of psychiatric problems, and engaging in inappropriate triage. Sidel sees no problem with using known effective immunizations in order to protect an individual against harm.[97] He disagrees with immunizations used for the good of the fighting force because this undermines a soldier's autonomy and is "destructive of good patient care in the long run because the soldier is not an active participant in decisions relative to his personal healthcare."[98]

There are also two methodological concerns Sidel identifies with military medical immunizations. Experimental immunization follows more "intuitive" protocols than "evidence based medicine" in that decisions to test vaccinations are less likely to be determined by clinical trials and more likely to be protocols from unproven techniques. In a recent case of anthrax vaccinations, the vaccine was untested and had unknown results. Moreover, experimental immunizations appear to suffer from a problem of inadequate record-keeping. "We disagree with the military's requiring administration of a vaccine that may have been of questionable efficacy and safety, as we allege in the case of the anthrax vaccination, when problems with medical record-keeping may make it impossible to track who might have received a 'bad' batch of vaccine."[99]

Along with imposing immunizations, military physicians do not ethically manage psychiatric problems, according to Sidel. Reminiscent of Colbach's account of combat

[97] Sidel agrees that communities have a right and a need to protect themselves from the spread of known and preventable diseases. It is not clear why Sidel objects to this practice in the military as, often, military decisions to immunize soldiers to protect the overall group are justified on similar grounds.
[98] Sidel and Levy, "Physician-Soldier," 299.
[99] Ibid. 300.

psychiatry, Sidel questions, "Is battle fatigue or a severe stress reaction to be treated by rest...and prompt return to the battlefield, or are these symptoms of illness that require more treatment?"[100] Over-evacuating (sending too many patient-soldiers to hospitals or areas away from the combat area) is considered a cardinal sin in combat psychiatry, thus significantly affecting the treatment of soldier-patients.

Finally, Sidel claims, military physicians are forced to engage in battlefield triage involving euthanasia. Sidel is particularly concerned with two situations that he claims result in unethical and unprofessional action. Sidel questions the appropriateness of using euthanasia for the dual purposes of relieving pain and hastening death for expectant patients. Sidel also questions the practice of battlefield euthanasia, as a practice of military physicians, when the decision is made not on medical grounds, but, for example to silence a wounded soldier's cries of pain and distress which may endanger other soldiers.

The third set of ethical dilemmas revolves around Sidel's claim that military physicians are guilty of failing to provide appropriate care to others, such as civilians and enemy soldiers, possibly violating requirements of the Geneva Conventions. Sidel explains that there are strong historical traditions of military physicians treating their own casualties first, allies second, civilians third, and the enemy (if at all) last. The Hippocratic tradition and the American Medical Associations' inscription on the Washington Monument "*Vincit Amor Pariae,*"[101] indicate that during times of war it is acceptable for military physicians to follow these traditions. Sidel views this as unethical procedure that violates the Geneva Conventions.

[100] Ibid. 300.
[101] Love of country prevails.

Moreover, Sidel asserts that physicians or other medical personnel sometimes use their medical knowledge to gain information from their patients. This tradition was also challenged with the adoption of the Geneva Conventions. Sidel interprets the Conventions to state:

> Regarded as 'noncombatants,' medical personnel are forbidden to engage in or be parties to acts of war...The wounded and sick soldier and civilian—friend and foe—must be respected, protected, treated humanely, and cared for by the belligerents...The wounded and sick must not be left without medical assistance and the order of their treatment must be based on the urgency of their medical needs...Medical aid must be dispensed solely on medical grounds, 'without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria'...Medical personnel shall exercise no physical or moral coercion against protected persons (civilians), in particular to obtain information from them or from third parties.[102]

Sidel provides accounts as to why or under what situations these duties are violated. For example, as military physicians become attached to their own group, they are at risk of failing to fully attend to the needs of patients from other groups. One result of this may be the rise of untreated civilian casualties in modern warfare. Moreover, enemy soldiers in need of medical care may not receive care due to reasons of patriotism or national security. Sidel believes that military physicians are psychologically at risk of adopting an "us" versus "them" mentality that undermines medical practice and ethics.

According to Sidel, the fourth moral dilemma is that military physicians are guilty of blurring combatant and noncombatant roles. There is a significant tradition of doctors as voluntary and active combatants. During the Crusades, the Knight Hospitallers were infamous for engaging in battle one moment then rendering medical aid to the survivors of combat the next. Sidel claims that more recently, U.S. Military surgeons have been awarded

[102] Sidel and Levy, "Physician-Soldier," 301.

Medals of Honor for commanding troops during U.S. engagements.[103] Sidel claims that Special Operations Forces' medics primarily use medicine as a weapon "to seek and destroy the enemy" first and "only incidentally to take care of the medical needs of others on the patrol."[104] Sidel believes, "physicians are always physicians and therefore should adhere to their ethical duty to 'do no harm.'"[105]

For Sidel, the blurring of combat duties and medical duties can be seen in several other areas. One area is that of developing weapons. When military physicians work on weapon systems, they may be in danger of violating the medical prescript to "first, do no harm." Another area of possible conflict is that of participating in or failing to report torture.

Sidel's final accusation against military physicians is that they are prevented from acting as moral agents within the military. There are three areas in which Sidel claims that physicians in the military are prevented from acting as moral agents: (1) attempting to protect military personnel, (2) taking moral actions in the military, and (3) expressing their moral protest. Sidel states that the institutional mentality of the military, especially the health professional's inability to refuse to obey orders, dictates that physician duties are overridden by military concerns; concerns which do not cohere to the principles of medical ethics. Not only are physicians forced to forgo their physician centered duties, they are prevented from protesting this situation. According to Sidel, when they are an active

[103] Which, given recent prohibitions against physicians taking command, sends a mixed message to soldiers on the ground.
[104] Sidel and Levy, "Physician-Soldier," 305.
[105] Ibid. 305.

member of the military, soldiers must relinquish their right to pro-actively participate in the political process, including public protests.[106]

Given the five broad areas of ethical concern addressed by Sidel, he claims that the conflicting principles of medicine and warfare are truly a moral dilemma:

> The role of the 'physician-soldier' [is] an inherent moral impossibility because the military physician, in an environment of military control, is faced with difficult problems of mixed agency that include obligations to the 'fighting strength' and, more broadly, to 'national security.' Furthermore, these physicians are assigned to specific duties and committed for a fixed period to military service, both of which preclude options that civilian physicians have for resolving role conflict and the dilemmas inherent in those situations.[107]

§2.2: Howe

As Colbach represents a position that survival in the military during active combat requires adopting the military point of view and abdicating physician duties, Howe represents a position that to retain their humanity, and for a society to remain civilized, physician values must be upheld, especially when they go against military values.

Howe concentrates on issues faced by U.S. military physicians since the terrorists' attacks against the U.S. on September 11, 2001. Howe's project is concerned with identifying the implications of taking military duties as overriding physician duties. Howe maintains that some values, particularly those held by physicians, must remain unchanged even if they go against optimal military interests or the interests of the society that a military

[106] At the 2009 Global Leadership Conference (GLC), Don Snider took this view farther and suggested that officers should relinquish their right to vote. March 26, 2009, United States Military Academy, West Point, NY.
[107] Sidel and Levy, "Physician-Soldier," 296.

serves. To hold otherwise, he claims, regresses society and turns society from civilized values to more barbaric values.[108]

These claims follow from Howe's general discussion regarding the leading issues faced by physicians tasked with being part of a team monitoring terrorist prisoners: Can physicians participate in the torture of terrorists? How do physicians deal with suicide and psychological care? How are prisoners of war treated? Should prisoners be given protective or preventive treatments such as vaccines or experimental medications? What should be done when the military medical triage principle is at stake? These issues are examples of the moral dilemmas which military physicians may encounter prompting moral distress.

Howe first considers issues of torture. He suggests that to engage in torture, a society must revert to pre-civilized standards, presumably standards that the society has abandoned. Howe does not categorically claim that physicians should not participate in torture. Instead, he claims that "If certain interrogation practices are deemed unethical or illegal, military physicians have professional obligations as doctors and military obligations, like all soldiers, to oppose them. If they remain silent, they, like the rest of society, will be guilty of moral complicity."[109]

Along with issues of participating in torture, military physicians also have to question to what degree they intervene in potential suicide attempts and to what extent they engage in psychological care or prisoners. Howe's concern is that terrorists are at a higher risk of suicide than typical civilian prisoners or prisoners of war. He claims that although physicians could use physical restraints on terrorists, this could be interpreted as a human

[108] Edmond G. Howe, "Dilemmas in Military Medical Ethics Since 9/11," Kennedy *Institute of Ethics Journal* 13, no. 2 (nd): 186.
[109] Ibid. 176.

rights violation. Howe believes that physical restraints increase long-term harms to prisoners and involves treating terrorists differently from other prisoners.

Further complicating the matter, quality health care requires trust between a patient and physician. Trust is significantly eroded when medical workers participate in interrogation or torture procedures. This implies, according to Howe, that medical workers should not participate in non-health related activities with prisoners.

The history of treatment of prisoners of war has significantly changed over the centuries. Historically it was not uncommon that all "enemies," soldier and civilian, were killed or taken for slave labor. Sacrificing the enemy to "the gods" was also practiced. In some wars, prisoners were given the option of offering an oath not to fight again or even granted the chance to join their capturer's army. As medical practice began to improve and gain acceptance in military campaigns, it was somewhat common to use prisoners as experimental test subjects. In modern times policies for some countries and militaries have developed that require a more humane treatment of prisoners.

Humanely treating prisoners of war still meets difficulty. According to law, POWs under capture by U.S. forces deserve the same medical care as U.S. soldiers. This follows from both pragmatic and moral concerns. Pragmatically, U.S. military forces hope for reciprocal treatment for captured U.S. soldiers. New standards of combat morality indicate a belief that equal treatment seems to be the correct thing to do. However, what does the requirement of "equality" really entail? According to Howe:

> Some soldiers and military physicians, however, believe that it is ethical to violate the Geneva Convention because, like terrorists, POWs can give valuable information. Others believe that, even if POWs cannot or will not provide information, they still should not be treated equally because they do

> not deserve to be: First, they may have killed U.S. soldiers; second, even if they have not, since they are enemy soldiers, they are not innocent bystanders; and, third, treating them equally would demoralize U.S. forces, especially if U.S. soldiers were not treated or their treatment was postponed, as a result.[110]

Howe claims that since some physicians have displayed the capacity to treat enemy soldiers equally, even when it is difficult to remain objective, all physicians ought to be willing to treat POWs equally. Howe's argument is not explicit. He converts the fact that some people are able to remain objective, to the moral rule that all people ought to be able to remain objective. Perhaps he relies on notions of professional responsibility to combine practice with moral approbation.

If military physicians treat enemy POWs equally with respect to allied soldiers, what does this entail when it comes to giving prisoners protective agents? "Protective agents," in the context of Howe's concerns, seems to be an euphemism encompassing vaccinations, experimental medications, and experimental procedures used on soldiers. For example, Howe claims that against standard civilian research protocols the U.S. Government frequently requires its soldiers to take bio-chemical "protectives," experimental blood clotting agents, and other "treatments" which have not been fully tested.[111] He believes medications are tested or used "off-label" to determine possible effects in cases of chemical or biological attacks.

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[110] Ibid. 178. Howe's belief that some prisoners are not subject to Geneva Conventions' protections is further enhanced by the U.S. refusing to classify some prisoners as combatants or citizens of the location of conflict where they were arrested or detained.

[111] Ibid. 180, 181, 182. See also John D. Rockefeller IV, "Is Military Research Hazardous to Veterans' Health? Lessons Spanning Half a Century." Staff Report Prepared for the Committee on Veterans' Affairs. United States Senate, December 8, 1994.

Howe holds that although the military should not require its soldiers to take medication as part of a testing program, it can nonetheless require the medication as a stipulation for entering battle.[112] That is, during peacetime soldiers should not be part of a general medical test, but during wartime, or in preparation of war, soldiers can be required to take the medication as part of their combat readiness preparation.

Would similar treatments apply to civilians or POWs who come under the care of a military physician? Howe points out that under the popular notion of "equality of treatment" not only would this be permissible, but also it is required. Although prisoners of war are not being prepared to participate in a battle, the prisoners must be treated as if the battle may come to them. In some situations, those who care for prisoners must consider or plan for action in the case that the prisoners are unwittingly forced into combat situations. For example, if soldiers are given medication to protect them from possible biological agents used against the compound where prisoners are being held, prisoners must also be protected.

Equality of care may also influence rationing of limited supplies. What should be done when military medical triage is at stake? According to Howe, "The medical triage principle holds that when resources are limited, military doctors may first treat soldiers who can return to the front, as opposed to those soldiers who cannot return. They may do this so that the war effort can succeed, even though they anticipate that as a result some of the

[112] Howe, "Dilemmas in Military Medical Ethics Since 9/11," 180, 181, 182. See also John D. Rockefeller IV, et el. "Is Military Research Hazardous to Veterans' Health? Lessons Spanning Half a Century." Staff Report Prepared for the Committee on Veterans' Affairs. United States Senate, December 8, 1994.

soldiers whose treatment is delayed or preempted may die."[113] Military physicians may then experience a problem as:

> The ethical question confronted by military doctors would be whether they could apply the military medical triage principle in the usual way by treating first U.S. soldiers who could return to the front, then more severely injured U.S. soldiers, and finally, equally injured POWs. They could not, since this would not treat equally injured POWs equally.[114]

Howe concludes with the following observations. "The cardinal question posed by these new issues is what priorities, if any, should stay the same. If there are any ethical priorities that should remain unchanged, it would seem that the values that should be retained are those relating to the treatment of captured terrorists and POWs."[115] This contrasts with Gross's view. Gross argues that ethical principles and priorities must change in time of war; Howe argues that certain principles must remain unchanged even in times of war.

Howe is especially supportive of maintaining principles and values when it comes to the treatment of prisoners. "To respect all persons, once captured, affirms human dignity. Respecting human dignity may be the major underlying, if not the sole justification, for conducting all wars. Thus if, after 9/11, no other time-honored values are continued, those regarding the treatment of these prisoners would seem most to warrant being retained."[116]

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[113] Howe, "Dilemmas in Military Medical Ethics Since 9/11," 182.
[114] Ibid. 183.
[115] Ibid. 185.
[116] Ibid. 186.

§2.3: Jadresic

Whereas Howe focuses on physicians retaining their humanity, and the dangers of social regression if physicians abdicate their patient-centric health-care focus, Jadresic focuses on professional integrity, following codes of ethics, and following international law. Moreover, not only does he address the illegitimacy of physicians participating in certain kinds of activities, Jadresic also addresses the immorality of not allowing physicians to treat those in medical need. In contrast to Sidel, who claims a physician cannot act morally and ethically as a member of the military, Jadresic represents an individual's search for a methodology that would allow active participation in the care of individuals while maintaining professional ethics even within a military climate.[117]

On September 11, 1973, the Chilean military staged a *coup d'état.* Chile's National Stadium was used as an internment center for those suspected of opposing the *coup*. One of the detainees was Alfredo Jadresic, a prominent physician. During his detention, Dr. Jadresic was asked to be a prisoner-doctor. Based partly on the reports from prisoners that "they had seen doctors and nurses participating in the interrogations"[118] Jadresic became a prisoner-physician in order to help relieve the suffering experienced by the prisoners. In this role, Jadresic witnessed the results of torture.

[117] Jadresic also represents the view of a prisoner of war. This adds an interesting aspect, which goes beyond the scope of this dissertation, as to what moral duties are required of prisoners when it comes to dealing not only with their fellow prisoners, but their captors. To borrow from Viktor Frankel, this may well represent a position where ideas are developed by a prisoner of war searching for some meaning and goodness in a life suddenly ripped apart by war and chaos. Also, Howe and Jadresic's positions are interesting as Howe represents a philosopher advocating the ethical treatment of prisoners by physicians, while Jadresic is a – physician-prisoner-philosopher experiencing how a physician should act ethically towards his fellow prisoners and possibly his captors.

[118] Jadresic, "Doctors and Torture," 125.

Although he found that some of the medical workers were supportive and sympathetic towards the tortured prisoners, he also found that the majority of medical workers either pretended to ignore the situation or rationalized it. "'What do you expect? We are at war!' Taking for granted, obviously, that the practice of torture should be acceptable in case of war."[119] This echoes the claim that ethics during times of war are different from ethics during times of peace. How does this apply when medical workers find themselves transformed from primarily working as healers of individuals to interrogators for the state? Jadresic accounts for the various ways medical workers may become directly or indirectly involved with torture, "as advisors in the use of drugs or the effectiveness of certain procedures, by ensuring that torture may continue, by covering up evidence of torture, by neglecting sick or injured prisoners and sometimes by participating themselves."[120] The involvement with torture sometimes includes experiencing moral conflict, particularly "between loyalty to the patient-prisoner or to the institution to which they belong."[121] Because of his own personal experiences, Jadresic developed a strong position against torture.

Jadresic's basic position is "the moral rejection of all forms of torture in all circumstances."[122] He rejects both retributive torture as well as interrogational torture. Implicit in this rejection is a rejection of claims that either state or military interests can provide mitigating circumstances for either type of torture. He emphasizes that medical personnel have *absolutely no* legitimate role to play in torture. "It has been considered a

[119] Ibid. 126.
[120] Ibid. 126.
[121] Ibid. 126.
[122] Ibid. 124.

fundamental responsibility of the medical profession to judge the moral and ethical propriety of each medical act that affects another human being. I would explicitly add that this responsibility commits all medical societies and medical associations to condemn the participation of any of their members in any way in the practice of torture."[123] This claim is followed by both general humanitarian prohibitions against torture as well as specific professional prohibitions of torture.

In general, humanitarian ideals dictate, "From a moral point of view the intention to break the will of the victim through degradation and destruction of the human personality is inadmissible."[124] Jadresic does not argue for this claim of moral inadmissibility of torture for all; however he does give specific prohibitions against torture from a medical point of view. Even if there does not exist a general prohibition against torture, various professional standards in medicine, as expressed in medical codes, do take a stance against torture.

Jadresic's reasoning that to maintain professional integrity physicians should not participate in torture is based on recognized codes of ethics. According to the *International Code of Medical Ethics*, "Under no circumstances is a doctor permitted to do anything that could weaken the physical or mental resistance of a human being, except for strictly therapeutic or prophylactic indications imposed in the interest of the patient."[125] 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

[123] Ibid. 126.
[124] Ibid. 126.
[125] Ibid. 126. See World Medical Association "Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment" for more specific details of this position.

offence or 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 or strife."[126]

The ethics surrounding torture are not associated only with direct participation of medical workers. According to Jadresic, medical workers should not be prevented from treating victims of torture. Others have a responsibility to allow medical workers professional autonomy in carrying out their duties. In a position similar to Sidel, Jadresic claims that physicians should be able to maintain professional autonomy. "Medical codes of conduct should also help to prevent negligence and improper treatment in the care of prisoners and should allow doctors complete freedom to treat any person regarding medical care."[127]

What insights does Jadresic provide? Jadresic raises the issue that it may be a common attitude among medical workers that during times of war their loyalties are allied with their nation or institution of service, but not with individual patients. This attitude potentially conflicts with normal patient care. It may allow medical workers to act in ways not in their patients' best interests or in ways consistent with professional autonomy. Jadresic suggests that most medical care personnel who witness or participate in torture ignore the conflict or deceive themselves into thinking that their patriotic duty overrides patient concern.

Yet, he maintains, there are some activities in which no moral human being should participate, such as torture. Additionally, he claims that medical workers have a special duty not to engage in or otherwise condone torture. Although this is not a blanket proposal that

[126] Jadresic, "Doctors and Torture," 126.
[127] Jadresic, "Doctors and Torture," 126.

physician duties override military duties, it suggests that there are physician duties that ought to override military duties.

Chapter Four: Challenges to the "Either-Or" Solution

> No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be.
>
> Isaac Asimov

> My basic principle is that you don't make decisions because they are easy; you don't make them because they are cheap; you don't make them because they are popular; you make them because they're right.
>
> Theodore Hesburgh

To reiterate, there are two common approaches in the literature to conflict resolution when situations arise in which physician duties conflict with officer duties: (1) officer duties should override physician duties, and (2) physician duties should override officer duties. Sometimes one or the other of these approaches is subtly implied as (3) a "case-by-case" approach where officer duties and physician duties are weighted depending on the circumstances such that one set of duties seems more appropriate than the other set of duties. Another approach claims that, (4) as a member of the moral community the military physician has duties above and beyond professional duties, thus non-professional duties can regulate the dilemma.[128]

Interviews with physicians, military officers, and military physicians, as well as a literature search, reveals that there is a preference for approaches (1) and (2). Moreover, it appears that even in the case where someone advocates for approaches (3) or (4), there is often an underlying default to (1) or (2). Clearly (1) and (2) provide a general framework for dealing with the moral dilemmas of a military physician and they are attractive for

[128] Other approaches are available for those interested in mathematico-logico systems including mapping logical systems onto duty systems. These types of responses go beyond the scope of this dissertation.

precisely this reason. In many instances, approaches (1) and (2) can provide a simple, principled manner to handle some types of conflict of duty, but these diametrically opposed either-or solutions do not always provide for satisfactory resolution of moral and ethical dilemmas that will prevent or lessen moral distress.

This chapter analyzes the positions expressed in the previous chapter's reviews of proponents of the either-or solutions. It discusses the challenges presented by following only the military proponents' view or of following only the medical proponents' view. Although there are some very key insights in approaches (1) and (2), and elements that are important in evaluating and negotiating moral dilemmas, both positions will be shown to be insufficiently nuanced and insufficiently sensitive to different contexts which shape the moral dilemmas faced by military physicians. There is not one set of reasons why all either-or solutions do not work; rather each attempt at an either-or solution can be inadequate due to either problematic assumptions or unacceptable consequences.

§1: Challenges to Military Proponents

§1.1: Huntington

Huntington argues that there is often an assumption that professionals should serve the public good or they do not deserve to receive the legalized monopoly of providing services for their clientele. Military officers serve the public good by managing and providing security for a state. In this capacity, military officers are tasked with directly serving the interests of the state. Military efficiency and security require that soldiers serve as instrumental objects within a chain of command. This includes, Huntington suggests, uncritically following orders in most cases. Moreover, the training and duties of soldiers often result in a dissolution of an individual's will into the group.[129]

Consequently, it has been argued, soldiers may essentially be rendered into mechanistic automatons or otherwise have their autonomy reduced. Moral responsibility may be lessened such that, at a minimum, an excusing condition has been provided for certain questionable behavior in the military. All of this, Huntington claims, arises from a need to limit personal liberty in favor of state security.

Is it true, as Huntington claims, that "The tension between the demands of military security and the values of American liberalism can, in the long run, be relieved only by the weakening of the security threat or weakening of liberalism"?[130] This could depend upon how we understand liberalism.

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[129] See Grossman's book, *On Killing: The Psychological Cost of Learning to Kill in War and Society*, for more details on the psychological effects of modern indoctrination techniques. Also see Chris White's "The Bedrock of Marine Corps Indoctrination."

[130] Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations* (Cambridge, MA.: The Belknap Press of Harvard University Press, 1957), 456.

If a classical liberalism stance is assumed which advocates both freedoms and responsibilities for individuals while stressing such components as human rationality, protected liberties, and constitutional limitations, then perhaps we may be dealing with a false dichotomy. Perhaps both military security and American liberalism can be accommodated if emphasis is placed on core values shared by physicians and military officers – protecting individuals, helping individuals flourish, or shielding individuals from harm. This would imply that we could somehow resolve the physician-officer conflict without resorting to the possible false dichotomy of an either-or solution.

Consider this in light of Huntington's statement that "Success in any activity requires the subordination of the will of the individual to the will of the group."[131] This seems to be a false dichotomy in that it is not clear whether a choice needs to be made between success with subordination of the will, or failure by maintaining individualism. It is certainly conceivable that a group could value individuality and uniqueness and that people could succeed in certain activities without subordinating themselves to the will of the group. We often reward successful artists, scientists, or businessmen precisely because they were able to maintain their individualism without succumbing to "groupthink." This provides the possibility that there is an option other than the either-or solution to the physician-officer conflict that will allow us to balance the duties and will of the individual with the duties and responsibilities of the group.

Another problem arises from Huntington's statement that soldiers cannot be effective in their duties unless they uncritically obey orders and act for the collective interests of the military. Consider various implications of this idea. The rationale seems to ignore that,

[131] Ibid. 63.

since the Nuremburg Trials, it is commonly acknowledged that soldiers are not required to obey illegal orders. In fact, the *Uniform Code of Military Justice* states that a soldier must obey only legal orders and has a responsibility to report illegal orders. Yet, it is sometimes claimed that allowing soldiers to disobey orders results in less effective military operations and thus reduces the efficiency of a military in working towards state interests. While this latter assertion awaits empirical evidence, a critical choice that the modern military and any liberal democracy may face is between being effective while having a policy where every order must be obeyed, versus possibly being less effective while allowing for the disobeying of illegal orders. In fact, perhaps one purpose of morality is to keep organizations from ruthlessly pursuing effectiveness.[132]

A related problem is that it has not been established how best to act for the collective interests of the military. This is a classic problem in some consequentialists' theories of ethics that claim that we should maximize the good for a group. In some situations it is possible to maximize the good for a group by maximizing the good for each individual. For example, if "health" is considered a good, then to maximize the health of a group it would be desirable, or most productive, to maximize the health of each individual within the group. That is, give each person what they need, better health, then the entire group is maximally healthier.

Situations where maximizing the good of the group is not achieved through maximizing the good of the individual are more complicated, but they are well established.

[132] I owe this point to John Hardwig. As he suggests, some might argue that in a state of extreme emergency – active combat or your country is in danger of being defeated – effectiveness could be a single-minded pursuit. Japanese and German citizens were, and are, grateful that their military did not do everything it could to avoid defeat at the end of WWII. See Appendix 3 for an analysis of obeying orders.

Garret Hardin's *Tragedy of the Commons*, or the infamous Prisoner's Dilemma in game theory, demonstrates this situation where trying to maximize benefits for each individual results in overall disutility for the group. In these cases, it is necessary to adjust utility for each individual to maximize utility for the group. Thus, with respect to acting for the collective interests of the military, it needs to be established what the interests of the military are and how these relate to individual interests and group interests.

This problem is replicated in Huntington's claim that "the military man emphasizes the importance of the group as against the individual."[133] Does the importance of the group get emphasized by focusing on the group at the expense of the individual, or does the importance of the group get emphasized by focusing upon the needs of the individuals? There is a need for empirical studies for these types of problems.

A final problem with Huntington's account is that although he acknowledges that obeying orders does have limits, he does not indicate when it is reasonable for a soldier to disobey orders due to "dictates of private conscience."[134] In fact, Huntington's view that "Moral aims and ideological ends should not be pursued at the expense of security,"[135] leaves solutions to some situations vague and unanswered.

Overall, Huntington provides an account as to where some of the conflicting roles appear for the military physician. A tension is felt between liberal concerns (as represented in physician duties) and national interests (as represented by officer duties). Although there are difficulties with Huntington's overall claim concerning the primacy of military duties, he does provide the perspective that it is appropriate, at times, to maintain that state interests

[133] Huntington, *The Soldier and the State*, 63.
[134] Ibid. 78.
[135] Ibid. 68.

should override individual interests. Therefore, it is possible to extract the claim that officer duties should *sometimes* have priority over physician duties.

However, this claim becomes conceptually confused when we consider Huntington's position on obeying orders and maintaining military efficiency. Huntington's position rests on empirical assumptions. Even if his premises are correct, it is not outside the realm of plausibility to suggest that a modern military or liberal democracy would maintain that liberal positions ultimately enhance security rather than threaten security. Moreover, it is plausible that there remains a balanced solution that is better than the either-or solution proposed by Huntington's arguments.

§1.2: London

London initially offers excusing conditions for what might otherwise be considered immoral behavior on the part of military physicians—that we should be cautious of casting moral blame on people when they are acting within the conventional morality of their society. This is especially true when people are under pressures where they are unable to consider and critically evaluate their situation. In such cases, they must rely on conventional morality, or in following the standards that are considered acceptable within their organization.

Although the notion of *excusing* a military physician for following his officer duties may be more acceptable than *mandating* that officer duties always supersede physician duties, there are some problems with London's thesis. London appears to advocate a type of cultural relativism. However, his account of morality seems to rely upon both a

questionable understanding of how individuals can generate their own morality and a questionable belief in the morality of socially generated beliefs.

In the former case, London claims that most people are too busy living life to be concerned with moral calculation. Even if he is correct in assuming the generally busy lives of individuals, this does not excuse professionals from not taking sufficient time and energy in their lives to develop an awareness and practice of morality and professional responsibility. This is especially true when we consider professions dealing with the possibility of causing great harm.

In the latter case, London seems to unabashedly accept that social norms imply morality. This is not a problem if he means that social norms inform us of moral belief, and perhaps help us to understand moral behavior. However, if he fully embraces the idea that social norms define moral behavior, some issues need to be considered.

London's position becomes morally problematic for anyone who believes in moral progress. A commitment to the ideal of moral progress suggests that German or Japanese physicians should not be excused for their participation in war crimes during World War II, such as the horrendous experiments on prisoners, even though their society appeared to accept their actions. Instead, those who believe in moral progress have the opinion that German or Japanese physicians who chose to engage in moral behavior by treating prisoners humanely, even when requested to do otherwise by the social norms of their country, should be praised.

Moral progress is incompatible with cultural relativism. Though London provides insight into understanding why people act as they do, he does not provide an adequate

defense for the belief that people can and should act according to social custom. London does provide specific reasons for excusing or justifying the actions of military physicians who constrain their medical duties in order to conform to military duty. This is problematic as the logic behind excusing someone is that we do not excuse people unless they have done something wrong. If it is not wrong for military physicians to act as they do, because they are following social sanctions, then there is no reason to have to excuse or forgive them.

The central insight London offers is that there are times when it may be appropriate to *excuse the behavior of a military physician*. London does not qualify these conditions other than to suggest that the military physician is excused whenever he is performing his military duties in conformance to social norms. This may become problematic in situations involving the "Nuremburg Defense" of "Following Orders." However, this type of reasoning allows claims to be introduced that sometimes officer duties should override physician duties. By combining an appeal to military necessity with an appeal to social norms, there is an attempt to justify excusing military physicians' actions, and to justify mandating that military physicians act in certain ways contrary to their physician norms. Yet, *the appeal to military necessity is lacking when it is unknown how to apply "necessity" conditions beyond appealing to social norms*.

§1.3: Colbach

Colbach offers several insights into medical care during combat conditions. Furthering the emphasis on the group, military physicians are tasked with helping preserve the fighting strength of the military. For militaries to succeed in their missions, soldiers are

sometimes returned to active duty as quickly and efficiently as possible. This includes situations in which patient care might not be optimal, in the long-term, for the individual patient. As Colbach notes, this causes moral distress in military physicians, as it conflicts with their medical training. Combat physicians must either adopt the view that officer duties override physician duties or risk psychological harm.

What makes Colbach's argument interesting is that rather than relying on notions of military security or cultural relativism, Colbach maintains that the adaptive perspective of his professional duties came about as a personal survival mechanism. As can be seen by the moral distress Colbach experienced, the decision to subordinate his moral principles as an adaptive survival mechanism changed his commitment to his previously held beliefs and the values that had formed part of his moral identity as a physician. Thus we see a direct example of the activation of conflicting moral scripts. Some aspects of Colbach's position remain troubling.

It might be troubling because it seems distasteful and morally wrong to find that someone is forced to change his or her beliefs due to institutional pressure. It is also troubling to think that someone is subordinating his moral principles in order to survive or succeed in an organization or position. This critically depends upon the nature of the organization. If someone were to say "In order to survive in the Mafia…" or "In order to survive as a political assassin…" one would not be inclined to grant that subordinating moral principles is a good thing. However, when one is working for an organization, such as the military, that has an arguably legitimate purpose, such as protecting the interests of a nation, one may need to re-evaluate one's moral stance in some situations.

It is unreasonable to hold that people must not change their beliefs. In fact, a healthy individual may voluntarily change his beliefs over time as he grows and develops. If this were not the case, there would be no progress in thought or moral development. What is required to evaluate the situations where professionals change their beliefs is a reasoned and morally acceptable account of *why* they changed their beliefs.

Consider, for instance, two psychiatric patients, Elijah and George, both undergoing behavior modification therapy. The difference between the two is that Elijah was involuntarily committed to a psychiatric care facility. He is undergoing a very aggressive multi-therapeutic routine involving drugs, group pressure, and individual counseling which is intended to change his behavior and, therefore, his identity. George is a willing patient who consciously desires to change his behavior. Moreover, George is undergoing long-term and gradual treatment. George is actively trying to change his identity, while Elijah is not. Elijah does not want to change his behavior nor does he want to alter his identity.

Consider this concept of changing identity more closely. According to Blustein, "Incorporating the requirement of morality into one's life should not have disastrous consequences for human personality. Morality may demand significant sacrifice and effort, but the cost of being moral should not be a distorted and undesirable personality."[136] We all have commitments that involve a person's centrally important values which contribute to one's identity. As Blustein claims, "[these commitments] make us what we are and they

[136] Jeffrey Blustein, *Care and Commitment: Taking the Personal Point of View*. (New York: Oxford University Press, 1991) 21. Maybe Blustein is assuming a relatively safe occupation in a safe environment. But maybe combat soldiers are sometimes required to do things that they cannot be morally comfortable with, things that may even change their identity. That may be one cost of war. As John Hardwig pointed out, "On a factual level, that seems accurate – 'He just never was the same after he came back from the war.'"

place constraints on our lives from which we may not be able to unbind ourselves without self-betrayal and personal disintegration."[137]

These commitments are, not surprisingly, called "identity-conferring commitments." These commitments are also a key part in defining our moral personality. In light of this, we might say that Elijah is suffering an attack on his identity-conferring beliefs. That is, he is being forced to suffer either from self-betrayal or from personal disintegration. Because George's therapy is informed and consensual, he is not suffering from self-betrayal or personal disintegration. He is simply trying to redefine his own self. How does this compare to the case of Colbach, a combat psychiatrist, or other military physicians who seek to reconcile their medical duties with their military duties?

It seems that a central issue is whether or not combat physicians are being forced into a position of self-betrayal or personal disintegration. This requires us to consider whether combat physicians lose integrity. According to Blustein, one way to lose integrity is for an individual to "freely and intentionally act contrary to their principles or commitments when it is difficult for these individuals to remain true to them."[138]

If combat physicians decide to emphasize their obligations to the military organization to the detriment of the individual soldier's health because of a *personal* commitment to the military, this would seem consistent with being true to maintaining personal integrity. Likewise, if combat physicians made the choice because they agreed with *society* sanctioned views of the proper relationship between a military physician and his relationship with individual soldiers and the military organization, they would be able to

[137] Blustein, *Care and Commitment*, 49-50.
[138] Blustein, *Care and Commitment*, 100.

avoid self-betrayal and personal disintegration. Either way, combat physicians would maintain their personal integrity. However, being true to one's personal integrity does not necessarily assure that one is acting in a moral and ethical manner as shown by the unethical actions some medical and military personnel have taken and defended throughout history.

In Colbach's account of combat psychiatrists it does not appear that the psychiatrists made adaptations to their personal or professional integrity because of personal commitment to the military or because society sanctioned the military view of proper medical conduct. Instead, his combat psychiatrists adopted their perspective in order to survive the military environment. Presumably, he does not mean physical survival, as he is not expressing fear of being physically hurt or killed in his service. Moreover, it does not seem that he would accept the argument "that's what I had to do to survive in the Mafia" or "in the Gestapo." Presumably, what he means is that he was doing what his job required in order to maintain his ability to function effectively within the military institution without facing reprisals for not conforming to military doctrine.

This does not imply that combat psychiatrists or other physicians who make a commitment to the military are automatically betraying themselves or destroying their personal integrity. However, it is a fair claim to suggest that it is possible and likely, that given the moral distress described by Colbach, his combat psychiatrists experienced either self-betrayal or personal disintegration. To understand the dilemma these psychiatrists

experienced requires a brief examination into some aspects of moral education and the process of moral action.[139]

There are various ways in which the process of developing ethical action can be ineffective. The first breakdown may occur because of a lack of awareness of a moral situation. In this case, the moral process never begins. The second breakdown may occur when an individual lacks the moral wisdom to evaluate the situation by identifying the relevant factors, considering options, and recognizing possible outcomes. In this case two primary risks are that the moral process can become "paralyzed by analysis" or wrong choices can be made. A third possible breakdown may occur when a person lacks intent, empathy, or a feeling of responsibility to intervene. This may result in an absence of a motivation for action. Finally, there may be either external or internal forces which prevent an individual from acting.

There are a series of "gaps" which must be bridged that enable a person to perform a moral action. The largest gap appears to be between the awareness of a moral situation and the ability to act. How might this compare to Colbach's, or others', ideas of trying to disentangle themselves from a situation that is causing moral distress?

Colbach demonstrated awareness of the situation and, as evidenced from his accounts of experiencing moral distress, demonstrated a deep empathy for the situation. This suggests that the breakdown occurred due to either a lack of moral wisdom or other forces preventing him from acting. There are two key components that directly led to

[139] A detailed account of moral psychology goes beyond the scope of this dissertation, so in this section I only highlight the problem to help us understand why people may be unable to act in certain circumstances. See Appendix 2 for a fuller account of moral psychology.

Colbach's experience of moral distress and inability to treat his patients as he felt he should as a physician.

First, because Colbach was operating within a combat zone there were both limited resources and institutional pressures which severely impacted treatment options. That psychological treatments were so effective during the war was a testament to the ability of combat psychiatrists to perform their job. But there were still limits. The limits were not only for treatment plans. The limits dictated that quitting was not an option for many people. Whether he was drafted or enlisted, the penalties were too high – ranging from punishment for desertion to the moral agony of abandoning people in need.

The second component which can impact moral wisdom and the ability to act is an often ignored phenomenon – moral fatigue. Moral fatigue results from morally distressful situations in which there exists a lack of strength and energy that causes emotional fatigue in the mind and immobilizes thoughts. Moral fatigue limits an individual's ability to evaluate situations and develop cogent courses of action. Moreover, moral fatigue inhibits, at times, the empathy or feelings which are sometimes necessary as motivation towards action. Individuals suffering moral fatigue often lack the ability to develop independent thoughts and make autonomous decisions. Instead, they revert to a state of compliance and often uncritically do what others tell them to do. When this is compounded with military training in obeying authority, morally fatigued individuals are less likely to thoughtfully evaluate the circumstances and instead do only what they perceive that they are told to do, without thought of more appropriate alternative action.

For whatever reason, Colbach did not quit performing his duties as a combat psychiatrist even though he believed he was not being completely true to his medical ethics and professional duty. Perhaps the penalties of quitting were too high. Perhaps he thought it was morally wrong to quit once the tour of duty started. Perhaps he felt he was offering at least some help to soldiers in need. Or perhaps he simply suffered from moral fatigue. We know that he made a conscious choice to change part of his identity to "survive the military."

It is unknown if combat psychiatrists' experiences more closely resemble the case of Elijah or of George. Were their experiences more like Elijah who was being coerced into changing his identity or of George who was an active and willing participant in his identity change? The closer the psychiatrists' situation was to resembling Elijah's case, the more likely it is that Colbach's position, that military duties should override physician duties, should be questioned. Likewise, the closer the situation was to George's case, the more likely it is, that Colbach's position that military duties should override physician duties has merit.

§1.4: Gross

The insight from Colbach's account is one of reducing personal integrity, and therefore relinquishing identity-conferring commitments, in order to survive organizational or institutional pressures. It suggests that in some situations people are not choosing one set of duties over another because of some sense of higher purpose or considered judgment as to the relative values of the conflicting duties. Rather it suggests that something more

insidious is happening to resolve personal moral conflict. Moreover, it suggests that either-or solutions lack an awareness of the possible psychological harm the solutions can cause to professionals.

Gross returns to the notion that during times of war, military duty overrides peacetime bioethics, because military necessity overrides civil liberty. This suggests the specter of the Nazi defense claim that following orders is a justifying or at least an excusing position under limited circumstances such as submission of individual will or under conditions of limited autonomy. For Gross, military efficiency requires that orders be obeyed when national interests are at issue. Moreover, national security requires overriding personal liberty and hence, physicians must allow their physician duties to be overridden by military duties.

Gross allows for invoking a principle of military necessity whenever an action is needed to preserve the welfare of the state, its army, and its citizens. Gross thus provides a "continuum" along which physician duties and military duties slide, or alternate in inverse proportion to each other, due to the intensity of warfare. In times of peace, according to Gross, physician duties reign supreme; but during times of war, soldier duties hold pre-eminence.[140] The "tipping point" for Gross is determined by military necessity. Thus, according to Gross, the realities of war dictate that military necessity severely curtails informed consent, privacy, and confidentiality. There is clearly some validity to this claim. Yet, it is difficult to determine what Gross defines as military necessity or to determine when conditions reach a critical status. Another problem with Gross's use of military

[140] We shall return to this continuum in Chapter Five.

necessity is the fear that this type of reasoning may lead to such atrocities as those seen in Nazi Germany, Japan's Unit 731, and the My Lai Massacre in Vietnam.

§2: Challenges to Medical Proponents

Just as the military has a strong tradition of service, the medical profession also has a strong tradition of service. However, military service tends to focus on group welfare while medical service tends to focus on the individual patient. Medicine's focus on the individual is often expressed in codes of medical ethics, such as the World Medical Association International Code of Medical Ethics that states, among other things, that physicians should always exercise their independent professional judgment by acting in the patient's best interest.

§2.1: Sidel

Sidel is a strong advocate of the view that physician duties should override officer duties. In Sidel's view, the primary ethical principles of medicine are concern for the welfare of the patient and to do no harm; the primary ethical principles of the military are concern for the effective function of the fighting force and obedience to the command structure. For Sidel, medical practice under a military system might be harmful to patients, harmful to the overall mission of the military, and harmful to the practice of medicine. Sidel believes military physicians risk subordinating the best interests of their patients, overriding patient interests, failing to provide care as required by international law, blurring combatant and noncombatant roles, and being prevented from acting as moral agents. A detailed and longer look at each of these claims reveals important differences between civilian and military medicine which Sidel does not take into account.

Sidel stresses that medical personnel are required to be impartial in their treatment of patients and that physicians must be noncombatants. This implies that Sidel might be relying on the assumption that physicians are healers only, while soldiers are only killers. This view of the physician and the soldier might be a relatively recent concept. Historical accounts of physicians indicate that impartiality and noncombatant status were not always common.

Many physicians understandably saw no reason not to treat their own wounded before dealing with either civilians or enemy combatants. During the U.S. Civil War (1861-1865), the American Medical Association endorsed a policy that physicians treat their own militia with priority. In that war, several physicians were awarded medals for their combat leadership. It was not until the advent of the Red Cross, founded in 1881, that the perspective of impartiality of care began to gain popular support. The Geneva Conventions, first started in 1949, led to modern perspectives of medicine in war: medical personnel were protected in exchange for noncombatant status, care for anyone in war, no abandonment of the sick, unbiased medical triage, and not participating in interrogation or torture.

As Sidel notes, from a psychological standpoint, medical neutrality can be difficult to achieve when you are part of the military. During the cold war, many U.S. physicians claimed, "the interests of the nation transcend those of the individual."[141] Similar attitudes exist with respect to the Gulf Wars and physicians involved with interrogation and torture.

Sidel claims that military triage forces physicians to subordinate the patient's best interests, violates the patient's confidentiality, and fails to maintain adequate patient medical records. Sidel indicates that the military physician, even one in a war zone, is not acting in

[141] Sidel, "The Roles and Ethics of Health Professionals in War," 285.

an ethical manner if he follows military triage procedure. Sidel is correct in his assessment that there are particular cases where it appears that an individual patient's long-term health interests are being subordinated "for the greater good." The ethical environment of the military places mission goals above individual interests. However, this analysis by Sidel may be suspect when applied to all military triage situations. It is plausible that military physicians may be acting in their patients' best interests, even when physicians are acting under a client-physician model of strong paternalism or service for the group.

During military triage, Sidel claims that physicians are not acting morally when they do not triage soldier-patients solely on medical criteria such as severity of wounds. There are at least three mitigating circumstances that would seem to argue against Sidel's claim. First, consider what it means to be operating under disaster situations. In civilian practice, allowances are made for changing triage criteria during emergencies. Typically, civilian triage follows guidelines consistent with the Geneva Conventions that require treatment of the most severely injured patients first.

Triage protocol changes during times of disaster and mass casualty. The criteria are changed so that resources are used so that a maximum of lives are saved. In some situations the criteria is changed so that key personnel, such as medical workers or government leaders, are given priority. This change in criteria acknowledges situations where the principles of medical ethics allow for discriminatory, non-prejudicial treatment of patients. To deny this practice for military physicians would seem a contradiction in triage decision-making ethics that are accepted in civilian practice. Consistency in applying such medical

ethics standards suggests that military physicians practicing military triage are, in fact, acting morally.

A second mitigating circumstance revolves around values held by soldiers. It can be conceded that most of the time it may not be in a soldier's personal interests to die. Similarly, in civilian situations, it is most often considered not to be in the patient's best interests to die. However, there are values regarding life other than maximizing the quantity of life, or in living as long as possible no matter what the circumstances or consequences. Such values as quality of life, or meaning or purpose in life, can mitigate circumstances of providing health care to a patient.

In this context, it is plausible that some soldiers place the welfare of the group over individual interests or value the group's commitment to duty and mission over personal welfare. This attitude of care for one's fellow soldiers and concern for accomplishing mission goals may be reinforced in a volunteer military. Although it may not be in a soldier's individual medical interest for a military physician to practice military triage, it may not go against his overall interests as a member of the moral community. If society places value in respecting individuals and respecting the choices individuals make—including their life goals—then society should respect individual choices regarding death or dying. By respecting the wishes of their patient-soldiers, military physicians may be acting morally.

In situations where a soldier may not value the survival of the group or the success of the mission over personal survival there might still be mitigating circumstances in which a military physician is nevertheless still acting morally with respect to military triage. In a

volunteer military, the governments contracts with individuals to join the military and accept certain rights and responsibilities including pay, housing, medical care, and substantial training, education, and development. As part of this contract, the individual may be required to sacrifice certain individual needs, rights, or comforts. This would include the possibility of being subject to military triage in extreme circumstances where individual medical needs might be minimized.

If military physicians respect their own contract to perform medical duties for the benefit of the military, it seems that consistency demands that they should respect the contract the individual soldier signed upon entering military service. Assuming that volunteers are made explicitly aware of the military's triage policies, as well as other medical practices within the military, military physicians may be considered to be acting morally by honoring contracts made between the military and its soldiers.

Next, consider the cases of informed consent and the violation of confidentiality. Informed consent and confidentiality are important tenants in the medical profession because they are indicative of respect for an individual patient. Within medicine, informed consent allows patients to make choices regarding their medical care, including the right to refuse treatment. Confidentiality allows patients to disclose fully their condition so that they may receive appropriate medical care.

In contemporary times, the patient is often allowed to determine whether to follow a prescribed treatment. The notable exception to this is when actions, or inactions, place others at risk. When someone refuses vaccinations, when mental patients refuse to take their stabilizing medicines, or when patients directly threaten or act to harm innocent third parties,

treatments may be mandated. In these cases, there is justification to violate informed consent or confidentiality to avoid harm.

It seems reasonable to suggest that similar reasoning can apply to military situations. At the least, soldiers should not refuse treatments if doing so would endanger their fellow soldiers or the strength of the military. Not only could this present a direct threat to fellow soldiers, but also a diminished fighting force could endanger a mission. If the risks are significant, there may be some justification for violating informed consent or confidentiality. Additionally, it may be plausible to suggest that in an all-volunteer military, soldiers have consented to various actions in certain circumstances including violations of confidentiality.

How does this apply to medical research of untested and experimental treatments, vaccinations, or medical technology? The justification for requiring soldiers to be immunized and/or receive medical care that has not been fully tested and accepted by conventional methods is based on professional beliefs that some experimental treatments are likely to provide protections or care not provided by traditionally approved treatments. Yet, mandated medical treatment for research purposes presents a controversy which lies in not adequately knowing the benefits or risks of participating in the research. Because of these unknowns, medical research is typically closely regulated to ensure that research subjects are informed and have consented to participate in the research. Medical research is typically not allowed to be performed on captive or vulnerable populations. Why should the use of soldiers in the military be any different, especially considering that soldiers may represent a captive and vulnerable population?

There is a critical difference for soldiers. In times of war, soldiers confront situations which non-soldiers rarely or never experience. They may well be exposed to risks (such as attacks with bio-chemical weapons) that civilians would rarely experience. Battlefield conditions also change rapidly and medical care must respond to swiftly changing situations. Of particular concern for medical workers is trying to provide proper care for injuries caused by new or different types of weapons, including the possible use of biological agents. During battle, there may not be time to follow conventional research protocols.

Given that soldiers are at special risks during warfare, it follows that to protect them there has to be adequate medical research. Therefore, during times of peace, medical workers need to conduct research to improve medical techniques, medicines, and procedures designed to improve patient care during warfare. In peacetime, the military should be required to provide the information necessary to allow informed consent for all research subjects and should be able to respect their confidentiality as it pertains to the research activities.

What about Sidel's claim that military physicians are guilty of violating the Geneva Conventions? There are five separate aspects of the Conventions that Sidel claims are violated by military physicians. First, as noncombatants, medical personnel are forbidden to engage in or be parties to acts of war. Second, anyone wounded—be they friend, foe, soldier, civilian—must be treated. Third, the wounded and sick cannot be abandoned and they must be cared for based on medical need. Fourth, medical aid must be dispensed solely

on medical grounds. Fifth, medical workers may not use medical coercion against individuals, including using medical coercion to obtain information.

Several responses can be made to Sidel's accusations: (1) Even assuming that military physicians are violating some aspects of the Geneva Conventions, it is not clear that they are contrary to principles of medical ethics; (2) specific aspects of the Geneva Conventions may be in conflict with each other; and (3) it is not clear when physicians (especially military physicians in the U.S. Military) are bound by the Geneva Conventions. These responses illustrate the difficulties of utilizing either-or solutions to solve conflicts of duties. Even though the Geneva Conventions provide suggested structure and context for rules governing war, there is still debate over the interpretation and application of the Geneva Conventions for both individuals and for nations. The Geneva Conventions attempt to define ethical behavior, but they do not relieve all tension of moral dilemma and distress caused by conflict of duties.

Assuming that military physicians are in violation of the Geneva Conventions by being involved in war, are they necessarily violating principles of medical ethics? Strictly followed, a "no participation" rule could imply that no medical care that contributes to war could be given.[142] This could be interpreted to mean a physician could not give treatment to soldiers or civilians in a war zone who might participate in war. This seems tantamount to abandonment of soldiers and civilians in need of medical care.

The Geneva Conventions have strict guidelines on unconditionally treating patients. In times of peace, and assuming adequate resources, there may be no problem with treating

[142] Certainly a minority view, but one encountered nonetheless, is the claim that physicians should not participate in any form of military care.

everyone in need of medical care. Yet in emergencies, it is allowable, under generally accepted medical principles, to practice mass casualty triage. There is little evidence to suggest that that principle should not also apply to military triage.

This suggests that concerns other than medical needs may exist. In the battlefield, treatment priority may be changed to protect mission goals, maximize allied care, or deal with a critical, dynamic situation. Much like in civilian triage of mass casualty, decisions can be made to maximize the number of lives saved or to save key personnel.

The Geneva Conventions prohibits medical personnel from using medical coercion against individuals. Directly participating in medical coercion violates medical principles. Yet it is sometimes difficult to determine what constitutes direct participation. Would caring for a patient after he is tortured constitute direct participation in the torture? What if the military physician knew that by caring for the patient the patient would be further tortured? If a military physician refuses to care for prisoners, is this abandonment?

There is also concern that specific aspects of the Geneva Conventions provide conflicting or ambiguous statements in certain circumstances. How can military physicians be forbidden from being parties to acts of war, yet at the same time require that they care for the wounded? Providing treatment to civilians and soldiers could aid one side or the other in hostilities. Providing indiscriminate aid may also result in prolonging hostilities and suffering, as returning people to active duty may result in longer combat operations. Finally, caring for prisoners can prolong torture or interrogation, resulting in medical personnel being participants in medical coercion.

It is not always clear under what circumstances military physicians are bound by the Geneva Conventions. Various interpretations of international law and international humanitarian rights come into conflict when deciding which laws are binding on which military physicians. Does the military physician belong to a country that has signed or ratified the Geneva Conventions, or that has a law that necessitates the following of international treaty? If the military physician is in the U.S. Military, has the President of the United States ruled that certain aspects of the Conventions no longer apply to U.S. personnel?[143] This makes it difficult to determine the legal standing of military physicians with respect to following the Geneva Conventions. This weakens Sidel's appeals that physicians should follow the Geneva Conventions, as physicians may have professional obligations to follow international law or their nation's laws.

Are military physicians significantly prevented from acting as moral agents? Sidel claims that military physicians are prevented from acting as moral agents because they are not allowed to protect military personnel, are prevented from taking moral actions in the military, and are forbidden to express their moral protests. As previously indicated, Sidel's accusations are not entirely warranted. It is not necessarily the case that military physicians fail to protect military personnel, nor is it necessarily the case that they are unjustified in their actions when they do not protect individual soldier-patients.

[143] The Military Commissions Act of 2006 "reaffirms and reinforces the authority of the President to interpret the meaning and the application of the Geneva Conventions." See Executive Order: Interpretation of the Geneva Conventions Common Article 3 as Applied to a Program of Detention and Interrogation Operated by the Central Intelligence Agency. See also Mark Danner's reports on medical personnel involvement with abusive interrogations of terrorist suspects in custody of the Central Intelligence Agency. Army Field Manual Interim, "Medical Support to Detainee Operations," (FMI 4-2.46) details current U.S. Army attempts to prevent physicians from participating in interrogation and torture. As with most modern medical codes of ethics, the manual offers an "escape" clause whereby "involvement," "participation," "interrogation," and "torture" are all defined according to U.S. law or standards set by the department of defense directorate.

The prevention of taking moral actions and expressing moral protest is largely a result of having to obey orders and having to subscribe to censorship. Sidel's claims suggest that obeying orders or subscribing to censorship is problematic for physicians because this might result in performing otherwise immoral acts. A military physician might be ordered to help interrogate a prisoner, or a military physician might be prevented from releasing information to the media about prisoner abuse.

Sidel also proposes that obeying orders or subscribing to censorship might interfere with professional autonomy. Yet, as indicated previously, obeying orders can be not only excusable but also justifiable. This particular concern of Sidel's must be addressed on a case by case basis, not in a general condemnation of military physicians.

Ultimately, what insights are gained from Sidel's position? Conditions ranging from the nature of one's enlistment as a volunteer or a draftee and conditions from peace to full-scale warfare influence the military physician's experience of moral dilemma. Sidel does not appear to take into account that these conditions may legitimately change the military physician's range of duties as relevant moral factors are taken into account.

§2.2: Howe

Howe engages in an issue-by-issue tactic against physician involvement in torture. Howe argues that this keeps central values of "civilized" society in perspective and helps prevent its subversion. He explicitly claims that physicians hold values which may never be compromised even though compromising may be necessary to optimize military interests or the optimal interests of the societies the military serves and protects. If we compromise

these values, he claims, our society will regress. We will have given up and lost what we have come to believe constitutes what it means to be civilized and will have readopted the once widespread rubric that "all is fair in war."

Howe claims that physicians and military officers have a duty to not participate in torture and to actively oppose torture that they witness *only* in situations when such torture is *illegal* or *immoral*. This stipulation of Howe's suggests that there are cases in which torture *is* legal or moral. While there are differing definitions of what constitutes torture, most ethical and moral codes view torture as wrong. Even when controversial methods of questioning are accepted as legal, Howe fails to address how to readily identify cases of torture and he does not provide insight into how to classify specific acts of torture as illegal or immoral. Given Howe's claim that some values held by physicians must remain unchanged, it is worth noting that he does not specify how this relates to participating in torture, beyond designating that military physicians should not participate in illegal or immoral activities.

Drawing upon history, especially the Nazi accounts,[144] it is known that physicians have been willing to participate in cruel and inhumane treatment of prisoners, including torture. It is conceivable that some physicians, as well as other interrogators, are in a moral dilemma when using torture, but feel no moral distress because they are insensitive to the dilemma or because they have found some rationalization for their behavior. Others may become insensitive or learn to rationalize in order to maintain a semblance of mental health. The long-term harm to the physician and the interrogator may be that they are no longer able

[144] See Appendix 3 for a case study of Nazi physicians. Appendix 4 is a copy of the Nuremburg Charges in the Nazi Medical Trials. The Charges provide a good summary of the types of activity mentioned here.

to make moral and ethical judgments of their own actions and they have lost the ability to determine if orders are legal and moral.

Perhaps these same factors enter into Howe's claim that torture results in harm to the society as a whole. If society gives approval to "wrong actions," society not only allows individuals to act immorally, but society also becomes insensitive and learns to rationalize questionable behaviors. Howe suggests that society as a whole then has difficulties making moral and ethical judgments and may regress to accepting pre-civilized actions.

Howe claims that if a particular instance of torture is illegal or unethical then the military physician has professional duties, both as a physician and as an officer, to refuse to participate in that torture. At this point, there is no conflict between the duties of an officer and the duties of a physician and there is no need for one to override the other. Howe's statement applies to "illegal" torture, but does not take into consideration that there may also be significant conflict in what constitutes torture. For instance, an action may be deemed lawful for U.S. soldiers because the President has declared the act does not constitute torture. The same action may be considered torture under international law and by medical ethics standards. The conflict between military and medical duty would then return. Howe could take his view of torture one step farther by considering that physicians have a professional duty to oppose all forms of torture.

Consider the following claims against torture: (1) torture is known to be unreliable in attaining actionable information, (2) torture causes preventable harms to the victim, and (3) torture causes harms to the people and society involved with the torture. It seems consistent with these claims to conclude that physicians do, in fact, have a professional duty,

as physicians, to oppose *all* forms of torture. The question would remain, however, as to whether or not these duties override the military duties which may require participating in activity which may be considered to be torture. Given claims (1) and (3) above, it appears that physician duties ought to override military duties in cases involving torture.

What about the military physician's duties related to preventing suicide and in providing psychological care for detained terrorists? Howe claims that military physicians cannot physically restrain terrorists even though they are at a higher risk of suicide. This is based on his reasoning that restraint is barred because it means treating the terrorists differently than other prisoners. This may be implausible given that standard medical care related to suicide watch includes physical restraints in some cases. This indicates that the focus should not be on an elusive notion of "equality of care," but on giving *medically appropriate* care to a patient as the situation warrants.

This reveals a problem shared with Jadresic's position. How are the moral and ethical boundaries identified that a military physician may establish when he becomes engaged in treating prisoners, especially when the prisoners are being interrogated or tortured? Howe claims that whether or not the prisoners are terrorists is immaterial to setting moral and ethical boundaries. By treating any prisoner, physicians may find themselves in a moral dilemma. By refusing to provide care they may be morally culpable of negligence, but by caring for the prisoner they may be morally culpable of prolonging torture.

Howe's discussion also seems to place the military physician in an ambiguous position when it comes to giving protective medical agents to civilians or POWs. Treating

POWs equally with soldiers implies that the POWs should also receive any protective agents that soldiers receive. The problem arises in determining when, or if, this would include experimental medications or treatments. At what point is there a significant risk to warrant giving prisoners experimental medications or treatments? Are physicians obligated to provide these treatments if the experimental medications or treatments are being used as standard care for soldiers? This is a problem because in civilian life, prisoners are considered a vulnerable population. They are normally, at least in modern times, excluded from many medical studies.[145]

What Howe has exposed is a general problem for military physicians in interpreting what it means to treat POWs "equally." Howe points out that some soldiers and military physicians see no problem with violating the Geneva Conventions when it involves dealing with the enemy. Howe's argument against this is that since some physicians exhibit the ability to treat enemy patients without bias, then others should also exhibit the ability to treat prisoners without bias. This argument is not conclusive. It does not necessarily follow that because some physicians can act in a certain way that others should also be able to act that way.

There is also a problem with determining what equality means. Does equality allow for treating all U.S. soldiers first or does it require treating U.S. soldiers and POWs "more equally" by providing treatment as Howe maintains on an alternating or random basis? The standard interpretation is that a physician treats all of their own soldiers first, then the enemy soldiers. According to Howe, there is an alternative. Enemy soldiers with equal injuries should be treated on alternating or random basis. If Howe's alternative is followed,

[145] At least in the U.S. prisoners are excluded from medical experiments in most cases.

"friendly" soldiers might die before receiving treatment. Howe's scenario risks military goals. Enforcing Howe's principles of equality in treatment may risk lives and mission objectives, becoming a self-defeating proposition.

Conflicting international and national guidelines, codes, and laws often confront physicians. For example, should military doctors treat captured enemy soldiers or civilians first? Adhering to the Geneva Conventions may require military physicians to treat POWs equally with respect to civilians. However, the Geneva Conventions also indicate that civilians may legally deserve priority care. The U.S. did not agree to this particular part of the Conventions, so, for the U.S. military, there may be implications that enemy soldiers should be treated before civilians.

There remains a problem with how terrorists are classified. If terrorists are classified as neither POWs nor civilians, then presumably they can be treated last. If they are civilians, they may legally deserve priority treatment. When it is not clear how to prioritize treatment, military physicians may be placed in an ambiguous position that could cause moral dilemma and moral distress.

Howe provides an intuitively appealing conclusion to the question of whether or not physician duties should override military duties. In some situations, according to him, in particular when it comes to the treatment of prisoners, interrogation, and torture, physician duties should override other concerns, even when this results in non-optimal military resolutions of military or national interests. Yet Howe's arguments to reach this conclusion are sometimes ambiguous because he strongly articulates both sides of the issues.

This strong articulation sometimes overshadows Howe's arguments that physicians' duties should override other concerns. Howe's claims that society regresses if its people approve of or participate in such actions has much initial appeal. However, the initial appeal needs further elucidation. Howe needs to provide more clarity in his claim that since some physicians can overcome operational bias then all physicians should be able to overcome that bias.

§2.3: Jadresic

Jadresic produces an issue-by-issue position that physician duties override military officer duties. His specific claim is that medical personnel have absolutely no legitimate role to play in torture. He bases this claim on international codes of medical ethics which dictate that doctors are to engage in therapeutic or prophylactic treatments that benefit patients. As such, doctors are prohibited from engaging in activity which weakens the physical or mental resistance of a human being.

Clearly, torture performed for sadistic pleasure, revenge, or punishment is considered to be improper. At issue for Jadresic is whether or not medical workers should participate in interrogational torture; Jadresic argues that ethically they should not. Whether or not interrogational torture produces valid results is highly debated.[146] However, Jadresic's position is that even if interrogational torture produces valid results, physicians have a professional duty to not actively participate in such activities and to not act negligently or

[146] In discussions with interrogators, the interrogators reported that torture is at best an unreliable method of gathering actionable information and at worst an exercise in inhuman treatment. This is consistent with reports given at the 2008 International Society of Military Ethics. See also Matthew Alexander and John Bruning's book, *How to Break a Terrorist: The U.S. Interrogators Who Used Brains, Not Brutality, to Take Down the Deadliest Man in Iraq.*

improperly in the care of prisoners. Both of these duties rely on a strong endorsement of professional medical autonomy.

There is a subtle conflict in Jadresic's position. It leaves unanswered the question of what, exactly, constitutes participation in torturous activity. Jadresic does not appear to consider that any medical treatment of a victim of torture could be construed as participation in torture. Consider the following scenarios.

A prisoner is brought to a physician for a "routine" health evaluation. If the exam allows interrogators to evaluate how much torture the prisoner can withstand, has the physician participated in torture? A physician is brought to a tortured prisoner to stabilize the prisoner. If the treatment allows the prisoner to recover so he can withstand additional torture, has the physician participated in torture?

In each case, failure to provide comfort or care can be construed as negligent or improper care of the prisoner-patient. However, providing care is often a crucial step in the torture process, especially in cases where it prolongs the torture or provides for a positive relationship of garnering trust between the victim and his interrogators. Having to choose between neglecting to care for a prisoner or participating in torture by providing medical care for a prisoner presents an ethical problem for any physician.

The dilemma occurs in cases where a patient is about to be or is currently being interrogated. Assuming that such activity has ended, the physician will not have a "participation dilemma" limiting his treatment of the patient. Physicians may participate in treatment, but only in ways that improve the health or safety of the person being interrogated. The issue is to make sure that such participation is not contributing to or

prolonging torture. Professional codes, which focus on protecting the rights of patients, may not provide the physician with adequate or sufficient guidance for action in cases where either choice has the potential to harm, as well as to help, an individual.

Because they are facing moral dilemma, physicians are in a position to experience moral distress over the choice they must make. It is also possible for a situation to produce the conditions necessary for a moral dilemma to develop, but an individual might not experience moral distress. Some individuals may not recognize the moral dilemma inherent in the choices they must make. Other individuals may whole-heartily accept the reasons behind the choice. If they believe their choice is acceptable, they may not experience feelings of moral distress.

§3: Summary of Either-Or Analysis

A common approach to resolving conflict in duty is to mandate that whenever there is doubt concerning which set of duties to follow military officer duties should override physician duties. This policy also mandates that a military chain of command, through enforcement of obeying orders, determines if and when officer duties override physician duties. Justification for this policy includes arguments for state survival, arguments for military necessity, and arguments for professional survival.

Despite various flaws in these arguments, they present valuable perspectives and insights into the problems that military physicians face when trying to resolve the moral dilemmas sometimes found between medical traditions and military traditions. The arguments suggest plausible reasons as to why some people accept that officer duties should override physician duties. However, this position is ultimately insufficient for resolving moral dilemma experienced by some physicians in the military.

The shortcomings of this position, as detailed in the previous sections, result from both theoretical and practical concerns. From a theoretical standpoint, the primary motivations for accepting this position are that national security, efficiency, and overall utility are best served by adopting such policy. As has been illustrated, this may not always be accurate.

The interests of the military and the state may be better served by focusing on classically liberal ideals of protecting the liberty and rights of individuals. "Military necessity" is often invoked to justify the overriding nature of military duties. Yet, the professional literature does not clearly show how military necessity is established to a

degree that warrants sacrificing individual liberty. Moreover, it is clear that military necessity will not serve to underpin a majority of either-or solutions because, as indicated in this dissertation, many cases of moral conflict do not really involve military necessity. Finally, it is also not clear when following orders changes from an excusable condition to that of a justifying condition.

From a practical standpoint the position that military duties always override physician duties does not always result in acceptable consequences. As history has shown, this position has the potential to be abused, e.g., military physicians engaged in harsh interrogation or torture, Nazi physicians engaged in terminal medical experiments, or Japanese physicians involved in Unit-731. Although adopting the position does not necessitate abuse, it can be interpreted as a justification for unjust actions which can result in horrible consequences, pain and suffering, and a lack of respect for humanity. There are situations where it is appropriate to claim that military duties override non-military duties. But just as certainly, there are negative consequences when this practice is taken to extremes, where humanity and the very beliefs that the military claims to be trying to protect are put into jeopardy.

The position that claims that physician duties override officer duties is compelling especially in light of the commendable efforts and commitment most military physicians demonstrate during their service. Although, as we have seen, there are some concerns with the arguments presented for this position, the arguments provide insights. Much like the alternative either-or solution, it is procedurally understandable to follow a policy that dictates that physician duties ought to outweigh military officer duties. In a world of limited

resources and limited timely information, especially during combat or other high stress situations, having one policy is convenient to implement, monitor, and enforce.

Yet, accepting the position that physician duties must always outweigh military officer duties is inadequate as a procedure for all moral action for some military physicians. The shortcomings of this position result from both theoretical and practical concerns.

In medicine the primary motivation for accepting this position is the prevailing tradition that the patient comes first. History and the progress of civilization seem to confirm this to be a worthy ideal. In a majority of medical ethics cases it has clearly been vindicated as the appropriate attitude to adopt. It indicates respect for patients and allows them to preserve their liberty.

Yet, from a theoretical standpoint, it is not clear that this tradition is so strong that it creates an inviolable principle. Primacy of patient care has fluctuated over the centuries. This is especially true when it comes to provisions in medical ethics which suggest that under certain situations an individual's health interests may be compromised to some extent to benefit third parties or society in general. There is no longer a sacrosanct physician-patient relationship mandating that at all times and in all circumstances a patient's medical needs come first.

The position that physician duties are paramount assumes that professional autonomy is legitimately independent of other considerations. But professional medical autonomy is not absolute. Professional organizations may regulate behavior, and society may regulate professional conduct, especially in times of emergency. Combat may be analogous to emergency or catastrophic situations. Clearly combat situations are

emergencies of a sort, not the normal conditions which commonly provide the background for professional medical codes. Therefore, it is not conclusive that a military physician is always free to relegate their military officer duties in favor of their physician duties.

There are medical codes of ethics that have clauses allowing physicians to act partially or solely for third parties. This would tend to add legitimacy to claims that military physicians may, in fact, act contrary to individual patient health interests in favor of group interests or service to society. However, it may be claimed that patients still have rights such as rights to be informed of third party conflict of interests and rights to refuse treatments or participation in medical trials.

In addition to these theoretical concerns, there are several practical concerns with suggesting that physician duties ought to always override military duties. This position, like the converse position, may be inadequate to relieve moral dilemma. Many cases of moral dilemma result from institutional pressures in forms of policies or orders that demand sacrificing one set of professional duties in favor of another set of duties.

These sacrifices may impinge on professional integrity, escalating problematic and stressful situations. While institutional pressures can be generated from HMOs, hospitals, insurance companies, or even private partnerships, the focus of professional and public scrutiny is often on that of a military physician enduring moral dilemma by being forced to abandon physician duties in favor of military duties.

We cannot ignore that similar situations of moral dilemma may occur in which a military physician may feel equally compromised in his professional integrity if he is told to ignore his military officer duties. Military physicians, especially in an all volunteer military,

may feel they are being asked to behave immorally when they are denied the opportunity to professionally serve as military officers dedicated to preserving the fighting strength of their military and, consequently, to serving their country.

A second practical concern relates to being required to always follow orders, or of being exempt from certain orders due to non-military professional responsibility. While the U.S. Military allows for disobeying orders in specific cases, a policy which endorses refusing to follow orders may lead to inefficiency or even confusion and chaos within an institution. This would be especially true during emergency situations and combat. Refusal to follow orders could seriously undermine group cohesion and satisfactory resolution of the situation.

Finally, as seen with the issues of torture, it seems that at most these arguments for physician duties overriding officer duties establish an issue-by-issue prohibition against certain behavior, not a profession-wide prohibition against prioritizing duties of a non-medical nature. This, together with the concern of allowing physicians to maintain professional medical integrity, suggests that a better approach to the problem is to allow military physicians the professional autonomy to make professional decisions on a case-by-case basis. This leads to the idea of a middle ground, where issues that are relevant exist somewhere on a continuum scale between prioritizing exclusively either military duty or physician duty. In order to develop a continuum scale it is helpful to examine Jonsen and Jameton's theories that help to better establish theoretical responsibilities and relationships among the various roles a physician assumes in his professional life and his life as a citizen of a community.

§4: Toward a Common Ground

Jonsen and Jameton propose the following paradigm of clinical medicine as the "premise in which an interaction between physician and patient becomes 'practicing medicine' – diagnosis and treatment of an illness or injury for an individual who presents a complaint within the context of an established relationship."[147] Jonsen and Jameton's paradigm arises from a project that was designed to explore the social and political responsibilities of physicians.

In addition to professional responsibilities physicians have the social and political responsibilities that any citizen has. Physicians *qua* citizens have responsibilities to their community. "Physicians should be concerned about war, racism, and poverty, but so should all citizens."[148] This ideal is a reaction to a perspective Jonsen and Jameton identified. "Physicians as a class have shown little interest in political activities unless political and social situations directly affected them."[149] During the 1970s, there was a growing call for physicians to assume more social and political responsibility.

Suggesting that physicians, *as citizens,* have increased responsibilities to their communities and should take more social and political responsibility may be an ambiguous claim open to differing interpretations and may give rise to special problems for physicians in relation to the military. As we have seen, physician responsibilities as citizens could mean that physicians have a responsibility to oppose all forms of war, refuse service in a

[147] Alfred Beasley, personal communication, 9-12-2007. See also Graber, Beasley, and Eaddy, *Ethical Analysis of Clinical medicine,* 118.
[148] Jonsen and Jameton, "Social and Political Responsibilities of Physicians," 376.
[149] Ibid. 377.

military, or actively campaign for social reform.[150] That responsibility can also be interpreted as a call to join the military as a citizen-soldier defending one's society and enforcing its ideals; to include engaging in preferential treatment of friendly soldiers, participating in medical experimentation and torture, and helping to manipulate or regulate soldiers' beliefs and attitudes.[151]

Although Jonsen and Jameton do not deal with the issue of military medicine, they try to clarify the ambiguity of social and political responsibility by identifying three areas where physicians, as physicians, have responsibility to the community. All three areas lead to special issues for physicians in the military.

The first area of responsibility Jonsen and Jameton claim is that "physicians are responsible for the economic and social forms which medical care takes."[152] But they do not note that the definition of "medical care" will decisively shape this responsibility and may give rise to different responsibilities for physicians in the military. For example, defining care as "the art and science of diagnosing and treating the organic manifestations of disease" imposes one model of medical care, i.e., reactive medical care. Defining care as "maintenance of health" imposes a different model of care, i.e., preventative medical care.[153]

Using a model of reactive medical care, a military physician might focus on individual patient care if and only if there is a manifestation of disease. If this is the only model utilized it may preclude such preventative measures as vaccines. Yet, military physicians opting for a model of preventative medical care may impose a level of

[150] See Section Two of Chapter Three, especially Sidel's account of physicians in the military.
[151] See Section One of Chapter Three, especially Huntington's account of military indoctrination. See also Appendix 3, the Nazi case study of either-or solutions.
[152] Ibid. 378.
[153] Ibid. 379.

paternalistic care that includes the administration of vaccinations, or the intervention into lifestyle habits such as smoking, drinking alcohol, diet, and exercise. This type of model resembles the Army Medical Motto, "To Conserve the Fighting Strength."

At issue here, is whether or not military physicians have chosen an appropriate model of medical care, i.e., a socially-accepted model of medicine. Criticism of the model of medical care implied in the Army Medical Motto may lead to the conclusion that military physicians have chosen a model that, by appealing to military necessity or mission success, is unacceptable.

Jonsen and Jameton's second area of community responsibility assumed by physicians is that "they are responsible for the environment of medical care."[154] It is argued that it is the physicians' professional "dedication to human good…which imposes the responsibility upon them."[155] Physicians are responsible, more so than the average citizen who may not express a dedication to human good, to engage in social and political activism on behalf of patient care. Jonsen and Jameton extend this area of community responsibility into situations outside of the medical care community. "The war in Vietnam was certainly a health hazard to millions, civilian and military, but the immorality of the war itself should have led physicians, who should encourage life rather than death, to oppose it."[156]

Unlike Jonsen and Jameton's first area of community responsibility that indicates that "the economic and social forms which medical care takes" is the responsibility of physicians, this second area clearly contains pro-patient implications. Even with an opposition to war, it does not clarify to what extent this community responsibility should

[154] Ibid. 378.
[155] Ibid. 379.
[156] Ibid. 380.

influence physicians' actions. Should a physician refuse military service? Should a civilian or military physician refuse to give medical clearance to potential or active soldiers? Should a military physician use his authority to medically evacuate soldiers even when their injuries would not normally meet the threshold for evacuation? If opposing an unjust war means aiding the enemy, should a military physician commit treason?

Jonsen and Jameton's third area of community responsibility is that "they [physicians] are responsible for the use of medical skills."[157] It is a combination of medical skills plus a dedication to human good that creates the obligation to work toward moral causes. "Physicians must take social and political action against the immoral appropriation of their skills."[158] As we have seen in this and the previous chapter, particularly in the discussion of Sidel, this view is clearly controversial as it dictates that a physician is culpable for the misuse of medical training which he conducts.[159]

Some physicians, according to Jonsen and Jameton, will claim that these three areas of community responsibility are not relevant as physicians have responsibilities only to their individual patients. This is one of the classic issues of conflict within professionalism. To what extent does a professional have social and political obligations that may go beyond individual client obligations or, possibly, go against the interests of their individual client? To answer this question, Jonsen and Jameton framed a paradigm of physician responsibility.

Graber, Beasley, and Eaddy explain the paradigm as follows. The interaction between a physician and patient becomes practicing "real" medicine when the following elements are present: (1) diagnosis and treatment (2) of an illness or injury (3) for an

[157] Ibid. 378.
[158] Ibid. 381.
[159] One aspect of the controversy is that this position may legitimize the *befehl ist befehl* defense.

individual (4) who presents a complaint (5) within the context of [an] established relationship.[160] Elements (1) and (2) are identified as the primary tasks "all modern physicians are trained to do."[161] Element (3) focuses attention to the fact that the primary client of a physician is an individual patient. Elements (4) and (5) establish the conditions of the relationship.

According to Jonsen and Jameton the physician, *qua* physician, has a primary responsibility to the individual patient. This primary responsibility may be altered, or regulated, by two factors. First, professional conduct is regulated, in part, by the interaction of the patient and society. Patients are not, normally, isolated from a communal network. "Physicians who acknowledge due care and personal concern for their patients as their primary ethical responsibility often undertake social and political activities because they feel obligated to do so in order to honor their responsibilities for their patients."[162] These "responsibilities [which are] contingent upon patient responsibilities" might include activities such as aiding in searches for resources, lobbying for legislation, or prescribing food or rest.[163] Thus, to honor patient responsibilities, physicians may participate in political or social activism.

In a military context for example, a soldier-patient has certain social obligations to the country he serves, e.g., engage in activity that protects the group over individual self-concern. A military physician may feel obligated to engage in certain activities to aid such

[160] Personal Communication with Alfred D. Beasley. See also, Glenn C. Graber, Alfred D. Beasley, and John A. Eaddy, *Ethical Analysis of Clinical Medicine: A Guide to Self-Evaluation*, Urban & Schwarzenberg: Baltimore-Munich, 1985, 118.
[161] Jonsen and Jameton, "Social and Political Responsibilities of Physicians," 382.
[162] Ibid. 383.
[163] Ibid. 384.

patients, e.g., provide vaccinations. Yet activities may extend to such things as procuring resources not provided by the military, lobbying for changes to harmful policy or orders, or prescribing food and rest. A military physician, in his role as an authentic leader, may even use his influence to change the social and ethical climate of his unit to benefit his patients.

Second, the primary responsibility to a patient may be further regulated by the specifics of the context of that relationship. The relationship between a physician and his patient is normally the result of actions on the part of both participants. In civilian medical practice the typical context of relationship is established though a patient actively seeking medical aid. Yet, there are certain overriding considerations that may establish relationships which begin to move away from paradigm cases of physician-patient relationships.

There are deviations, normally enforced by law, from patient-centered duties. Consider situations of involuntary or non-voluntary treatment. This could happen through having a patient who does not present a complaint or when an established context of a physician-patient relationship is not present.

When someone may cause harm to another due to mental illness, the mentally ill person may be forced into treatment. In other situations, such as emergency cases, it is assumed that a rational, competent individual would consent to treatment. In some situations, such as abusive relationships, there is a point when it is recognized that the abuser must be controlled by society either through restrictive, punitive, or medical intervention. Finally, if a person has assumed certain obligations, they may be required to receive certain treatments to help prevent harm to others or themselves. In some cases it is conceivable that they may be required to receive treatments designed to benefit themselves or others. People

who routinely work with the public – medical workers, social workers, teachers, caregivers, etc. – may have to accept certain vaccinations to continue work.

A third regulating aspect of a physician-patient relationship is the idea "that primacy be given to principles governing actions or situations which are initiated by a distinctive act of one's own rather than those principles which direct attention to some future or remote situation which may be modified by present action only in some tenuous way, if at all."[164] Jonsen and Jameton claim that this is recognized in legal discourse where individuals gain responsibility for actions in relation to their initiation of the action and their ability to actively control the action. "Since medical acts are initiated by physicians, responsibility for them has a primacy for physicians over acts or situations which exist prior to them or may exist subsequently, such as the economic system of medical care or the existence of polluted air."[165]

The context of a physician-patient relationship may be regulated by the manner in which the relationship was established. For example, once a physician begins care of a patient they cannot, normally, abandon that patient without due cause. However, a patient who enters into a medical relationship with a physician may be constrained from or limited to certain services or treatments due to his insurance policy establishing the limits of care he will receive. This type of situation, one in which services are denied due to overriding non-medical considerations, has implications for physicians in the military that will be explored in the next chapter.

[164] Ibid. 388.
[165] Ibid. 388.

However, one implication for military medicine that should be mentioned here is the consideration revolving around the principle "respect for persons; self and all others are acknowledged as ends."[166] This is fundamental in interpersonal relationships and interactions. In a medical context this is normally seen as an appeal to respect patient decisions regarding medical care, especially in the case of refusing medical care. Yet, in a military context the physician-patient relationship may also be seen as allowing and respecting the decisions of soldier-patients who choose to emphasize group concerns over individual patient medical needs. This also is present in civilian contexts, e.g., when a patient prioritizes family concerns over his own health. One concern with this, for the military physician, is a situation where the military physician must decide whether respect for a soldier means honoring the soldier's former decision to become a soldier or the current desire not to be returned to combat.

This is consistent with my findings from interviews with physicians who have served in the military. I have found a perspective that accepting the military persona of the patient can make one a better physician to the people being served. By "better" it appears that these interviewees meant that the military physician is better able to attend to the needs of his patients, when a patient's medical needs and life ideals are both taken into consideration. Military physicians make this claim, or justify it, by stating that embracing the military attitude shows respect for the men and women being treated. Respect is shown, in these cases, by treating soldier-patients as rational beings who have made conscious choices to enter into military service.[167]

[166] Ibid. 384.
[167] See analysis of Sidel, §2.1, for a detailed analysis of this position.

Jonsen and Jameton provide a conceptual framework where a physician's primary duties are to his individual patients. Physicians also have responsibilities to their communities. These include establishing the economic and social forms of medicine, the environment of medical care, and the responsible use of their medical skills. Physicians primarily attend to the needs of individual patients, but their professional-client relationships may vary due to the context of their relationships, social interactions, and their commitment to the protection of society.

Jonsen and Jameton offer this warning about their paradigm "We caution that we speak only of responsibilities of physicians as physicians, not as spouses, parents, or wage earners."[168] By extension, the dual role of physician as military officer is not covered in their paradigm. Jonsen and Jameton claim that "Determining priorities among one's professional and personal or familial responsibilities would require an analysis rather different from the one we offer in these pages."[169] A new decision-making topology for military physicians will be presented in Chapter Five. By providing a mechanism for analyzing the responsibilities, duties, and ethics of the two professions, my proposed topology will offer an additional model for conflict resolution.

[168] Jonsen and Jameton, "Social and Political Responsibilities of Physicians," 388.
[169] Ibid.

Chapter Five: A Moral Topology of Military Physician Decision-Making

> The soldier, be he friend or foe, is charged with the protection of the weak and unarmed. It is the very essence for his being.
>
> Douglas MacArthur

> It doesn't matter which side of the fence you get off on sometimes. What matters most is getting off. You cannot make progress without making decisions.
>
> Jim Rohn

Reports from military physicians who experience moral dilemma often contain some element of a perceived conflict in their professional duties. As has been shown, conflict often emerges from combining two professions that may contain elements that appear to be in conflict. Common themes of conflict are saving lives versus taking lives, personal responsibility versus following orders, serving individual clients versus serving the public, or serving an individual versus serving a group. Part of this conflict exists because of theoretical professional concerns and internal constraints due to professional identities, norms, and expectations. Another part of this conflict exists because of external constraints due to the actual practice of combat medicine where the operational climate, or ethical climate, strains the nature of the military physician's relationship with his clients – clients who include both his individual patients and the larger military organization he serves. The internal and external factors influence the military physician's moral working self in such a way that sometimes identity confusion or scripting conflict manifests themselves in moral dilemma.

When either-or solutions ignore or downplay the conflict of the moral working self, they result in an inadequate moral topology of decision-making for military physicians.

In this chapter, I propose a topology of moral decision-making, which I will refer to as Topology-AMC, suitable for physicians in the Army Medical Corps.[170] Topology-AMC utilizes four basic guidelines and multiple variables that help establish the parameters of a moral interaction between a military physician, his patients, and the military he serves. This moral topology starts with a basic understanding of a professional moral identity suitable for a military physician. This, combined with a view of the dual nature of the military physician, allows for consideration of the various needs of a nation state when a combat arms profession requires the professional skills of medical workers.

An advantage of Topology-AMC is that it makes use of the moral psychology surrounding self-identity in order to assist individuals to reach moral and ethical decisions in performing their professional duties. Topology-AMC goes beyond merely establishing what is involved in moral processing; it suggests how to move beyond what "is" to what "should be." By identifying morally relevant criteria in professional decision-making, the topology also allows for identifying and retaining appropriate levels of moral dilemma or moral distress.

The complete elimination of moral dilemma or moral distress is not necessarily a desirable end-state of professional-client interactions.[171] Unlike either-or solutions, Topology-AMC does not claim to dissolve all cases of moral dilemma or moral distress. Nevertheless, it presents a moral topology of decision-making that allows military

[170] In the U.S. Army, soldiers are assigned into a branch, or functional area. The basic branches are: Adjutant General's Corps, Air Defense Artillery, Armor, Aviation, Chemical Corps, Corps of Engineers, Field Artillery, Finance Corps, Infantry, Medical Service Corps, Military Intelligence, Military Police Corps, Ordnance Corps, Quartermaster Corps, Signal Corps, Special Forces, and Transportation Corps. Civil Affairs and Psychological Operations are two non-basic branches. Military physicians are in the Medical Service Corps.

[171] See Appendix 3: The Either-Or Solutions: Nazi Case Study.

physicians the conceptual space to preserve professional and personal integrity while upholding professional standards of competence and ethical behavior embraced by both professions.

§1: Topology-AMC

As we have seen, proponents for either-or solutions tend to be committed to the static identity of a military physician. Yet, this static identity is not necessarily a blend of a medical identity with that of a military identity. Rather, either-or proponents tend to view a physician as a healer, and a soldier as a killer. When either-or proponents combine the identities of a physician and an officer, they seem to assume that one professional identity can and should dominate, as the other is submerged or discarded.

Topology-AMC addresses the tendency to identify a physician as only a healer and a soldier as only a killer. Although these classifications may represent the primary tasks of the respective professionals, the foundation that formed, and consequently comprise, the professions' codes of ethics are more complicated. Topology-AMC proposes that it could be more appropriate to understand and emphasize that both professions may share a mental model of protecting or shielding people from harm, even though the methodology for reaching that goal is very different. Serving those in need of aid, either on an individual level or on a national level, is the foundation of the moral authority that physicians and soldiers receive that forms a public trust.

Topology-AMC would assist in the training of the military physician by allowing for a methodology that would utilize appropriate codes of ethics supported by both professions to produce a mental model that promotes a primary duty for a military physician *to protect or shield people from harm.*[172] This allows for a dynamic view of professional identity that provides the conceptual space to identify different guidelines and variables that can help

[172] Thanks to MAJ Danny Cazier, a professor at the United States Military Academy who teaches philosophy, for introducing me to this concept. MAJ Cazier argues that the legitimacy of soldiers' actions rests on a moral foundation of protecting or shielding people from harm.

regulate a sliding scale of military physician rights and duties with respect to patient care. The conceptual space is provided through the use of four general guidelines used in conjunction with the relevant physician and patient variables that impact the military physician–patient relationship.

Following the lead of Gross, and Jonsen and Jameton, Topology-AMC proposes that for a majority of cases it is possible for a military physician to default to traditional "medical" or "physician" duties. This is justified because in many cases performing his customary medical duties will enhance, or at least not be detrimental, to the missions of a military. Yet, there could be cases where focusing overly on individual patient care could result in harm to what the military perceives as the greater good. Thus, it is necessary to provide a mechanism, or procedure, whereby military physicians can work through ethical dilemmas and know when military necessity may be of a compelling enough nature to tip the balance of care from an individual to the needs of the military institution.

§1.1: Preliminary Conditions and Guidelines

The First Guideline of Topology-AMC

For the first preliminary condition, or guideline of military physicians' dual loyalties, Topology-AMC draws upon common elements in both the medical profession and the military profession. Common elements suggest that the professional identity of a military physician centers on t*he duty to offer medical knowledge, skills, and abilities to protect and shield the innocent*. Where "innocent" is understood less as a legal or moral evaluation of an individual, and more as an "ideal" where medical need is present and there are not

compelling factors to contraindicate providing care, e.g., the potential patient is "vulnerable" to preventable harms and does not himself present a significant threat. Moreover, the "innocent" may be broadly construed to include not only an individual person, but also a group or collection of individuals that are in some sense vulnerable or helpless in their medical needs.

The Second Guideline of Topology-AMC

The second guideline of Topology-AMC states that military physicians should practice due care and personal concern, and exercise due responsibility to *the individual* in order to optimize the diagnosis and therapy of their patients. While the military physician's primary duty is to individuals, military physicians should be cognizant of situations where the military mission may necessitate optimizing care for the group, protecting the group, and assisting in mission goals even to the detriment of the medical needs of the individual. This can be justified from both military codes of ethics and medical codes of ethics.[173] In general, medical codes of ethics acknowledge situations where physicians may consider group interest above and beyond the needs of a particular individual or patient. Conversely, although military codes often focus on the group, there are indications that military needs can best be achieved, in some situations, by focusing on the needs of individuals. Just as medical ethics have slowly evolved to focus on group needs, military ethics are currently evolving to focus on the needs of the individual.

[173] See Section Two of Chapter Two of this dissertation for details of professional codes. See also Appendix 6 for a primer on professionalism.

The Third Guideline of Topology-AMC

The third guideline of Topology-AMC states that military physicians should manifest themselves in their social role as offering dual loyalty to individual patients and the military they serve. Professions, including the medical professions, have long recognized that a professional may have competing interests, and hence dual loyalties, between a client and other entities. Either-or solutions tend to overlook the fact that medical codes of ethics often have an "escape" clause whereby physicians are relieved of their primary obligation to patient care in order to satisfy obligations to a third party.[174] While his primary obligation may be to the individual patient, Topology-AMC recognizes a military physician's legitimate obligation to the military and helps establish parameters of action.

Legitimizing social roles requires acknowledgment of the roles from the professional organizations and the public. The medical profession, the military profession, and the public must acknowledge the dual loyalty of the military physician. This acknowledgement should include an understanding and acceptance that situations can dictate that military physicians must exercise professional autonomy that does not always conform to either patient-centric duties or mission-centric duties. The acknowledgment can be made possible by developing and communicating professional codes that address the dual role of the military physician and by providing full disclosure to potential patients of military physicians as to rights, responsibilities, and prohibitions with respect to medical care provided by the military. A constant reminder of the dual nature of military physicians could be the uniform that

[174] See Section Two of Chapter Two for a medical code that offers an "escape" clause, T*he American Medical Association Code of Ethics Preamble*. Section Two of Chapter Three starts with another code with an escape clause, *The World Medical Association International Code of Medical Ethics*.

military physicians wear. It should have elements of both the medical role (e.g., white coat) as well as the military role (e.g., insignia of rank and branch of service).[175]

The Fourth Guideline of Topology-AMC

The fourth guideline of Topology-AMC confirms that to the extent that the military has caused injury or illness, or that a military physician has control of a patient or situation involving medical care, they are responsible for the diagnosis and therapy of the patient. This follows from both the idea of reparation for causing harm to an individual and, assuming that the individual is *hors de combat*, from the military physician's duty to shield and protect the innocent.

Meeting these guidelines requires understanding the rights and duties of military physicians to treat patients, the rights and duties of patients to receive treatment, and conditions that may affect these rights and duties. To help in this understanding, Topology-AMC proposes that there are parameters regulating the rights and duties of military physicians and their patients with respect to access and treatment of medical services.

§1.2: A Selection of Morally Relevant Parameters

Topology-AMC does not provide an exhaustive list of all morally relevant relationships. The topology is a start towards helping identify conditions that indicate when military necessity may, or may not, override individual patient care. These parameters may be used to help define physician and patient rights and duties within a military context. They help identify aspects of military medicine that influence the nature of the professional-

[175] Glenn Graber, Professor of Philosophy at the University of Tennessee at Knoxville, Knoxville TN, pointed out this simple, yet effective, way to communicate and symbolize dual loyalty.

client relationship of military physicians dealing with a variety of clients. These parameters are expressed by the following *dependent* variables:

Y_1 = Range of patient rights and responsibilities with respect to their medical needs. Across a range of values these would be represented as: Obligation to receive medical treatment; permission to receive medical treatment; permission to refuse medical treatment; and an obligation to refuse medical treatment.

Y_2 = Range of military physician rights and responsibilities. Across a range of values these would be represented as: Obligation to provide medical knowledge, skills, and abilities; permission to provide medical knowledge, skills, and abilities; permission to refuse to provide medical knowledge, skills, and abilities; and an obligation to not provide medical knowledge, skills, and abilities.

Values on these ranges can be treated as either discrete or continuous variables.

Y_1 represents a patient scale of rights that seeks to categorize a patient's rights or responsibilities to receive health care. This scale may be further demarcated into two parts:

Y_1 – Patient Rights

a. Right to receive medical treatment;

b. Right to refuse medical treatment.

Rights to receive medical care depend on a need for care, a desire for such care, and a right to that care. Rights to refuse treatment occur when a patient has a medical need but has legitimate reasons to not want such care, e.g., not wanting to prolong a terminal illness.

Y_1 – Patient Obligations

a. Obligations to receive medical treatment;

b. Obligations to refuse medical treatment.

Obligations to receive treatment may be voluntary or involuntary. For example, health care professionals may voluntarily fulfill an obligation to receive a vaccination in order to prevent the spread of disease. In contrast, if an individual refuses to fulfill his obligations, a court could determine that the individual has an obligation to receive treatment in order to protect a third party or the public.

Overriding values may cause an individual to reason that there exists an obligation to refuse medical treatment. Likewise, a soldier may be obligated to refuse medical treatment because it would prevent him from participating in a mission.

Y_2 represents a military physician's scale of rights that seeks to categorize a physician's rights and responsibilities to provide medical services. As with the other Y variables, this may be further demarcated into two parts:

Y_2 – Physician Rights

a. Rights to initiate or continue medical service;

b. Rights to refuse or discontinue medical service.

Rights to treat may be granted when a physician has the knowledge, skills, and ability to treat an individual in medical need where there exists a relationship between parties that is not obtained through an emergency situation e.g., under non-emergency conditions staff physicians at a high school may have permission, but no obligation, to also treat the faculty at that school in addition to the students they are obligated to treat.

Y_2 – Physician Obligations

a. Obligations to initiate or continue medical service;

b. Obligations to refuse or discontinue medical service.

Obligations to treat may be generated in various ways. A physician may have the knowledge, skills, and ability to render medical aid to a person in urgent need of such care, e.g., emergency conditions may obligate a physician to render medical aid. A court order may require medical treatment of a patient. A principle of non-abandonment may obligate a physician to provide continuing medical care to his patients.

Finally, there may exist an obligation that prohibits treatment. An age-old medical dictum is "First, do no harm."[176] Normally a physician is prohibited from committing acts that are expected to result in long-term or permanent harm or death.[177] There also exists an ideal that in triage situations patients are sorted by medical need, so that the most severely injured are treated first. However, this may not apply in mass casualty triage where there are numerous injured individuals and limited resources. Therefore, a physician may be prohibited from treating the most severely injured in order to treat a greater number of injured individuals who are expected to have a greater chance of surviving. Other types of prohibitions may arise due to third-party interventions. Insurance limits, not being a member of a health group or organization, or (possibly) following orders may represent prohibitions to treatment.

The Y *dependent* variables can be used to help establish a moral space in which a military physician may function. To determine the value of these variables it is necessary to

[176] From the Hippocratic writing *Epidemics*.
[177] Nazi examples come to mind, as do the Tuskegee Studies.

establish some of the *independent* variables that factor into the *dependent* variables. There are at least seven *independent* variables:

X_1 = the medical role of the individual;

X_2 = which "side" the individual is on;

X_3 = combatant status;

X_4 = the current "spectrum of war;"

X_5 = the context of the consent status of the individual;

X_6 = the location of conflict;

X_7 = the relative security of the location of conflict. [178]

These *independent* variables will be treated as discrete variables. The *independent* variables can be described as follows.

X_1. The medical role assumed by an individual may be classified as:

a. Medical worker – someone with the knowledge, skills, and ability related to providing medical care;

b. Potential medical worker – an individual with the knowledge and skills for providing medical care;

c. Patient – an individual in need of medical services who has been accepted into a professional–client relationship;

d. Potential Patient – an individual in need of medical services;

e. Neither – not a patient or a medical worker.

X_2. The "side" of an individual may be "friendly," "allied," "enemy," or "neutral."

[178] Topology-AMC does not claim to give an exhaustive list of the morally relevant X-variables that help determine the Y-variables. Rather, Topology-AMC presents some relevant variables that appear to deal with moral dilemmas as experienced by some military physicians.

a. Friendly – a member of your own force or allied forces' military who actively supports your cause or mission;

b. Allied – a member of a foreign organization, such as a military force, who is supposed to support a cause or mission, but may be unenthusiastic or passive towards mission objectives;

c. Enemy – a member of an organization which actively opposes a cause or mission;

d. Neutral – a member of an organization which does not take a position one way or another.

X_3. There is a tradition in Western warfare that categorizes the combat status of individuals as:

a. Combatants – an individual who is a legitimate target;

b. Noncombatants – an individual who is not a legitimate target.

Historically, as seen in Chapters Three and Four, there are mixed accounts of how medical personnel treat the combatant versus noncombatant distinction. As also seen in those chapters, international law now indicates that all individuals *hors de combat* deserve some level of consideration. This is difficult in some cases, as the combatant versus noncombatant status may be blurred, especially in modern, counter-insurgency operations or asymmetric warfare.

X_4. According to the U.S. Army's "Spectrum of Conflict" [179] classification system, military operations are classified as:

[179] Army Field Manual FM-03, 1-15, 2001. The general U.S. goal in major theater war is to "fight and win war." The general U.S. goal in Military Operations Other Than War (MOOTW) is to deter war and resolve

- War
    a. General War – armed conflict between political units aimed at a desired political end-state;
    b. Insurgency – a rebellion against a constituted authority when those taking part in the rebellion are not recognized as belligerents.[180]
- Military Operations Other Than War (MOOTW)
    c. Unstable Peace – an absence of aggression, violence, or hostility, but without the more positive aspects of safety, welfare, equality, and fairness associated with peace;
    d. Peace – an absence of aggression, violence, or hostility, while within an environment of healthy relationships, safety, welfare, equality, and fairness.

X_5. There are various ways the context of the consent status of an individual may be categorized. In medical ethics classification systems, an individual who becomes a patient may be classified as voluntary (known to be actively consenting), presumed voluntary (there is no evidence to the contrary that the individual is actively consenting), involuntary (known to be actively refusing), presumed involuntary (there is no evidence to the contrary that the individual is actively refusing), or non-voluntary (there is no evidence one way or the other as to whether the patient is consenting or refusing). Patients who are traumatized and

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conflict, and to promote peace. MOOTW may operate within conditions of Stable Peace, Unstable Peace, Insurgency, and General War. During General War, the military concentrates on offensive and defensive capabilities. During Insurgency, the military concentrates slightly less on offense and defense, but more on stability operations. During Peace and Unstable Peace, the military focuses most on stability operations, with limited defensive operations, and little to no offensive operations. In both War and MOOTW, stability operations are performed as needed.

[180] Belligerents are entities either recognized as sovereign states or officially associated with sovereign states.

disoriented, wounded and unconscious, etc. would, baring evidence to the contrary, be classified as presumed voluntary. In a military classification system, soldiers may be presumed volunteers, presumed willing conscripts, or presumed unwilling conscripts. Unless there is compelling evidence to suggest to the contrary, Topology-AMC drops the "presumed" qualification and proceeds "as if" the classification is accurate.[181] A soldier, as a patient, may have a relationship with the medical apparatus as a:

a. Voluntary patient, voluntary soldier;
b. Voluntary patient, willing conscript;
c. Voluntary patient, unwilling conscript;
d. Involuntary patient, voluntary soldier;
e. Involuntary patient, willing conscript;
f. Involuntary patient, unwilling conscript;
g. Non-voluntary patient, voluntary soldier;
h. Non-voluntary patient, willing conscript;
i. Non-voluntary patient, unwilling conscript.

X_6. The location of conflict, relative to either the physician or the patient, can be classified as "home," "friendly territory," "allied territory," "enemy territory," or "neutral territory."[182]

a. Home – geo-political area in which the individual is a citizen;

[181] Compelling evidence would switch classification. A soldier in an all-voluntary army is presumably voluntary, yet when she tells you her story, you know that "she had no choice…she had to enlist…that's all she could do." This soldier could be reclassified "unwilling conscript," even in cases where she was not literally conscripted.

[182] To use this variable requires making it relative to either the physician or the patient.

b. Friendly territory – geo-political area in which the individual is either a citizen or non-citizen and the local government is providing active support to the missions associated with that individual's military;

c. Allied territory – geo-political area in which the individual is not a citizen and the local government is supposed to provide active support to the missions associated with that individual's military;

d. Enemy territory – geo-political area in which the individual is not a citizen and the government is actively or passively hostile to the missions associated with that individual's military;

e. Neutral territory – geo-political area in which the individual is not a citizen and the government is not taking a position for or against the missions associated with that individual's military.

X_7. There are various ways to define the relative security of the location of conflict. In decreasing order of potential for close quarters combat:

a. On the front lines or "outside the wire" – a location away from a stable "secure" location, away from direct access to supplies, and an enemy has relatively easy access to the location to engage in hostilities; these are generally areas where active combat is expected;

b. In a forward operating base or "inside the wire" – a location that is relatively stable and "secure" (with gates, guns, and guards), and contains direct access

to supplies and support; these are generally areas where active combat is possible, but not as likely or intense as outside the wire;

c. At a pre-deployment stage – a location used as a temporary gathering of resources (which may include both men and material) before they are sent to mission areas; in contemporary warfare, pre-deployment stages are relatively safe such that they are essentially non-combat situations;

d. At a "secure" area – a presumably location that is reasonably safe from active combat situations or preparations; a safe location that normally would not be threatened by combat activity but may contain patients or potential patients; the location used as a permanent, or semi-permanent, gathering of military personnel and supplies.

These are general guidelines as a war can be so encompassing in an area that there is no defined forward operating base or pre-deployment stage. Moreover, long-range weapon systems, incendiary explosive devices, and other factors may change this dynamic so that the status of an area is uncertain.

§1.3: Guidelines, Parameters, and Relationships

The guidelines formulated by Topology-AMC provide the basic context and framework within which the military physician should act. The X and Y variables may be used in establishing the parameters of the rights and duties of military physicians and patients. They provide information concerning the balance of patient medical need versus military necessity and military obligations. They do this by helping to establish the

relationship between a medical worker and his patient. Understanding the relationship helps define a physician's appropriate medical involvement with an individual. Particularly, the context of how a patient becomes a patient, and the context of the classification of the patient with which the military physician is dealing, can define the limits of patient autonomy and the patient's rights to health care.

As with other medical relationships, the military's health care system consists of policies, procedures, and guidelines for both rights and responsibilities. Individuals have certain rights to health care when injured or suffering from illness, and certain responsibilities to take reasonable, preventative measures to maintain health. This relationship includes such policies as the individual's access to emergency combat medicine and the individual's responsibility to take vaccinations to maintain not only his own health, but also the health of his unit. Friendly soldiers score "high" on the scale of a right to receive care from their military physicians. Yet, due to the nature of their chosen line of work, they score "low" on the scale of patient autonomy. However, they might score relatively higher on a right to receive care than willing conscripted allied soldiers, but lower (if relatively healthy) relative to wounded civilians.[183]

A relationship between the soldier and military, including the medical apparatus, is introduced when an individual joins the military. To the extent that we approach the "voluntary soldier" end of the spectrum in X_5, soldiers may have justifiably limited autonomy within military service due to their choice of joining. Inherent in their degree of choice is an agreement to undergo diagnosis and treatment not only to prevent harm to

[183] See Gross's *Bioethics and Armed Conflict* for a discussion on relative rights. This assumes that conscription procedures are fair and just.

themselves, but also to prevent harm to others. Rather than seeing this as inappropriate or paternalistic, it could be viewed as showing respect for the soldiers' choice to serve their nation assuming proper information was provided to the individual upon joining the service.

There is a limitation to the nature of the relationship between military physicians and civilians. Friendly civilians do not normally have access to military physicians unless the civilians are family members of service personnel, civilian employees of the military, or have some other relationship to the military. Civilians associated with the military are granted a "higher" right to access of military health care compared to other civilians. Yet, the autonomy of civilians who enter into a health-care relationship with a military physician should be "higher" than that of a soldier, as less autonomy does not serve national interests. They can voluntarily seek medical aid. Although they cannot be ordered to seek medical care, there may be certain moral requirements that dictate or strongly encourage them to do so, e.g., if their health status jeopardizes the health of soldiers.

However, in a situation in which a civilian's illness or injury is caused by the military, the military can, and possibly should, offer medical treatment to the civilian. Military physicians, for example, should care for civilians located in a war zone, if the military was the cause of the medical problem. There are other appropriate circumstances, such as various humanitarian efforts, where the military offers medical aid to individual civilians and civilian populations.

The treatment of enemy soldiers may be more complicated. According to the Law of Land Warfare, the Geneva Conventions, and opinions among some military leaders, military personnel are responsible for the care and safety of enemy soldiers that are *hors de combat.*

This includes medical care. Some enemy soldiers, who might be called "traditional enemy soldiers," are presumed to consent to care from their enemy, and this includes care from an enemy's military medical personnel. This tacit consent is a result of a shared mental model by the participants of warfare.

According to some military organizations, the shared mental model consists of two basic beliefs. Although actively engaging in hostile combat, there is a sense of the basic value of life and that it is best to (1) incapacitate but not necessarily kill combatants and (2) fighting should be accomplished with the minimum force adequate to achieve mission goals.[184] It can be considered that enemy soldiers may have tacitly given consent to treatment due to their participation in combat. By being wounded and *hors de combat*, enemy soldiers qualify for emergency care. If resources are available, it is not only assumed that medical personnel are obligated to render aid, but that enemy soldiers have given presumed consent to receive aid. This may include emergency treatments and vaccinations. It also potentially applies to experimental treatments that are also legitimately used on friendly or allied soldiers. However, historical accounts of the treatment of enemy prisoners of war suggest that there is a risk of abuse in this area. Policy and professionalism must be exercised prudently to ensure that the rights of enemy soldiers are respected.

Notice that this implied consent for proper medical treatment cannot be taken as permission to allow enemy soldiers to be subject to otherwise unethical treatment. For

[184] From discussions with soldiers at West Point, the United States Military Academy. Although there are historic examples of enemy troops that practiced no quarter, these tend to demonstrate that this practice has devastating results to warfare. Some soldiers indicate that when anyone engages in battle they agree to the rules (whatever those are!), specifically the legitimacy of trying to kill combatants and caring for noncombatants. Modern asymmetric warfare may change this conceptual model. Terrorists do not share a conceptual perspective of the illegitimacy of using noncombatants as targets. Militaries may also espouse a belief in using "overwhelming force" to overwhelm an enemy, minimize losses, and maximize force protection.

example, they should not be tortured, humiliated, used as slave labor, or used as experimental subjects.

Medical personnel would likely not enter into a medical relationship with hostile civilians unless, as stated above, the military causes the injury or illness. In that case, as the fourth guideline of Topology-AMC states, if the military causes the injury or illness, medical care should be available to civilians.

Recently terrorists have become increasingly difficult to classify for both civilian and military authorities and this classification has been subject to much debate by both civilians and military personnel.[185] Typically, terrorists do not act under "color of authority." Terrorists are often not legally recognized as enemy combatants. Yet, their activities certainly seem to resemble enemy combatants more than enemy civilian populations.[186] Their tactics of fear and destruction, which critically rely on nonmilitary targets, make it unclear to what extent they should be treated as traditional enemy soldiers, or lawful combatants. Arguably, medical workers may still have a responsibility to render aid when possible. Terrorists may consent to aid just as anyone may consent in an emergency. As with all hostiles, there is also a degree of involuntariness to their relationship. As with the treatment of all prisoners of war, policy and professionalism must be exercised to insure their basic dignity and that their human rights are respected.

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[185] For discussion on how terrorists are not classified as "soldiers" or due the legal rights of citizens, see Martin L. Cook's article "Ethical Issues in Counterterrorism Warfare." He argues that unlike soldiers, terrorists are not protected under war conventions. He further argues that unlike civilians, terrorists are not due legal processing as criminals. He then argues that until terrorists formally take up "combatant" or "noncombatant" status they are subject to elimination by military force. http://ethics.sandiego.edu/Resources/PhilForum/Terrorism/Cook.html

[186] The U.S. has been trying to label some terrorists as "unlawful enemy combatants." If the U.S. and international courts allow this classification, terrorists so labeled will fall into a legal "grey" zone where criminal or military law does not protect them, yet they will be subject to punishment and treatment from either.

From the previous examples, it becomes clear that there are two primary ways that relationships can be created between medical personnel and patients. First, there are *relationships initiated by potential patient actions*. These normally include soldiers who enlisted in the military, civilians who actively seek treatment, and civilians who serve the military. However, as we have seen, it may include enemy soldiers, civilians, conscripts, or terrorists whose actions place them within a medical relationship with the military. Each classification can initiate a different level of treatment that is determined by the parameters of care established on the Y scales of dependent variables.

The second primary method that relationships can be created between medical personnel and patients is *through the actions of a military organization*. Military physicians have a professional obligation that expresses responsibility, to care for individuals harmed by military action. Intuitively this might be expressed by the dictum that a person, or organization, is responsible for the consequences of their actions. In particular, this can be understood as something similar to Ross's notions of a *prima facie* duty of reparation, or a duty to redress wrongs committed against others. In the U.S. Army soldiers are instructed that as professionals they have responsibility to people they harm but do not kill (assuming the harmed individual is not a threat).[187] Soldiers should be responsible for the safety of those who are *hors de combat*. From these policies, it can be extrapolated that when the military is the cause of illness or injury, it obtains an obligation to care for those afflicted.

[187] Although reports from the field indicate that "double tapping" is practiced with more frequency than might be expected. "Double tapping" is the practice of shooting a wounded person twice to ensure they are dead. This is done to "circumvent" the law in that a soldier who "double taps" bypasses the need to check if someone is alive and in need of medical care.

This creates the basis of a relationship established by the military between its medical personnel and the resulting patients.

After considering the four guidelines offered by Topology-AMC, the Y and X variables can help regulate the criteria of care for illness, injury, and emergencies. These variables help to indicate the level of obligation of care the military physician obtains due to the initial conditions of the relationship and the level of patient rights and responsibilities, again, due to the nature of the relationship.

Determining the level of the relationship and the nature of the relationship on a sliding scale becomes problematic for medical personnel in cases of torture, interrogation, or medical experimentation. Two differing perspectives illustrate these relationship issues. One perspective argues that insofar as these actions are not part of a normal therapeutic relationship it is understood that they fall outside the medical purview and are not subject to professional medical ethics. However, another perspective states that it has long been recognized that physicians, as are other professionals, are bound by professional standards of ethics that shape their actions even when situations are not strictly within their professional purview. Therefore, torture and certain practices of medical experimentation, such as that used in Nazi Medicine, the Tuskegee Syphilis Experiments, or Willowbrook Hepatitis Studies, are unethical for physicians.

Most modern military codes of conduct, and standards of professionalism within a military, prohibit the use of torture and other inhumane practices by military personnel, including officers. Therefore, since both physicians and military officers are prohibited by their professions from committing torture, conducting certain types of medical experiments,

or engaging in inhumane practices towards prisoners of war, it appears that a conflict of duty would not exist, as both professions would condemn these types of actions.[188]

Conflict of duty and moral dilemma could still occur if either profession or, in the case of the military, the U.S. Government, defined torture, certain medical experiments, or inhumane practices in a manner not acceptable to professional medical ethics. For the military physician the conflict would then center on whether or not to obey an order, especially if it appeared the order was legal under government guidelines, and the obligation not to engage in inhumane practices.

Although the paradigm presented in Topology-AMC helps one to understand the limits of rights, responsibilities, and obligations of physicians and patients in a military context, there needs to be more study to clarify the military physician's professional ethics and code of conduct as differing roles and duties are assigned to them. The next section explores some advantages contained in Topology-AMC that may assist military physicians resolve conflict.

[188] The legality of U.S. Military involvement with torture has been greatly confused and complicated since George W. Bush signed "Executive Order: Interpretation of the Geneva Conventions Common Article 3 as Applied to a Program of Detention and Interrogation Operated by the Central Intelligence Agency," on July 20, 2007. Yet, even when torture is illegal, it continues. Physicians and other medical workers are ordered to participate in various ways. See Mark Danner's New York Times article, "Tales from Torture's Dark World," 15 March 09.

§2: Advantages of Topology-AMC

Through the training, education, and development of individuals, Topology-AMC reveals relevant aspects of what is missing in applications of the either-or solutions thus allowing for better resolution of conflict of duties. It seems that proponents of the either-or solution who claim that military duties should override medical duties may draw their conclusions by overly emphasizing the following three conditions: (1) an "us versus them" mentality, (2) conditions are largely restricted to combat and general warfare, and (3) military necessity can override individual liberty. Likewise, proponents of the either-or solution who claim medical duties should override military duties may draw their conclusions by emphasizing the following conditions: (1) in all circumstances a patient's individual medical needs come first, (2) downplaying situations of combat and general warfare, and (3) there are reasons to ignore or minimize military necessity. Topology-AMC allows for an awareness and evaluation of the deciding factors to reach a more balanced conflict resolution.

§2.1: Military Proponents

Topology-AMC's system can be utilized to analyze how military proponents utilize factors that define the relationship of the physician to the patient to reach their conclusion that military duty should override medical duty. By using the variables of Topology-AMC to analyze the either-or solutions we can see that military proponents often focus on X_2 (the "side" the patient is on), X_{4a} (the Spectrum of Conflict is considered to be at the level of armed conflict, General Warfare), X_6 (the location of the patient is not-home), X_7 (the

relative security of the location of conflict is "outside the wire" or at a forward operating base), or X_3 (the combatant status of the patient). Topology-AMC shows that by focusing on these parameters and their values, and excluding or minimizing other possibilities, the military proponents' view generates several problematic implications, some of which are detailed below.

First, by focusing on X_2 (the "side" the patient is on) there is an understandable psychological tendency to follow an "us versus them" mentality. Although this is more often found in the non-medical personnel of a military, it creates an ethical culture and climate that may influence the thoughts or performance of medical personnel. Focusing on X_{4a} (they are at war) also increases the "us versus them" mentality. It focuses on an awareness of combatant status, which introduces a concept of military necessity. This concept allows for sacrificing individual interests, including safety of civilians or noncombatants. Focusing on X_7 and X_6 (they are in combat situations away from home) creates an emergency triage situation. Emergency triage places less emphasis on medical need, and more emphasis on resource management, group survival, or saving "key" personnel. Finally, relying solely on outdated "combatant" status indications, X_3 (individuals are combatants or noncombatants), creates confusion and a potential for lost time as military physicians try to evaluate what to do with the patient.

When these selected factors are the *default* conditions used by medical personnel, they create psychological mental models where military needs become more important than individual patient care.[189] For example, soldiers on the military physician's "side" may be seen as more important than the "others" who are not on their side. This could be a bias

[189] Recall the motto of the Army Medical Department, "To Conserve Fighting Strength."

favoring one's own group over that of another. This could also be interpreted as a case of military necessity where patients that are "us" are more in need of medical attention as their survival may be "necessary" for the group. Moreover, soldiers on "our" side may be seen as more deserving of care as they have been injured in the line of duty for "our" cause.

There may be situations where these reactions are appropriate, where military physicians should act as indicated. However, what Topology-AMC reveals is that by ignoring the variability of the moral factors involved in the military physician-patient relationship, the either-or proponents begin to assume the validity of subsuming one moral working self, or professional identity, under the other, sometimes going so far as to claim this for all situations. In this case, the physician identity is subsumed under the soldier identity, thus increasing the acceptance of claiming that military duties should always override physician duties.

There is a second problematic implication associated with focusing on *select* moral variables – X_2 (the "side" the patient is on), X_{4a} (the spectrum of conflict set at the condition of general warfare), X_7 (the location of patient care is "outside the wire" or at a forward operating base), or X_3 (the combatant status of the patient). Proponents that favor military duties overriding physician duties may, regardless of the situation, implicitly use these variables to answer the following four questions: (1) Can the patient harm individuals on "our" side? (2) Will providing medical care have a significant, negative influence on the care of individuals on "our" side (perhaps by making medical resources scarce). (3) Will providing care have a negative impact on military missions? (4) What medical care is needed and how urgently is it needed in triage situations?

If the answer is "yes" to any of the first three questions or the patient is rated as "expectant" with respect to the fourth question, then, it is argued, the military physician is prohibited from providing medical care, possibly even including the relief of pain and suffering. In the extreme case where the patient under consideration acts violently, otherwise harms, or threatens to harm others, pro-military proponents may argue that the military physician may have a duty to incapacitate or even to use lethal force on that individual. In their argument, given the conditions of general warfare, the military physician may have a duty to defer when soldiers on his side attempt to subdue or kill the individual in question.

In a combat zone (X_4, X_6, X_7), enemy prisoners of war who attack medical personnel or patients should be dealt with quickly and, perhaps, lethally (third guideline, X_2). Acting in self-defense, or in the defense of their patients (first guideline), presents a reasonable justification for a military physician to react lethally to end the threat or harm. Yet this action seems unreasonable in less extreme conditions. For example, considering other Topology-AMC variables such as different levels of the spectrum of conflict (X_4), as well as the location of conflict (X_6), can, and should, change the obligations and permissions of the military physician (Y_2). During peacetime (X_4, X_7), the military physician should not be required to defer if soldiers attempt to mistreat an individual who may cause harm (first guideline). Instead, a military physician should insure that the patient is properly restrained and then provided with medical care appropriate to his medical needs (second guideline). By considering such variables Topology-AMC presents and defines additional factors beyond those factors utilized by either-or proponents. These additional factors can be

utilized for more informed moral decision-making and can allow the physician the conceptual space to incorporate a different set of moral variables into his moral working-self.

There is one further problem to address concerning proponents claiming that military duties should always override physician duties. This is their use, or misapplication, of the concept of military necessity. In theory, this concept is uncomplicated. Military necessity, "as understood by modern civilized nations consists of the necessity of those measures which are indispensable for securing the ends of war, and which are lawful according to modern law and usages of war."[190]

Following guidelines from just war theory,[191] military necessity is regulated by the two conditions of discrimination and proportionality. Discrimination asks, "Who makes a legitimate target?" while proportionality asks, "What is the acceptable collateral damage when compared to military goals?" In this case, "collateral damage" generally means anything not a legitimate military target such as noncombatants, hospitals, and holy buildings.

Most of the examples and case studies used in this dissertation demonstrate that, for some military physicians, the conflict of duties involves the explicit or implied claim that military officer duties should override physician duties because of military necessity. The claim is that when situations exist where there is a conflict between medical professional practice and military mission requirements, the military mission *must* come first to preserve the peace, stabilize conditions, or end a war. Discrimination and proportionality are applied

[190] General Order No. 100, Section 14. 1863.
[191] See Appendix 4 for the conditions associated with a just war.

to define who makes legitimate "patients" and in determining which individuals are considered acceptable "losses" from the military's perspective.

A problem with military necessity is that determining military necessity is largely decided by whoever is in power or control of the military apparatus. What is viewed as proportional, discriminatory, or even necessary appears to be largely based on intuition. Sometimes this intuition is based on developed and thoughtful experience, but this is not always the case. The ethical culture and the climate of the military may make it difficult to obtain a view that is not dominated by military culture and tradition. Topology-AMC may be useful to help develop a more informed and ethical decision-making process than is presently available under dynamic situations. Topology-AMC may not provide an exhaustive calculus for military necessity versus medical need, but it does provide additional, relevant variables for consideration. The paradigm could be used to help train military physicians, and other officers, to recognize complex ethical situations and to reach ethical judgments.

§2.2: Medical Proponents

Recall that proponents of the either-or solution that claim *medical* duties should override *military* duties may draw their conclusions by focusing on and emphasizing the following three factors: (1) a belief that in all circumstances a patient's medical needs come first, (2) conditions are such that combat and general warfare variables are minimized, and (3) there are reasons to ignore or downplay military necessity. The variables of Topology-AMC can again be utilized to explore the factors that cause some to claim that medical

duties should override military duty. It appears that medical proponents tend to minimize some of the variables presented in Topology-AMC that emphasize that in some situations group concerns are legitimately overriding factors when compared to individual patient concerns. Topology-AMC suggests that although the military physician's initial duty is to his patients (second guideline), it is possible, through the "escape clauses" in medical ethics, to consider appropriate third party duties (first, second, and third guideline). This consideration may be achieved, in some situations, by providing more consideration to X_2 (the "side" the individual is on), X_4 (the spectrum of conflict), and X_5 (the consent status of the individual).

Historically, there has been controversy as to how much consideration "side" should receive in military medicine. On one extreme, "side" was critical in determining that only "us" or "our side" should receive care, from the point of view of the military physician. The other extreme suggests that "side" never matters; only medical need is important. Both extremes are understandable, given the appropriate conditions. Limited resources, patriotic duty, loyalty to one's own, and a need to return troops to the field of battle make compelling arguments that suggest a need to treat "our side" first. However, this may not always be an ethical argument when dealing with individual patients.

The origins of equal care for soldiers on any "side" appear to arise for both pragmatic reasons and moral reasons. Pragmatically, soldiers realized that it was in their own best interest to foster a belief in medical neutrality when the injured were treated based on medical need and medical personnel were "protected" in combat. Morally, people exposed to the tragedy and horror of the battlefield decided, on humanitarian grounds, that

anyone wounded deserved treatment. This reinforced the pragmatic concerns and further solidified medical neutrality, but did not totally solve the practical problem of providing care to everyone in every situation.

There are times when medical neutrality reaches a point where treating people on the other "side" (X_2) or those not involved in the missions of a military, can negatively affect those missions. In such cases, it seems reasonable that medical care may be limited.[192] For example, during general warfare and situations of active combat (X_4, X_7), it may be reasonable for a military physician to consider the needs of his own side when evaluating the level of medical care given to those of the other side (X_2), assuming that resources are limited or need to be preserved for future use. This follows not only from military considerations but also from standard medical ethics surrounding triage situations.

Medical neutrality may also not apply when considering the context of consent status of the patients or potential patients (X5). Soldiers may consent to less than optimal medical care.

By considering Topology-AMC guidelines, such as a duty of reparation for harm done (fourth guideline), and an awareness of the spectrum of conflict (X_4), location of conflict (X_6), combatant status (X_3), and possibly the context of consent status (X_5), Topology-AMC may help military physicians determine who to treat by helping to identify the balance between medical neutrality and military necessity.

[192] This is reasonable because a military physician's professional services have been retained for the express purpose of benefiting people on his or her "side." It is when his professional services become counter-productive to fulfilling his duty to aid and shield those in need of aid that the parameters begin to shift.

§3: Applying Topology-AMC – Cases Revisited

Crucial to applying Topology-AMC is the understanding that training, education, and development are necessary elements in implementing the topology. One aspect of training, education, and development is to apply elements of the topology to cases that appear to present a conflict of duty for the military physician. Analyzing the following cases from the perspective of Topology-AMC can assist in providing physician-officers with cognitive, moral decision-making skills and processes.

Should physicians participate in a war in any capacity?

An issue is a tension between the justice of engaging or seeking recourse in war (*jus ad bellum)* versus acting justly or morally within the acts or conduct of war (*jus in bello*). Traditional just war theory claims that these are two distinct areas.[193] Under just war theory, it is ideal to act morally in a justified war. It is also expected that soldiers will act morally when forced to participate in an unjust war. It is considered wrong, even tragic, when soldiers act immorally in a just war. It is also wrong when soldiers act immorally in an unjust war. Yet, Sidel's account of medical duties, as well as the Gold and Sidel case of the protest of U.S. medical students, reveals denial or lack of understanding this interpretation of just war theory.[194]

According to Gold and Sidel's account, if a war is unjust (as they claim the Vietnam War was), any participation in that war becomes immoral and a conflict of the physicians' codes of ethics. To the extent that participating in an unjust war can lead to harm and

[193] See Appendix 4 for conditions listed in just war theory.
[194] See Section Two of Chapter One for review of cases.

suffering of innocent people, it is understandable how one can conclude that participating is immoral. However, is it possible to conceive of moral actions within an immoral war?

It is possible that being able to act morally in an immoral war would be a sign of moral courage and triumph; it may not be appropriate to condemn any or all actions within an immoral war as immoral, *ipso facto*. According to the first guideline of Topology-AMC, military physicians acting under the value of shielding or protecting innocent lives are in a position where they may morally participate in war by providing their medical services to those in need. They are fulfilling their medical duties while serving the military and also fulfilling their military duty.

For example, in the Vietnam War, assuming that it was an unjust war does not mean that soldiers in need of medical care did not have a right to receive medical care (Y_1). Unwilling conscripts may be analogous to innocent civilians who are injured by the actions of the military (X_3, X_5). Topology-AMC indicates that these soldiers deserve medical care. Willing conscripts and volunteers who are unaware that they are involved in an unjust war would likewise deserve medical services insofar as they are "innocent" (first guideline, X_5, Y_1).

According to the fourth guideline of Topology-AMC, innocent civilians in the crossfire of combatants also deserve medical treatment due to the unjust harms caused to them. As the fourth guideline states, medical care would be, at a minimum, a moral requirement of reparation for the harm and disruption caused them. Studying the theoretical foundations of Topology-AMC reveals that opposition to all war or even unjust war is not so much a conflict between professional duties as it is an issue of a personal determination of

the ethics of war itself, or a personal determination of which wars are just. Topology-AMC allows the military physician the moral space to evaluate complex situations and to perform within his dual professional obligations.

Should military physicians participate in the torture of enemy prisoners of war?

A resolution can be approached by understanding that, at least currently for a U.S. soldier, there should not be a conflict of duty, *per se*; participation in torture has been determined to be illegal and immoral for soldiers in both international and U.S. Law. Thus, a military physician has no professional *military* obligation to participate in interrogational torture. Depending on the details of the situation, a U.S. soldier would have a duty to report the incident of torture to his chain-of-command, directly intervene in the activity, or take other measures to deal with the situation. Understanding Topology-AMC's account of professional identities of physicians, military officers, and military physicians can assist the military physician to evaluate the situation and to determine that there is not a conflict between his duty as a physician and his duty as a military officer. As both a physician and as an officer he has a duty to protect and shield the innocent (first guideline).[195]

This is clearly the case if the proposed victim of torture is an innocent civilian or a captured enemy soldier. But what should the physician do if the victim is a known violent terrorist responsible for the deaths of hundreds of people? Even in this case, Topology-AMC would indicate not participating in torture. Not only would participation violate the first guideline, but as has been shown recently in the media, conferences, and other forums,

[195] For a discussion on the conflict of duty that develops when a physician is confronted with acts deemed to be torture, but classified as legal, see Section Two of Chapter Three and Section Two of Chapter Four.

torture is not a reliable method of gaining actionable intelligence.[196] Thus, torture is not justified because it does not do what it purports to do, help save innocent lives (first guideline) or further the military's mission (second and third guidelines). Moreover, torture has been directly linked to the rise of violence against innocent civilians. Topology-AMC indicates that there is actually a professional duty, of both military officers and physicians, to avoid using torture in the pursuit of interrogating detainees (first, second, and third guidelines).[197]

The difficulty may be in having the moral maturation to determine if specific interrogation techniques are torture, as opposed to legitimate interrogation techniques. If the military physician has reason to believe that torture is being committed, it is a matter of having the moral potency to act against the torture. If the government changes the definition of torture, a dilemma could develop between the physician's duties to the individual and his duties to the military. Training, education, and development programs that include Topology-AMC would assist in developing moral maturation and moral potency to evaluate a situation and to respond in an ethical manner.

To what extent should physicians participate in weapons research?

The either-or solutions argue that either (1) military duty overrides physician duty so a military physician should participate in weapons research whenever directed to do so by proper military or civilian authority, or (2) physician duty overrides military duty so a

[196] An excellent account of this is in Matthew Alexander and John Bruning's book, *How to Break a Terrorist: The U.S. Interrogators Who Used Brains, Not Brutality, to Take Down the Deadliest Man in Iraq.*

[197] Matthew Alexander and John Bruning's book, *How to Break a Terrorist: The U.S. Interrogators Who Used Brains, Not Brutality, to Take Down the Deadliest Man in Iraq.*

military physician should refrain from participating in weapons research, even when directed to do so by military or civilian authority.

By using Topology-AMC it appears inadequate to personal and professional integrity, and the combined moral working-self of the military physician, to suggest that in all cases of weapon development, or use, a military physician either must refuse to participate due to medical duties or must participate due to military officer duties. Rather, various factors should be taken into consideration to help the military physician determine to what extent he should participate in weapons research. The type of research would be one determining factor. For example, terminal experiments are *prima facie* not allowable (first guideline), but research to discover how to treat potential victims of biological attack might be appropriate (second guideline, X_5). Topology-AMC variables such as the context of consent status of the individual (X_5), spectrum of conflict (X_4), and location (X_6) would also be determining factors.

Consider a case in which the military is experimenting with the potential use of bio-chemical weaponry by an enemy. Eventually there will have to be some amount of human testing for efficacy of neutralizing the bio-chemical agent and, importantly, treating exposure to allied or friendly personnel (second guideline). Topology-AMC would allow the physician the moral space to recognize his ethical obligations on a case-by-case evaluation. If the test subjects were enemy prisoners of war (X_2) during general warfare (X_4), the military physician would have a high obligation to refuse participation (Y_2). Yet, if the test subjects are volunteer soldiers (X_2) during a stable peace (X_4), the military physician might have a high obligation to participate (Y_2).

Should military physicians participate in battlefield euthanasia?

Battlefield euthanasia has long been a controversial topic within military history. In military medicine "battlefield euthanasia" takes on a different meaning than "euthanasia" has meant in contemporary bioethics. Medical euthanasia on the battlefield (killing a soldier to spare that soldier pain and suffering) is no more or less problematic in a battlefield situation than it is in a modern hospital in peacetime. "Battlefield euthanasia" extends the paradigm of medical euthanasia to include using non-medical criteria to decide whether or not a patient may be allowed to die, e.g., a commanding officer or a medical officer may consider allowing a wounded soldier to die if his cries of pain and distress may endanger other soldiers. The cruelty of the necessity of battlefield euthanasia arises when wounded individuals, often helpless, are "sacrificed" for the good of others. This seems to violate a respect for life as it uses them as a "mere means" for the "ends of others" (first guideline). Yet, there are rare and debatable factors that indicate that the military physician may have moral permission (Y_2), perhaps even an obligation (Y_2), to participate in battlefield euthanasia in extreme circumstances.

The first three guidelines of Topology-AMC allows military physicians to reach a morally acceptable course of action when during war, as in other emergency triage situations, medical treatment of severely wounded soldiers is limited to care and comfort, rather than life-saving measures. Even when resources are relatively plentiful, the area is relatively secure (X_7), or the patients are not combative (X_3), these might become cases of passive euthanasia when a patient is medically terminal. Yet, some circumstances

surrounding cases of wounded soldiers are extreme and are not, strictly speaking, only medical cases. There are aspects of military necessity that include or introduce values related to promoting and protecting the group and the mission of the soldiers. According to Topology-AMC, the relevant factors would be the combatant status (X_3), the current spectrum of conflict (X_4), the context of the consent status of the individual (X_5), and the relative security of the location of conflict (X_7, X_6).

This is analogous to a triage situation in which decisions must be made as to who will live and who will have to die. For soldiers and medical workers, a tragedy of battlefield euthanasia is in actively participating in causing death because medical care is unavailable and, in extreme situations, there exists the possibility of having to "sacrifice" individuals in order to save a larger number of individuals. Rather than take an absolutist position, such as that of the either-or solutions, Topology-AMC suggests that there may be morally relevant parameters that can help guide a military physician in the participation of euthanasia and battlefield euthanasia.

Should military physicians participate in experimental medicine, especially when their "patients" lack informed consent?

As a physician, it is normally considered unethical to administer trial medication to patients without the patient's informed consent (X_5). However, as the first and second guidelines suggest, military physicians not only have a responsibility to the individual soldiers, but they have a responsibility to respond to the military necessity of having healthy soldiers. Have soldiers given their fully informed consent to receive treatments, even

experimental treatments, to the extent that they have freely joined the military (X_5)? Does this generalized consent relieve a military physician from the professional responsibility of providing and obtaining individual informed consent from each patient (Y_2)? Does a military physician who is following orders need to provide individual patients with the option to refuse treatments (Y_1)? Topology-AMC helps to enlighten this issue.

To help place the usefulness of vaccinations in context, consider the experience of the British Army during the Boer War.[198] Before the Boer War began, a vaccine for Typhoid Fever was successfully field-tested. The British Army allowed its soldiers the choice of whether or not to receive the vaccine. Ninety-five percent of the British soldiers refused. Over the course of the Boar War, 6,000 soldiers died because of combat. Fourteen thousand died of Typhoid Fever. Historically, it appears that in many military engagements, illness and disease are more deadly and costly to a military force than enemy soldiers.[199]

Given a clear medical need, perhaps made more urgent due to the spectrum of conflict (X_4), location of conflict (X_6), and other emergency conditions arising due to the nature of warfare, soldiers have an increased obligation to receive such vaccinations (Y_1). Absent standards of care, or effective treatments, soldiers may also have an increased obligation to receive trial or experimental medications in Phase-3 testing (Y_1).

As a corollary to this, under the same conditions, military physicians have an increased obligation to treat soldier-patients (Y_2) with vaccinations and trial or experimental

[198] For details of this account, see Gross's *Bioethics and Armed Conflict*, 106-107.

[199] According to Gerald N. Grob, "During the Revolutionary War perhaps 200,000 served in the military. According to the most careful estimates, 7,174 were killed in military engagements, 10,000 died in camps, and 8,500 perished as prisoners of war…Deaths in camps and among prisoners resulted from a variety of diseases…many battlefield deaths were the direct result of secondary infections," *The Deadly Disease: A History of Disease in America. N.r.*

medications in Phase-3 testing. The obligation, for both soldier-patients and physicians, may become even greater for volunteer soldiers as they have tacitly rendered consent (X_5, Y_1, Y_2). Nevertheless, Topology-AMC would remind military physicians, as guideline three indicates, that as part of their social covenant, there may need to be better information provided to individual soldiers explaining their rights and obligations in medical matters as members of the military (Y_1, Y_2).

How would this apply to enemy combatants who are captured (X_2)? Given a condition of general war (X_4), and a location close to combat (X_6, X_7), military physicians would have an obligation to treat soldier-prisoners with vaccinations and trial or experimental medications (Y_2). This would be to provide for both the safety of the prisoner and also the general population and the military (first and second guidelines). Enemy combatants who are transported to a more secure location and away from combat (X_2, X_6, X_7, X_4), may be offered the chance to decline treatment (Y_1), if they agree to be segregated or quarantined from the general population.

Should military physicians train soldiers in medicine?

This is an area where Topology-AMC may have a subtle or minimal impact as a guide for military physician behavior. However, this may not be a problem as this type of situation is, perhaps, a case in which a moral dilemma between professional duties may not exist. The issue may actually be a conflict in personal ethics and professional duties. It is not clear to what extent someone is responsible for the use, or misuse, of training he provides to other individuals. If an educator or trainer has good reason to believe that a

particular individual will use his training to harm innocent people, the educator or trainer would have a legitimate reason to refuse to train that individual.

This could be derived from both medical and military ethics. The first guideline of Topology-AMC indicates that knowingly providing someone with the means to cause harm could violate the professional identity of a military physician to protect and shield the innocent. On the other hand, without good reason to believe that a particular individual will misuse his training, it could be a misplaced accusation to say the educator or trainer should receive moral blame. The first and second guidelines of Topology-AMC would indicate an educator or trainer would be acting ethically to increase the ability of the military to care for individual soldiers and to meet the requirements of a healthy military. The physician would be fulfilling his dual obligations to his medical and military roles by acting in his dual role as a military physician (third guideline).

To what extent should a military physician care for a civilian?

As the second guideline indicates, a military physician has the individual as his primary concern, but the degree of an individual's rights to care (Y_1) and a physician's responsibility to care (Y_2) are influenced by the civilian status of the individual (X_2, X_3). Care for a civilian will critically depend on the external factors (the X variables) to determine what appropriate actions are available to the military physician. Nevertheless, even those may not be enough. Consider, again, Paul J. Schenarts account of the problematic situations developing in modern warfare as medical personnel find themselves

in situations where they must choose how to use limited resources of personnel and materials when caring for non-military personnel:

> As a reservist with a U.S. Army Forward Surgical Team, activated as part of the Global War on Terror, I fully considered the many ethical conflicts I might face. There would likely be young men who died as a result of resource limitations. The apparent conflicting duties of a physician/soldier needed to be contemplated and justified. The Geneva Convention, which sets forth that a physician must care for both U.S. soldiers and enemy combatants using standard medical triage and practice, had to be adhered to….I had not, however, considered the impact societal differences would have on my perceptions of what constitutes the ethical practice of medicine….A 3-year-old boy presented to our forward surgical team 22 days after a forced emersion scald burn. The wound, which covered approximately 25% of his little body, had a pattern consistent with abuse. As anticipated, without any medical care, he had developed advanced burn wound sepsis with progression to systemic shock. Upon arrival, he was toxic and in the act of dying. Despite this, with aggressive treatment, normal physiologic parameters were restored relatively quickly. After initial stabilization, there would be the need for continued fluid resuscitation, metabolic stabilization, antibiotics, excision of the wound, nutrition, and, eventually, skin grafting. This was an overall straightforward therapeutic plan. However, although our unit is well equipped for initial stabilization and our collective knowledge base was more than adequate to care for this child, we did not have the necessary facilities to continue his therapy. A combat support hospital just 2 hours away could easily provide the needed resources.[200]

The boy had a good chance of medical recovery, and was medically eligible for treatment. However, if the hospital had only limited supplies, supplies that may be needed to perform their primary mission of combat support, what should the physicians have done to uphold their medical duties as physicians and to uphold their military duties as officers?

The either-or solutions are inadequate for providing insight in this case. Medical and military ethics for the military physician fail to give adequate support for reaching a decision. Medical ethics fails in various ways. According to the military physician in this

[200] Paul J. Schenarts, MD "Thee-year-old Boy with Burn Wound Sepsis: A Challenge to the Ethics of a Responsible Surgeon." *Current Surgery* 2004. n.r.

case, "I discovered that there might be societies where these ethical principles may in fact do more harm than good."[201] As he experienced in mid-East culture, belief in the worth of children is not universal.

In Afghanistan, "children are a resource that is easily reproduced and easily replaced should one become damaged. In this place, saving this child may be a wasted effort because he is in fact replaceable."[202] In addition, "…the injured [child] represents a real threat to the resources needed by other members of the family." Saving the child could result in harm to other children, harm to the family unit, or harm to other more needy members of society.[203]

"Child abuse," as Schenarts describes, especially of children not "normal," is a social norm. Scars and other problems experienced by the burn victim would lead to others abusing him, as well as his being ostracized from society if he survived and grew older. Thus, according to Schenarts, it is not clear that medical treatment would have any lasting long-term benefits for the patient. Schenarts was also fearful that medical care could lead directly to prolonged agony and suffering as the child struggled to live in his culture.

Military guidance is equally unclear as to how to proceed. A military hospital, located about two hours away, had adequate resources to provide medical care to the child. Helping the burn victim was possible, and perhaps would fall under the military mission of "winning the hearts and minds of the local population." Yet, that assumes that the medical care is perceived, by the involved society, as a legitimate use of medical care. It is not inconceivable that such care could be seen as futile, and ill-conceived due to the impact on the family or social environment.

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[201] Ibid. 245.
[202] Ibid. 246.
[203] Ibid. 246.

My inclination, in this tragic situation, is that Topology-AMC strongly supports providing medical care for the burn victim. The first and second guidelines place the care of innocent individuals as a military physician's primary duty. The boy was clearly in need of medical care. He was a non-combatant (X_3), neutral in the fighting (X_2), and not participating or consenting in any military or para-military activity (X_5). Resources were not limited; however, they were located across dangerous territory (X_4, X_6, X_7). Due to the possible danger of transporting the patient, the physicians may not have been obligated to continue treatment (Y_2). Yet, the danger was not great enough to prohibit attempting to move and treat the boy (Y_2). The military physicians would have permission to treat (Y_2). The topology does not directly take into consideration social factors surrounding treatment of civilians who would need long-term care, and where a strong support network would be needed for them to survive or to thrive in society. However, it is suggested through the first and fourth guideline that once a military physician accepts the civilian as a patient, then he has an obligation to provide reasonable care to that patient. This would imply that the military physician should try to place the boy into a civilian medical network where a more supportive social situation could be provided when discharged.

§3.3: Educating to Navigate Ethical Challenges

A crucial step in negotiating moral dilemmas is by strengthening the training, education, and development opportunities for military physicians. Formal and informal educational opportunities, including the use of Topology-AMC, can assist military physicians to correctly identify moral dilemma caused by a conflict of duty. Training and

education can assist in the development of moral maturation and moral potency which will allow military physicians to better navigate the moral process when faced with ethical challenges. Military physicians should be trained in leadership skills that allow them to differentiate between the extremely complex situations they may encounter and situations of true conflict of duty. Proper development can help them obtain the knowledge, skills, and abilities necessary to seek solutions to both situations.

When engaged with a moral situation it is possible to classify the situation in at least one of three ways. First, the situation can be categorized as a "black and white" moral situation. A black and white situation is characterized by there clearly being both "right" and "wrong" actions available to the moral agent. For example, an employee with access to a cash box "lunch fund" may be involved with a situation in which it is permissible to use the money, e.g., taking a visiting dignitary to lunch at the faculty club. Likewise, the employee may be involved with a situation in which it is clearly not permissible to use the money, e.g., personally using the "lunch fund" money to pay for a matinee at the local theatre.

A second way in which a moral situation may be categorized is as falling within a "gray" zone. Gray situations are characterized by a general lack of clarity as to what is "right" or "wrong." Gray situations are more complex than black and white situations due to lack of knowledge related to morally significant facts, or a perception of conflicting values. Gray situations may have multiple outcomes that are morally appropriate.

For example, consider again the employee with access to the lunch box funds. Suppose that one afternoon the office is entertaining a visiting speaker. For the final

meeting the speaker has brought his family so that they can meet the people with whom he is working. It may be customary after such a meeting to take the speaker to lunch. The employee in charge of the lunch box fund has to decide whether or not to pay for the lunch of the speaker's family. This is a gray area. Although family members are not, strictly speaking, visiting dignitaries working with the office, they are nonetheless part of the visiting dignitary's party. It would help foster good relations if their lunch was provided. It might also be seen as an abuse of the use of funds. In this case it seems that either decision is defendable, but each decision can also be criticized.

The third type of situation is a "right versus right" situation. In these situations moral dilemmas exist because values, duties, or moral principles conflict. Moral dilemmas are different from gray area situations in that there really are conflicting values so that any "correct" action simultaneously results in an "incorrect" action.

In implementing Topology-AMC, an important factor for guiding military physician behavior in the face of moral dilemma or moral distress is the recognition that not all situations initially identified as moral dilemmas are in fact moral dilemmas. Assisting in recognizing a moral dilemma can be accomplished through the promotion of moral awareness which can be partially achieved by formal and informal education to foster moral maturation and moral potency. Training, education, and development can help military physicians understand that a situation may not be a "right versus right" but a "right versus wrong." This may entail that their choices really are not conflicts in professional duties, i.e., this may entail that choice then collapses into choosing the "right" course of action.

Topology-AMC provides a mechanism to help regulate such decision-making by providing four general guidelines that utilize Y and X variables to analyze a situation. Using the topology might make it possible to find a middle ground and act upon it. This approach has benefits when considering identity-conferring commitments.

We all have commitments that involve centrally important values which contribute to one's identity. "[These commitments] make us what we are and they place constraints on our lives from which we may not be able to unbind ourselves without self-betrayal and personal disintegration."[204] I have shown that moral dilemmas that arise from conflicting professional duties result, in some cases, in moral distress that is difficult to overcome when identity-conferring commitments are threatened.

Identity-conferring commitments are threatened because the moral topology of decision-making for the military physician, like other professions, has become a hybridized combination of two differing professions.[205] This combination is unsuccessful when the theoretical or practical aspects of the professions are not taken into consideration. By using the new topology of moral decision-making for the physician-patient relationship, a moral space is created between the two professions, linking them in a way that may be used to preserve both professional and personal identity. As another example of the usefulness of Topology-AMC, consider the conflict Colbach experienced between his medical duty and his military duty, first introduced in Chapters Three and Four.

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[204] Jeffrey Blustein, *Care and Commitment: Taking the Personal Point of View*. (New York: Oxford University Press, 1991) 49-50.

[205] As noted in Chapter One, this is not a unique challenge to military physicians. As Glenn Graber, Professor of Philosophy at the University of Tennessee at Knoxville, notes, "One notorious example from the field of engineering came in the tense discussion about whether to launch [the Space Shuttle] Challenger. The Vice-President for Engineering of Morton Thiokol was told [paraphrasing] 'You need to take off your engineer hat and put on your corporate executive hat.'" Personal Communication, 13 May 2009.

Colbach was a combat psychiatrist who felt that the way to survive his military service was to adopt the military dominated perspective that military duties should override medical duties. Colbach was troubled by his actions and has continued to experience moral distress. Topology-AMC allows us to understand that Colbach's central problem was that he lacked an adequate topology of moral decision-making to reconcile his role to the situation. The difficulties in his situation came about because combat conditions impacted his ability to provide the level of individual medical care to which he was accustomed, and wanted, to provide his patients. Colbach was in a war (X_4), often close to combat (X_7) in hostile territory (X_6). With scarce resources triage situations and resource allocation was necessary. As a professional physician, Colbach embraced a mental model where patient needs came first. He was unable to reconcile the ethical possibility of military needs holding primacy over medical needs. When he placed military duty first, he felt he had failed to uphold the ethics and standards of the medical profession. He made his choice, not by choosing one "right" duty over another "right" duty, but by trying to suppress his moral and ethical beliefs. Consequently, he viewed his own actions as "going along to survive."

The reality of combat, Topology-AMC would emphasize, creates morally relevant conditions where medical care for the individual is constrained (by such parameters as listed on the X scale of variables) but not abandoned (as indicated in the guidelines and Y scale of variables.) Colbach was providing the medical care that he could, under limited and restricted "emergency" conditions. Colbach assumed the dual role of a military physician; therefore he had obligations not only to his individual patients, but to a third party – the military. By utilizing the training, education, and development used in Topology-AMC,

Colbach could have more clearly recognized the nature of his experience of moral dilemma. Moreover, through the development of moral maturation and moral potency it is possible that Colbach could have better understood and accepted his dual role as a military physician. By understanding the military physician role as developed in Topology-AMC, Colbach might have been able to use imagination to create better solutions to the demanding situations he encountered. Learning the process of implementing Topology-AMC not only provides a framework for moral decision-making on individual cases for the military physician, it also provides a psychological mechanism hereby moral distress can be lessened. Yet, implementing Topology-AMC requires more than the training, education, and development of military physicians.

There are external factors that have to be addressed for this approach to be implemented. The acceptance of the moral topology depends upon a public acknowledgement, acceptance, and promulgation that the position of military physician combines, alters, and adds to the duties of two distinct professions. Their duties are not identical to, nor limited to, either a physician's duties or a military officer's duties. Rather, a military physician's duties are divided between patient needs and the needs of the military mission.

Acceptance of this moral topology also requires developing more effective ethics development education, or ethics awareness education programs that enable military physicians to gain the moral maturity and moral potency necessary to utilize the topology of moral decision-making. Critical features of these programs would assist individuals in developing morally acceptable identity-conferring commitments.

Finally, acceptance of the topology would need institutional support, possibly better professional protection through the establishment of policies that protect the military physician from institutional harms when they act within their professional areas of authority. Institutional support within the military could be enhanced by ethical awareness programs directed to other branches of the military outside of the Army Medical Corps.

§4: Final Thoughts

Moral dilemmas surrounding professional duties may arise due to internal "theoretically driven" factors, such as conflicts between codes of ethics, conflicts between moral identities, and conflicts between social roles. Moral dilemmas surrounding professional duties may also arise due to external "practically driven" factors, such as policies, procedures, or laws that create a culture and climate that places professional practice in jeopardy. Successfully dissolving moral dilemmas requires addressing these various types of constraints.

The moral topology of decision-making I propose for the military physician primarily addresses the internal aspects of conflict between professional ethics, values, and norms. The topology does not attempt to address all aspects of even this internal dimension of the moral dilemmas of military physicians and it does not attempt to provide the only method of resolving issues of moral dilemmas caused by conflict of duty. The topology is offered as one of many tools ethicists can utilize in helping individuals recognize and address perceived conflicts in professional duty. This topology has advantages over either-or solutions because either-or solutions attempt to provide a wholesale resolution of the conflict in duties experienced by military physicians by prioritizing military or medical duties in a wide range of situations.

Not all cases of moral dilemmas caused by conflict of duty may be eliminated. This is because of a variety of reasons. It may be unclear how to minimize or dissolve a specific case into moral non-dilemma. There may be external constraints in a case that prevent the military physician from acting under his professional guise. A military physician may be

embedded in a situation in which a he lacks the moral courage to act, lacks efficacy in action, or lacks "ownership" in the case. The cause of the moral dilemma may be the result of personal moral and ethical beliefs and not solely the result of conflicts in professional codes. These differing sets of criteria can provide obstacles that go beyond modifying the moral framework of professional decision-making.

There may also be "appropriate" or "legitimate" moral dilemma and stress that is desirable as part of professional or personal development. It may have been desirable if more Nazi physicians had experienced dilemma and distress in their actions and, hopefully, re-evaluated their actions that supported the Nazi Party.[206] Ethicists need to engage in discussions with military trainers concerning the *appropriate* experiences of moral distress. There is a legitimate need for individuals to recognize issues that cause moral dilemma, to experience the emerging conflict, and to develop moral and ethical resolutions.

Finally, aspects of self-identity need to be analyzed and addressed. As with the concern with appropriate or legitimate feelings of moral distress, there needs to be discussions of appropriate self-identities. Some identities are not morally praiseworthy. Appeal to these types of identities should not be encouraged through attempts to solve moral dilemmas with appeals that legitimize immoral identities. For example, Nazi physicians with strong Nazi identity should not have been satisfied with their decisions even though their decisions preserved their professional identity.

Overall, this dissertation provides several lessons-learned for future ethicists and educators. A crucial step in minimizing or dissolving moral dilemmas and decreasing moral distress is by strengthening the training, education, and developmental opportunities for

[206] See Appendix 3 for examples of German physicians' support of the Nazi Party.

military physicians. Formal and informal educational opportunities can assist military physicians in correctly identifying both appropriate and inappropriate perceptions of moral dilemma. Training and education can assist in the development of moral maturation and moral potency that will allow military physicians to better navigate the moral process when faced with ethical challenges. Military physicians should be trained in leadership skills that allow them to differentiate between the extremely complex situations they may encounter and situations of true moral dilemma. Proper development can help them obtain the knowledge, skills, and attitudes necessary to seek solutions to both situations.

Topology-AMC presents a moral topology of decision-making that would often allow military physicians the conceptual space to preserve professional and personal integrity while upholding professional standards of competence and ethical behavior embraced by both professions.

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Moral Dilemmas: Medical versus Military

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Appendices

Appendix 1: Terms and List of Abbreviations[207]

ACPME – Army Center of Excellence for the Professional Military Ethic.

Agglomerative Principle – if one ought to do one thing and one ought to do another, then one ought to do both.

Allocation – the distribution of both medical and non-medical resources without necessarily implying scarce resources.

AMA – American Medical Association.

Arrest – the act of apprehending a person for the alleged commission of an offense or by the action of an authority.

Battlefield Euthanasia – euthanasia when the decision is made based on other than medical grounds, e.g., to silence a wounded soldier's cries of pain and distress which may endanger other soldiers.

Biscuit – used within a military intelligence context, a slang term for a behavioral science consultation team; biscuit teams often include psychiatrists and psychologists.

Burnout – a sense of failure and of being "worn out" or exhausted through excessive demands on one's energy, strength or resources.

CO – Commanding Officer.

Culture – a pattern of basic assumptions invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration, that has worked well enough to be considered valid and therefore is to be taught to new members as the correct way to perceive, think, or feel in relation to these problems.

Crisis Military Deployment – a situation in which military personnel are suddenly ordered to duty to support an operation away from their home station and in a potentially dangerous environment.

Defensive Operations – operations that defeat an enemy attack, buy time, economize forces, or develop conditions favorable for offensive operations. Defensive operations alone

[207] A collection of terms, definitions, and acronyms found in the literature, i.e., "working" use of terms in this document. Due to formatting concerns sources were not cited in this list, however in the main document citations were used when necessary. As these terms often deal with controversial interpretations, major deviations or refinements from the working use will be noted in the main document.

normally cannot achieve a mission. Their purpose is to create conditions for a counter-offensive that allows a military to regain the initiative.

Detained Person – any person deprived of personal liberty except as a result of conviction for an offense.

Detention – the condition of detained persons.

Development – lasting changes in one's identity, perspectives, and meaning-making system, e.g., creating an identity in a leader to see themselves as a mentor and leader-developer.

Discrete – from mathematics, describes objects that are individually distinct or non-continuous, e.g., time is measured in continuous units whereas the number of people who voted in the last presidential election is measured in discrete units.

Duty – in a broad sense, an action, or course of action, which is morally incumbent without regard for personal likes or dislikes and is without external compulsion. Often implied is some kind of necessity of the will or consciousness. In a narrow sense, duties result from roles, e.g., physician, teacher, lawyer, soldier, etcetera.

Education – transferring knowledge, e.g., teaching the leader the human development process behind mentoring techniques.

Enlisted Soldier – a soldier, either non-professional or professional, who does not hold command responsibilities. Enlisted soldiers perform specific job functions and use their knowledge to ensure the success of their unit's current mission within the military.

Essentialism – when applied to professionalism, a mostly descriptive approach of identifying professionals or professions by categorizing the necessary conditions that must exist for an activity to qualify as a profession or that an individual must meet to be classified as a professional. Professionalism is characterized by characteristics, e.g., specialized knowledge, high pay, etc.

Ethical Leadership – the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision-making. This includes the transformation of similar capabilities for sustained moral conduct in followers through development and inspiration.

Ethics – historically, ethics was synonymous with morals. Contemporary or popular usage understands ethics as the body of moral principles or values governing a particular culture or group. As a philosophy discipline, ethics is the study of morality.

Eugenics – a term coined by Francis Galton to encompass the idea of modification of natural selection through selective breeding for the improvement of humankind; often associated with pseudo-scientific Social Darwinism.

Functionalism – when applied to professionalism, a mostly normative approach for identifying professionals or professions. This approach defines professional norms that an organization or person must meet in order to gain the benefits and obligations of public recognition as a profession or professional. Professionalism is defined by the function, or role, played in society.

Hidden Curriculum – the unspoken curriculum of rules, regulations and routines, that teachers and students must follow if they are to successfully navigate the social institution and environment of school.

Hors de combat – out of action, out of combat, disabled.

ICRC – International Committee of the Red Cross; associated with International Committee of the Red Crescent, International Committee of the Red Shield and Lion.

Identity-Conferring Commitments – commitments that involve a person's centrally important values which contribute to one's identity.

Imprisoned Person – any person deprived of personal liberty as a result of conviction for an offense.

Imprisonment – the condition of imprisoned persons.

Initial Moral Distress – moral distress where a person feels frustration, anger and anxiety when faced with institutional obstacles and interpersonal conflict about values.

Judicial Authority – an authority under the law whose status and tenure should afford the strongest possible guarantees of competence, impartiality and independence.

Just War Theory – theory of warfare that deals with both the historical and theoretical justification of, and the conduct of, war. Usually divided into *jus ad bellem* "right of war," justification for engaging in war, (also seen as *jus ad bellum*) and *jus in bello* "laws of war," appropriate conduct for carrying out war.

Leadership – influencing people – by providing purpose, direction, and motivation while operating to accomplish the mission and improving the organization.

MED CAP – Medical Civil Action Patrols.

Medical Disaster – A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demand for health care.

Medical Euthanasia – euthanasia initiated for medical reasons by a physician.

Medical Neutrality – (1) Impartiality—medical personnel treat all patients with respect and without discrimination based on age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing. (2) Immunity—medical personnel must be granted access to patients and provided with the protection necessary to provide patient care.

Mental Model – an explanation of someone's thought process; a model of mental representations of the surrounding world; a map of how someone knows, perceives, makes decisions, or constructs behavior.

Meta-cognitive ability – the level of one's ability to possess greater knowledge of, and the ability to regulate, one's own cognitive process(es), or *thinking about thinking*.

Meta-Moral Knowledge – a representation of a specific domain or component of general knowledge that can be automatically or intentionally accessed during cognitive processing. These mental representations "become" the moral lenses that one uses to interpret moral dilemmas.

MI – Military Intelligence.

Military Necessity – as understood by modern civilized nations consists of the necessity of those measures which are indispensable for securing the ends of war, and which are lawful according to the modern law and usages of war. Often "regulated" by conditions of discrimination (who makes a legitimate target?) and proportionality (what is the acceptable collateral damage when compared to military goals?).

Modal Logic – in a narrow sense, modal logic is the study of the syntax and semantics of alethic (truth) modalities, i.e., the study of the deductive nature of truth modifiers such as "must," "might," "could," "can," "have to," "possibly," "contingently," and "necessarily." In a broad sense, modal logic designates the study of other sorts of propositional modalities, e.g., deontic (ethical) modalities, propositional attitudes (relations between sentient beings and propositions), and tenses (e.g., the past, present, and future tense).

MOOTW – Military Operations Other Than War.

MOOTWISUF – Military Operations Other Than What I Signed Up For.

Moral Agency – the capacity to exercise control over the nature and quality of one's life- the essence of humanness.

Moral Autonomy – the freedom, right and responsibility to make choices.

Moral Capacity – the measure of a person's ability to cognitively process a moral situation and behave in a moral manner in regard to that situation.

Moral Comfort – an individual's feeling of ease about a decision related to ethical problems.

Moral Competency – an aspect of moral autonomy highlighting the ability to understand the moral issues of situations, use good moral judgment and intention, and engage in morally appropriate behavior.

Moral Courage – the level of ability one has to act upon a moral issue, especially in the case of adversity.

Moral Dilemma – a situation in which there is more than one right thing to do, but to act on one necessarily precludes acting on the others; moral dilemmas result when at least two clear moral principles apply to a case, but they support mutually inconsistent courses of action; or when information suggests that an act x is both right and wrong, or the evidence is inconclusive, or a person believes on moral grounds that one both should and should not perform x.

Moral Distress – a negative feeling state experienced when a person makes moral judgments about a situation in which he or she is involved, but something or someone restricts their ability to pursue their course of action. Unresolved moral distress expresses itself in harm and suffering that affects personal relationships, employment, and one's outlook on life. Symptoms include crying, anger, depression, nightmares, heart palpitations, diarrhea, and headaches. Painful feelings and/or psychological disequilibrium that occurs when people are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory support, exercise of others' power, institutional policy, or legal limits.

Moral Domain Complexity – the combination of the moral aspects of one's self-identity and the knowledge required to understand the moral domains one is exposed to.

Moral Efficacy – one's belief (confidence) in his or her capabilities to organize and mobilize the motivation, cognitive resources, means, and courses of action needed to attain moral performance, within a given moral domain, while persisting in the face of moral adversity.

Moral Fatigue – morally distressful situations in which there exists a lack of strength and energy that diminishes the mind and immobilizes thoughts.

Moral Identity – one's self-schema that is comprised of moral traits and a person's awareness that arises out of interactions with his environment, of his own beliefs, values, attitudes, the links between them, and their implications for their behavior.

Moral Imagination – the ability to understand the complexities and dimensions of moral dilemmas; also, the ability to create novel moral solutions to ethically problematic situations or dilemmas.

Moral Integrity – adherence to moral values affecting the sense of dignity and self-respect.

Moral Intensity – the degree of immediacy and urgency when it comes to moral matters; determined by six key factors 1) magnitude of consequences, 2) social consensus, 3) probability of effect, 4) temporal immediacy, 5) proximity, and 6) concentration of effect.

Moral Judgment Processing Lenses – the ability to use multiple lenses to meta-cognitively process a moral situation. Three different common "lenses" are Deontological (laws and rules based processing), Teleological (consequence or goal based processing), and Areteological (virtues or values based processing).

Moral Maturation – one's overall capacity to attend to, store, retrieve, process, and make meaning of morally relevant information. Moral maturation is enhanced through developing moral identity, cognitive complexity, and meta-cognitive ability.

Moral Outrage – an intense emotional state triggered when a person sees others (not themselves) performing immoral actions.

Moral Ownership – the level of one's ability to be responsible for the values associated with a moral action.

Moral Potency – a state of ownership over the moral aspects of one's domain, reinforced by efficacy beliefs in the capabilities to act to achieve moral purpose in that domain, and the courage to perform in the face of adversity.

Moral Schema – a person's mental representation of something related to morals (where "something" is a situation, person, decision, etc.).

Moral Sensitivity – the ability to recognize a moral conflict, show a contextual and intuitive understanding of the situation, and have insight into the ethical consequences of decisions.

Moral Uncertainty – a state of mind in which one is uncertain about which principles or values apply, or if one really has a moral problem, or when individuals feel that something is not quite right, but need assistance in determining what that something is.

Moral Working-self – the contextually activated portions of one's cognitive, affection, and behavioral schemas and complexities that are applied during ethical issue processing.

Noncombatants – persons taking no active part in hostilities, e.g., prisoners of war, wounded, and civilians who do not bear arms.

Obligation – as distinct from duty, an action, or course of action, which is morally or legally incumbent without regard to personal likes or dislikes and may include external compulsion. Obligations are often concurrently gained with rights or powers and involve a legal bond and enforcement between two or more people. Obligations result only from voluntary action.

Offensive Operations – operations that aim at destroying or defeating an enemy. Their purpose is to impose the will of the aggressor on the enemy and achieve a decisive victory.

Officer (military) – a professional soldier who holds command responsibilities, except in the cases of non-line officers, e.g., medical personnel, chaplains, and sometimes lawyers. In these cases non-line officers are professionals in a non-combat respect but they are also soldiers.

Passive Euthanasia – euthanasia in which no direct measures are taken to terminate a patient's life, rather the patient is "allowed to die."

PMFs – Privatized Military Firms; corporate bodies that specialize in and contract for the provision of military skills, including combat operations, strategic planning, intelligence, risk assessment, operational support, training, and technical skills. Not identical to mercenary units.

Primary Health Care – essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every state of their development in the spirit of self-reliance and self-determination.

Prisoner of War – any persons belonging to one of the following categories, who have fallen into the power of the enemy: (1) Members of the armed forces of a Party to the conflict as well as members of militias or volunteer corps forming part of such armed forces. (2) Members of militias or volunteer corps belonging to a Party to the conflict and operating in or outside their own territory provided that such militias or volunteer corps fulfill the

following conditions: (a) that of being commanded by a person responsible for his subordinates, (b) that of having a fixed distinctive sign recognizable at a distance, (c) that of carrying arms openly, (d) that of conducting their operations in accordance with the laws and customs of war. (3) Members of regular armed forces who profess allegiance to a government or an authority not recognized by the Detaining Power. (4) Persons who accompany the armed forces without actually being members thereof, such as civilian members of military aircraft crews, war correspondents, supply contractors, members of labor units. (5) Members of crews of the merchant marine and civil aircraft of the Parties to the conflict. (6) Inhabitants of a non-occupied territory, who on the approach of the enemy spontaneously take up arms to resist the invading forces, without having had time to form themselves into regular armed units, provided they carry arms openly and respect the laws and customs of war.

Privilege – permission to perform certain acts provided specific conditions are fulfilled.

Professional – someone who provides a service in return for payment in accordance with special training, licensure, ethics, and standards of service; sometimes associated with a special body of knowledge and service to the community.

Professionalization – the social award of a legitimate monopoly of practice in that area to the organized profession.

Psychological Doubling – separating off one side of the self in order to maintain oneself in situations that conflict with one's sense of the good.

Rationing – as opposed to allocation, resource distribution when resources are scarce.

Reactive Moral Distress – moral distress that people feel when they do not act upon their initial moral distress.

Realism – the view that the truth-value of a statement or judgment is determined by the world, where the world is taken to be something independent of human reason, perception, will, desire, and the like.

Relativism – without an objective standard, "truth" is determined by the desires and beliefs of the individual (individual relativism) or group (group relativism).

Responsibility – a state or condition in which it is justifiable to ascribe praise or blame to an individual.

Right – a sound claim that one be permitted (or assisted) to act in some manner without interference.

Schema – in psychology, core identity elements; those parts of one's identity that are central to self-concept. Schemas lead to motivational patterns. Contrast with a-schema, or the peripheral elements of one's identity. A-schema lead to enhancing patterns. Disrupting schema leads to psychological reactions.

Scripts – in psychology, a sequence of expected behaviors for a given situation. Scripts are acquired through habit, practice, and routine.

Social Cognitive Theory — a theory that proposes an interactive and reciprocal causation between the person, their behavior, and their environment.

Social Darwinism – pseudo-science based on misinterpretations of Darwinian evolutionary theory; focuses on "survival-of-the-fittest" as applied to business, politics, and other social organizations.

Soldier (military) – a person enlisted with or conscripted to serve in the armed forces of a nation.

Stability Operations – operations that promote and protect national interests by influencing the threat, political, and information dimensions of the operational environment through a combination of peacetime development, cooperative activities and coercive actions in response to crisis. Regional security is supported by a balanced approach that enhances regional stability and economic prosperity simultaneously.

Sui generis – its own kind, being the only example of its kind, or original.

Support Operations – operations employed to assist civil authorities, foreign or domestic, as they prepare for or respond to crisis and relieve suffering.

Tactical Euthanasia – euthanasia as a decision of the line commander incorporating factors not directly related to the medical condition of the patient.

Terminal Experiment – experiments where the death of the subject is an expected, and often necessary, outcome of the experimental plan. Terminal experiments were made infamous by accounts of Nazi medical experiments.

Tiger Teams – slang term for military intelligence teams.

Training – transferring skills and abilities, e.g., training a leader on mentoring techniques.

Triage – the sorting of patients for treatment priority in emergency departments and in multi-casualty incidents, disasters, and battlefield settings. In military triage the less critically wounded or ill receive priority treatment, particularly if resources are scarce, and the most seriously wounded are the lowest treatment priority; this is a reverse of

most non-military situations in which those who are most in need of care receive priority treatment.

UCMJ – Uniform Code of Military Justice.

U.N. – United Nations.

Appendix 2: "Ought → Can", or A Primer on Moral Psychology

There are at least two "ought" principles that are sometimes utilized in ethical dialogue. The first was made famous by David Hume and is sometimes referred to as the "is-ought" problem. In his discussions, Hume criticizes how some arguments go from statements of "is" to claims of "ought" without providing justification for the belief that because something "is" the case, it also "ought" to be the case. To this I would add that consideration should also be given relating the possible to the probable. Just because something is theoretically possible, it is not necessarily probable in practice.

The second "ought" principle is "ought implies can" (symbolized as "ought → can"). This principle expresses the idea that to legitimately require that someone "ought" to do something it must be possible that they "can" do that something. Alternatively, to say that someone "ought not" do something it must be possible that they can choose not to do that something. Possibility, in a moral sense, has to be something less than strict logical or physical possibility – it has to be referring to what a moral agent can reasonably and rationally be expected to do, or not do, in a given situation.

In light of this principle, ought → can, it is necessary when applying ethics to establish the basic framework of moral processing. This helps to clarify the "can" so that the "ought" may be reasonably assessed. This appendix summarizes current psychological research on the "can" aspects of moral processing as it relates to leadership and ethical development. An understanding of the psychological dynamics of moral processing can

assist philosophers train, educate, and develop ethical behavior in individuals, particularly those individuals who may experience moral conflict in their professional duty.

James Rest argues, "ethical behavior occurs when an individual sequentially processes a moral dilemma through the stages of *moral recognition, judgment, intention,* and *behavior.*"[208] Hannah and Avolio argue that developing the capacities of *moral maturation* and *moral potency* enhances the moral-working self and helps negotiate the stages of processing a moral dilemma. Developing moral maturation and moral potency transforms people by "enabling and motivating them to take greater ownership of their moral experiences, increasing the depth and breadth of their moral reasoning and decision-making, and ultimately, enhancing their confidence and courage to carry those decisions through by taking moral actions."[209]

Moral maturation is "*one's overall capacity to attend to, store, retrieve, process, and make meaning of morally relevant information.*"[210] Moral maturation occurs in at least three areas: moral domain complexity, moral identity, and moral meta-cognitive ability. "Cognitive complexity is domain specific," such that "individuals are depicted as more or less complex, or expert in their mental representations (schemes) of various domains of knowledge."[211]

Domain complexity is "a product of long-term semantic memory where schemes are developed and reinforced through a broad range of experiences across the life span, and then

[208] Sean Hannah and Bruce Avolio, "Transforming Follower Moral Capacity: Toward a Holistic Developmental Model." NR, 3. In this case "ethical behavior" is a descriptive, not a normative term.
[209] Ibid. 4.
[210] Ibid. 5. Italics in original.
[211] Ibid. 7. See also, Ericsson and Lehmann, "Expert and Exceptional Performance: Evidence of Maximal Adaptation to Task Constraints." Annual Review of Psychology, 47, 273-305.

altered through the meaning-making one extracts from those experiences."[212] Information retrieval by human beings is limited by each individual according to the cognitive complexity of an individual. Individuals with more complex cognitive abilities "have developed more integrated, organized schemas that allow them to create better linkages between different and oftentimes competing concepts."[213] Cognitive complexity is desirable in the moral realm because "higher levels of complexity affords individuals the opportunity to make better sense of competing information that characterizes most moral dilemmas, while also being able to acquire and spend more time interpreting new information that may assist them in resolving these dilemmas."[214]

Cognitive complexity, or the development of rich and complex mental representations related to morality, "should enhance the recognition of moral dilemmas." Cognitive complexity is desired as people "tend to use the highest stages of cognitive development available to them while processing and making judgments on moral dilemmas."[215] Hannah and Avolio suggest that as a person achieves higher domain complexity, "facets of their immediate and perhaps distal environment that have moral implications will be more likely to 'fit' existing mental representations and thus prime the individual's schema to attend to and process the dilemma using a greater level of cognitive

[212] Hannah and Avolio, "Transforming Follower Moral Capacity," 4. See also, Avolio, *Leadership in Balance: Made/Born.;* Kelly, *The Psychology of Personal Constructs*; Lord and Foti, "Schema Theories, Information Processing, and Organizational Behavior;" Taylor and Crocker, "Schematic Basis of Social Information Processing."
[213] Hannah and Avolio, "Transforming Follower Moral Capacity," 8.
[214] Ibid. 8. See also Bower and Hilgard, *Theories of Learning*; Dollinger, "Environmental Boundary Spanning and information Processing Effects on Organizational Performance."
[215] Hannah and Avolio, "Transforming Follower Moral Capacity," 9.

resources."[216] They propose, "*Greater complexity in domains of moral knowledge will increase the efficacy of recognizing and processing moral dilemmas.*"[217]

Moral identity, or the self-schemas referenced in respect to an individual's sense of a moral self, influences "cognition and behavioral self-regulation" and supports "the more in-depth processing to resolve complex moral dilemmas."[218] Self identity is less of a unified whole than an assemblage of selves.[219] Self identity has both content and structure such that "*Content* refers to the self-hypotheses held in memory by individuals and includes both knowledge components…and evaluative components…*Structure* refers to how these contents comprising self-identity are organized and categorized."[220] Individuals who are more morally developed exhibit higher levels of self unity "across various roles and situations."[221]

Self-identity is important as "people are motivated to behave in ways that are consistent with those self-attributes they hold as important…have high levels of unity in terms of self identity."[222] Moral dilemmas require people to deal with both competing values and choices. Hannah and Avolio suggest that "in areas where the self is less 'invested' the individual will be more likely to sway to other values and consequently away

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[216]Ibid. 9.
[217] Ibid. 9. Italics in original.
[218] Ibid. 10. See also Kihlstorm, Beer and Klein, "Self and Identity as Memory;" Markus, "Self-Schemata and Processing Information about the Self."
[219] Hannah and Avolio, "Transforming Follower Moral Capacity," 11. See also Markus and Wulf, "The Dynamis Self-Concept: A Psychological Perspective."
[220] Hannah and Avolio, "Transforming Follower Moral Capacity," 11. See also Jones and Gerand, *Foundations of Social Psychology*; Aquino and Reed, "The Self-Importance of Moral Identity;" and Campbell, "Self-Concept Clarity: Measurement, Personality Correlates, and Cultural Boundaries."
[221] Hannah and Avolio, "Transforming Follower Moral Capacity," 11. See also Block, "Ego-Identity, Role Variability, and Adjustment."
[222] Hannah and Avolio, "Transforming Follower Moral Capacity," 12. See also Swann, "Self-Verification: Bringing Social Reality into Harmony with the Self," "Identity Negotiation: Where Two Roads Meet;" Sheldon and Elliot, "Not all personal Goals are 'personal': Comparing Autonomous and Controlling Goals on Effort and Attainment;" and Lord and Brown, *Leadership Processes and Follower Self-Identity.*

from taking moral action, while, conversely, their more salient values will prompt moral engagement and a deeper level of processing of the dilemmas."[223] "A highly-developed moral identity will prompt one to engage themselves in processing of those moral dilemmas and would sponsor intentions to act and take moral action consistent with core values."[224] Hannah and Avolio argue that "*Levels of development in moral identity, as indicated by the richness of moral content structured with high unity across social roles, will be positively associated with engagement in moral processing and self-consistent moral behaviors.*"[225]

The third component of moral maturation is meta-cognitive ability. According to Hannah and Avolio, meta-cognitive ability is "*thinking about thinking*—the awareness of one's cognitive processes, cognitive strengths and weaknesses, and capability for cognitive self-regulation."[226] The two main functions of meta-cognitive ability are "*monitoring* and *controlling* (regulation) cognitions and processes, and thus serves as both a self-referential and executive-control functions critical to the processing of moral issues."[227] This is possible because thinking about thinking allows for the "monitoring and control" of thought processes such that "personal biases and limitations can be identified, scrutinized and controlled" in such a way that "moral reasoning oriented toward effective, issue-specific outcomes can be employed."[228] Hannah and Avolio argue that "*Level of moral*

[223] Hannah and Avolio, "Transforming Follower Moral Capacity," 13. See also Integrated Self-Schema Model (ISSM), Peterson, *Self-Concept and Information Processing;* Stahlberg, Peterson and Dauenheimer, "Preferences for the Evaluation of Self-Relevant Information Depending on the Elaboration of the Schema Involved."
[224] Hannah and Avolio, "Transforming Follower Moral Capacity," 13.
[225] Ibid. 14. Italics in original.
[226] Ibid. 14. See also Flavell, "Speculations about the nature and development of metacognition;" Metcalfe and Shimamura, *Metacognition: Knowing about Knowing.*
[227] Hannah and Avolio, "Transforming Follower Moral Capacity," 14+.
[228] Ibid. 15.

metacognitive ability will be positively associated with the level of utilization of moral complexity and subsequent efficacy of moral evaluation."[229]

Moral potency is "*a state of ownership over the moral aspects of one's domain, reinforced by efficacy beliefs in the capabilities to act to achieve moral purpose in that domain, and the courage to perform in the face of adversity.*"[230] Moral potency is required for action as one may have moral maturation and yet fail to possess the necessary characteristics that lead to action. For example, consider the murder of the Iraqi taxicab driver Dilawar. One of the U.S. soldiers who helped beat him to death said "Sometimes I feel I should have gone with my own morality. More than what was common."[231] Another soldier said "Some would say 'What! Hey you should have stopped this, you should have stopped that. Why didn't you do something?' …well it was us against them. I was over there; I didn't want to appear to be going against my fellow soldiers. Which, is that wrong? You could sit here and say that was dead wrong. Go over there and say that."[232] In these and similar situations of high levels of moral intensity, "individuals require more than a capacity to act, they must feel strongly that it is their place to act (i.e. ownership), that they can be successful in those actions (i.e. moral efficacy), and can overcome their fears and persevere to see those actions through to final resolution, which may invoke moral courage."[233]

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[229] Ibid. 15.
[230] Ibid. 6. Italics in original.
[231] "Taxi to The Dark Side," Interview of Sgt. Thomas Curtis, Military Police, Bagram.
[232] "Taxi to The Dark Side," Interview of Sgt. Thomas Curtis, Military Police, Bagram.
[233] Hannah and Avolio, "Transforming Follower Moral Capacity," 20. See also, Jones "Ethical Decision-Making by Individuals in Organizations: An Issue-Contingent Model."

As with moral maturation, there are three components to moral potency: moral ownership, moral efficacy, and moral courage.

Hannah and Avolio suggest that "having a sense of moral ownership provides the motivation required to employ a greater extent of one's moral capacity to figure out what to do when confronted with a moral dilemma."[234] Ownership is "the state in which individuals feel as though the target of ownership or a piece of that target is theirs."[235] Ownership is sufficient to begin a process of moral judgment that leads to a sense of responsibility to initiate judgment and action. This is because, according to Hannah and Avolio, "an individual's sense of ownership will sponsor a higher propensity to utilize a greater level of his or her moral maturation both to recognize moral issues and perform deeper meta-cognitive processing to and during the enactment of moral judgments."[236] Based on this concept of ownership, Hannah and Avolio propose that "*Levels of moral ownership will be positively associated with levels of utilization of moral maturation when processing moral dilemmas…Levels of moral ownership will be positively associated with the formation of intentions to act in concordance with moral judgments.*"[237]

One hindrance in engaging with moral dilemma is a lack of confidence.[238] A person may be aware of a moral dilemma, take ownership of the dilemma, process relevant moral considerations to reach an evaluation of the situation, and form the basis of intentions, yet

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[234] Hannah and Avolio, "Transforming Follower Moral Capacity," 21. See also Chaiken, "Heuristic versus systematic information processing and the use of source versus message cues in persuasion;" Perry and Cacioppo, "Self-concept and Information Processing;" Van Dyne and Pierce, "Psychological Ownership and Feelings of Possession: Three Field Studies Predicting Employee Attitudes and Organizational Citizenship Behavior."

[235] Hannah and Avolio, "Transforming Follower Moral Capacity," 21. See also Pierce, Kostova, and Dirks, "The State of Psychological Ownership: Integrating and Extending a Century of Research."

[236] Hannah and Avolio, "Transforming Follower Moral Capacity," 22. Italics in original.

[237] Ibid. 22. Italics in original.

[238] Ibid. 22.

not feel confident in their ability to actively engage in the situation. Moral efficacy is "one's belief (confidence) in his or her capabilities to organize and mobilize the motivation, cognitive resources, means and courses of action needed to attain moral performance, within a given moral domain, while persisting in the face of moral adversity."[239]

Efficacy has two components: self-efficacy and means-efficacy. Self-efficacy deals with confidence in one's own capabilities, while means-efficacy deals with confidence in the available resources at one's disposal. A critical aspect in action is that "one must therefore believe they not only have the ability to perform a moral task (e.g. to disclose unethical accounting), but that the supporting means will allow them to perform successfully (e.g. 'whistle blower' protection)."[240] Hannah and Avolio propose "*Levels of moral efficacy will positively moderate the relationship between moral intentions and moral behaviors."*[241]

The final aspect of moral potency is moral courage. Moral courage is the "fortitude to convert moral intentions into actions despite pressures from either inside or outside of the organization to do otherwise."[242] Moral courage interacts with moral identity in that "strongly held core values (high unity) prompts courage in individuals to manifest those values in action."[243] Hannah and Avolio propose that "*Levels of moral courage will*

[239] Ibid. 23. See also Eden "Means Efficacy: External Sources of General and Specific Subjective Efficacy;" Bandura, "Social Cognitive Theory in Cultural Context."
[240] Hannah and Avolio, "Transforming Follower Moral Capacity," 25.
[241] Ibid. 25.
[242] Ibid. 26. This definition is specific for moral courage in the workplace, but is applicable in an organizational structure. See also May, Chan, Hodges, and Avolio, "Developing the Moral Component of Authentic Leadership."
[243] Hannah and Avolio, "Transforming Follower Moral Capacity," 26. See also Sandage and Hill, " The Virtues of Positive Psychology: The Rapprochement and Challenges of an Affirmative Postmodern Perspective;" Shepela et al., "Courageous resistance: A Special Case of Altruism."

positively moderate the relationship between moral intention and moral behaviors, and will be positively associated with persistence in those behaviors when faced with adversity."[244]

Moral maturation and moral potency can be developed. Moral maturation can be developed because "the manner in which people attend to, perceive, store, access, and make meaning of information in their moral reasoning processes are malleable and open to intervention."[245] Hannah and Avolio propose three main mechanisms that can be used by leaders to develop moral maturation of those that follow them, "1) guiding followers through a series of experiential moral events that create states of cognitive disequilibrium that forces a deeper inquiry to resolve, while facilitating and enhancing their interpretation and understanding of those experiences, 2) personally modeling moral behavior, and 3) teaching deliberate cognitive moral decision-making skills and processes."[246]

I contend that this development in moral maturation will be effective in helping resolve conflicts in duty as experienced by military physicians. By facilitating and

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[244] Hannah and Avolio, "Transforming Follower Moral Capacity," 26. Italics in original.
[245] Ibid. 15.
[246] Ibid. 15+. See also Kegan, *In Over Our Heads: The Mental Demands of Modern Life;* Kohlberg, *The Philosophy of Moral Development;* Avolio, *Leadership in Balance;* Street, Douglas, Geiger, and Martinko, "The Impact of Cognitive Expeditor on the Ethical Decision-Making Process: The Cognitive Elaboration Model;" Walker, "Sources of Cognitive Conflict for Stage Transition in Moral Development;" Young and Wasserman, "Theories of Learning;" Dutton and Jackson, "Categorizing Strategic Issues: Links to Organizational Action;" Isenberg, "Drugs and Drams: The Effects of Two Dramatic Events in a Pharmaceutical Company on Manager's Cognitions;" Bass, "Transformational Leadership: Industrial, Military and Educational Impact;" Bartunek, Lacey, and Wood, "Social Cognition in Organizational Change: An Insider-Outsider Approach;" Dukerich, Nichols, Elm and Volrath, "Moral Reasoning in Groups: Leaders Make a Difference;" De Cremer and van Knippingberg, "How Do Leaders Promote Cooperation? The Effects of Charisma and Procedural Fairness;" Lord and Brown, *Leadership Processes and Follower Self-Identity*; Dvir and Shamir, "Follower Developmental Characteristics as Predicting Transformational Leadership: A Longitudinal Field Study;" Gardner and Avolio, "The Charismatic Relationship: A Dramaturgical Perspective;" Lord, Brown and Freiberg, "Understanding the Dynamics of Leadership: The Role of Follower Self-Concepts in the Leader/Follower Relationship;" Shamir, House and Arthur, "The Motivational Effects of Charismatic Leadership: A Self-Concept Based Theory;" Bebeau, "The Defining Issues Test and the Four Component Model: Contributions to Professional Education;" Rest and Thoma, "Education Programs and Interventions;" Hunt and Vitell, "A General Theory of Marketing Ethics;" May and Pauli, "The Role of Moral Intensity in Ethical Decision-Making: A Review and Investigation of Moral Recognition, Evaluation, and Intention."

enhancing the interpretation and understanding of moral situations, military physicians will be better able to identify whether or not they are truly in a moral dilemma. If not in a moral dilemma, but still suffering moral distress resulting from not knowing what to do, they may be able to model the moral behavior of others. Alternatively, if they have developed cognitive moral decision-making skills and processes they will be able to better exercise their own moral judgment. However, to effectively enable action, military physicians must also be allowed to develop moral potency.

Moral potency can be developed, although it faces organizational challenges. Within organizations, people tend to "look to and comply with what they interpret to be the moral desires of 'higher authority' when making moral judgments."[247] Consequently, people reduce their ownership in addressing moral issues.[248] Further challenges are present as "people tend to conform to the expectations of peers and others either to be liked or accepted (normative influence), or to be validated and affirmed (informational influence)."[249] Hannah and Avolio propose three ways in which these challenges may be overcome.

First, leaders should foster intellectual stimulation that "encourage followers to question and challenge their positions and decisions, as well as those of their leaders, thus raising followers' sense of autonomy and moral ownership."[250] Second, leaders should add "salience, clarity and personalization to moral issues."[251] Third, leaders should increase "the perceived level of moral intensity through moral issue-framing."[252]

[247] Hannah and Avolio, "Transforming Follower Moral Capacity," 27.
[248] Ibid. 27.
[249] Ibid. 27.
[250] Ibid. 27.
[251] Ibid. 27.
[252] Ibid. 27.

Moral ownership can be increased by placing moral dilemma issues "in humanistic terms, discouraging sanitizing language (e.g. euphemisms that 'sugar coat' situations), encouraging responsibility, making salient the injurious effects of potential actions, and limiting attribution of blame to or dehumanizing of victims."[253] Moral ownership can also be increased by "raising the *moral intensity* associated with an ethical dilemma."[254]

Issue framing, "the way information about an issue or situation is presented," is an important factor in whether or not, and how, an individual recognizes an issue as a moral dilemma.[255] Moral language used in framing moral situations "triggers peoples' moral scripts and therefore behavior repertoires."[256] Thus, by repeated exposure to typical ethical dilemmas (through training, modeling, etc.) individuals can better recognize and act in moral dilemmas.

Finally, ownership and engagement can be increased by organizational reward and control systems.[257]

Self-efficacy can be developed through five elements: "1) *enactive mastery experience,* 2) *vicarious learning,* 3) *social persuasion/feedback,* 4) *psychological and emotional arousal…*5) *providing and articulating the quality and utility of means and support offered by the organization."*[258]

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[253] Hannah and Avolio, "Transforming Follower Moral Capacity," 27.
[254] Hannah and Avolio, "Transforming Follower Moral Capacity," 28. See also Jones, moral intensity is influenced by six factors: magnitude of consequences, social consensus, probability of effect, temporal immediacy, proximity, and concentration of effect.
[255] Hannah and Avolio, "Transforming Follower Moral Capacity," 28. See also Butterfield et al.
[256] Hannah and Avolio, "Transforming Follower Moral Capacity," 28. Scripts are from schema developed through experience, especially experience of successful behaviors. See Gioia and Poole.
[257] Hannah and Avolio, "Transforming Follower Moral Capacity," 29. See also Trevino, et al.; Schlenker, Dlugolecki, and Doherty; Tice.
[258] Hannah and Avolio, "Transforming Follower Moral Capacity," 29. Italics in original. See also Bandura.

Moral courage is developed in several ways. First, individuals tend to identify with self-sacrificing leaders. This influences a person's identity and willingness to sacrifice himself for moral action.[259] Second, sets of personal and social resources promote courage.[260] Such sets include "personal resources such as efficacy, locus of control, conscientiousness and other positive states and traits mitigate against fear and open up a broadened set of behavior repertoires with which one can contemplate action in the face of fear."[261] Third, Hannah and Avolio propose "an individual's values and beliefs such as duty and loyalty, as well as social forces such as cohesion and group norms will promote courageous action in the face of fear."[262] Moral courage is an emergent property coming from "an interaction of personal and social resources that prompt moral action."[263]

How will this help in negotiating moral dilemma and relieving moral distress? If leaders take responsibility to help increase an agent's moral potency, they are, in effect, helping restructure organizational barriers which exacerbate moral dilemma and moral distress. Given that many reports of moral dilemma and the resulting moral distress indicate that organizational barriers are one of the chief causes of moral distress, this could be a significant change. By increasing agents' autonomy and moral ownership, leaders in an organization can better trust that agents will engage with and appropriately deal with moral dilemma. By regaining a sense of professional autonomy, agents are in a better position to remain true to their moral working-self. They are less likely to suffer from moral distress.

[259] Hannah and Avolio, "Transforming Follower Moral Capacity," 30.
[260] Ibid. 31.
[261] Ibid. 31. See also Hannah; Fredrickson; Fredrickson, Tugade, Waugh and Larkin.
[262] Hannah and Avolio, "Transforming Follower Moral Capacity," 31.
[263] Ibid. 31.

Through training in issue framing, agents are less likely to be unaware of moral dilemmas. They will be in a better psychological state to successfully negotiate moral dilemmas and, consequently, less likely to experience moral distress. Finally, by developing moral courage agents are less likely to feel helpless and hopeless when confronted with moral dilemma. Again, this increases their likelihood of successfully negotiating moral dilemmas and decreases their likelihood of experiencing moral distress.

My proposal that developing moral maturation and moral potency to help military physicians deal with moral dilemma and moral distress is consistent with Hannah and Avolio's conclusion of the relationship between moral maturation, moral potency, and the moral working-self. Aspects of the self become prominent based on current experiential contexts.[264] For example, when engaged in a sport, such as basketball, certain cognitive processes and physical activities are activated while others are suppressed. While reading the newspaper, other cognitive processes and physical activities are activated, depending upon the work in which a person is currently engaged. The moral working-self is that part of the self that becomes activated and engaged when contextual triggers prompt that part of the self into action.

How does this relate to the self? Identity is "a memory structure developed over the life span where individuals have interpreted and encoded their experiences into memory."[265] Hannah and Avolio point out that some current theories of the self indicate that the self is formed through narrative interpretation and both a current self-view and images of possible

[264] Ibid. 31. See also Kihlstrom et al.
[265] Ibid. 18. See also Kelly, "*The Psychology of Personal Constructs;* Kihlstrom, Beer and Klein, "Self and Identity as Memory."

selves.[266] The self and personal identity is malleable. To understand how this will help with resolving moral dilemma and decrease moral distress, I return to Bluestein's understanding of identity-conferring commitments.

Bluestein's position is that "Incorporating the requirement of morality into one's life should not have disastrous consequences for human personality. Morality may demand significant sacrifice and effort, but the cost of being moral should not be a distorted and undesirable personality."[267] Bluestein identified "identity-conferring commitments" that involve a person's centrally important values which contribute to one's identity. These commitments "make us what we are and they place constraints on our lives from which we may not be able to unbind ourselves without self-betrayal and personal disintegration."[268] These commitments are a key part of defining our moral personality.

The analysis of moral distress reveals that one underlying cause of moral distress is from a perception of moral dilemma resulting from a perception of a conflict of professional duties. In fact, it appears that underlying this conflict is a conflict in identity-conferring commitments. As we have previously seen, contextual cues activate identity schemes. When contextual cues are predominantly military related, such as a formal review or briefing, a military physician is most likely to respond with his military identity. When contextual cues are predominantly medical related, such as when working in an emergency

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[266] Hannah and Avolio, "Transforming Follower Moral Capacity," 18. See also Shamir and Eilam, "What's your Story? A Life-Stories Approach to Authentic Leadership Development;" Sparrowe, "Authentic Leadership and the Narrative Self;" Lord and Brown, *Leadership Processes and Follower Self-Identity*.

[267] Jeffrey Blustein, *Care and Commitment: Taking the Personal Point of View*. (New York: Oxford University Press, 1991) 21. Maybe Blustein is assuming a relatively safe occupation in a safe environment. But maybe combat soldiers are required to do things that they can never be morally comfortable with, things that may even change their identity. That may be one cost of war. As John Hardwig, professor of philosophy, University of Tennessee, Knoxville, TN, said, "On a factual level, that seems accurate – 'He just never was the same after he came back from the war.'"

[268] Blustein, *Care and Commitment*, 49-50.

room, a military physician is most likely to respond with his physician identity. Prolonged engagement with mixed cues, such as in combat theaters, can provide rapidly changing contextual cues. This can force a military physician to become cognitively aware of both his physician and his officer identity schemes. The military physician may be faced with an appearance of a conflict of identity-conferring commitments. This conflict forces cognitive dissonance.

Cognitive dissonance is important because it is at this time that a person is most likely to either develop or to be further cognitively fractured. Continued cognitive dissonance can lead to moral distress, especially if the individual either lacks the internal resources to effectively conceptionalyze the situation or external sources continue to lead to pressure.

Character development, through ethical transformative leadership, can assist a military physician (or others in similar situations) cope with cognitive dissonance. Moral maturation and moral potency allow for both preserving and protecting or, when appropriate, adapting and changing identity-conferring commitments. Thus, developing these moral traits is important as they allow for successfully negotiating moral dilemma and reducing incidences of moral distress related to action against identity-conferring commitments. The question remains as to how a military physician determines which set of identity-conferring commitments, or blend of sets, he ought to adopt. Topology-AMC provides additional means of assisting ethics educators to present scenarios of the complex situations military physicians must confront as they combine their duties as medical personnel and military officers.

Appendix 3: The Either-Or Solutions: Nazi Case Study

Sometimes it's the smallest decisions that can change your life forever.
Keri Russell

What luck for the rulers that men do not think.
Adolf Hitler

Nazi Germany provides an illuminating case study in applications of the either-or solution. It is illuminating in that within one study it is possible to apprehend the conflicting claims that (1) military officer duties should outweigh physician duties and (2) physician duties should outweigh military officer duties. This is possible because Nazi physicians often used (1) in a defense of their actions, but from a historical perspective both (1) and (2) account for a shifting in physician duties as directed from an individual patient to a society at large.

Whereas Chapter Four's analysis of the either-or solution provided accounts of possible inadequacies in the various articulations of the either-or solution, this extended case study is used to show a concrete, real-world example of the possible danger of whole-heartedly embracing an either-or solution without taking precautionary steps to prevent its possible abuse. Section One of this appendix details how an either-or solution focusing on military duties is used as a defense of questionable actions. Section Two details how an either-or stance focusing on medical duties helped lead to the atrocious actions committed by Nazi physicians.

§1: Karl Brandt's Defense - Military Duty Prevails

Assume it is true that a nation's security is of such importance that it warrants military necessity as an overriding concern and that military necessity requires soldiers to obey orders to maximize the efficiency of the military organization. This is one of the arguments that officer duties should outweigh physician duties. Dr. Karl Brandt used such a defense in the *War Crimes Trials* at Nuremburg. To challenge the claim that officer duties should override physician duties I offer a counter-argument to Brandt's defense. If it is assumed that it is true that soldiers always have a general duty to obey orders, we reach an unacceptable conclusion. It is not the case that military necessity is always a justification to override physician duties.

§1.1: On the Moral Acceptability of "Befehl ist Befehl"

Often used by those committing atrocities, the defense of "I was just following orders" has been criticized and largely considered invalid since World War II. In legal terms, this is known as *Respondeat superior* (Latin for "let the master answer"). From its appearance in the Nuremburg Trials, "just following orders" is also known as *Befehl ist Befehl*, variously translated as either "instruction is instruction" or "order is order."

This section will explore some of the complexities of the *Befehl ist Befehl* defense. When taking into consideration the complexities of war, human psychology, and suppositions of moral responsibility, it is plausible that in some cases soldiers may be justified in following orders, uncritically, when they are involved in a moral dilemma or in

the "heat of battle." On the other hand, there are numerous examples in history where uncritically following orders has led to unimaginable and unconscionable suffering.

There is little plausibility in suggesting that people who have been given orders have *no* moral responsibility when they follow those orders. It is more plausible to suggest that people who have been given orders *do* have individual responsibility. The responsible and proper action for individuals is to obey legal and moral orders. In exploring the defense of "just following orders" in the "heat of battle," the issue in these situations is not just that orders should not have been followed, but that illegal and immoral orders should not have been given. Moral condemnation must rest heavily on those who initiate illegal or immoral orders, those who enforce the ideals which lead to morally questionable practices, and those who continually foster unethical cultures and climates which lead to a breakdown in moral practice. However, *a lack of individual responsibility*, on any level, cannot be wholeheartedly accepted, because to do so might lend justification to atrocities such as those seen in Nazi Germany, Japan's Unit 731, or the My Lei Massacre.

Interpretations of this defense require having some clarity regarding the appropriateness of following orders in everyday situations: it is, in fact, necessary for the properly functioning society. "Why did you . . . ?" is frequently justified with "Because so-and-so told me to!" This is not offered as a simple excuse. It is offered as a justifiable reason and expectation for an action.

This justification is allowable precisely because in many situations people are expected to follow orders. Children are expected to follow the orders of adults (especially their parents), students are expected to follow their teachers' instructions, employees are

expected to follow employers' rules, soldiers are expected to follow officers' commands, patients are expected to obey doctors' instructions, and parishioners are expected to obey their church laws.

This appropriateness of following orders is not always the case. Nor is it desired, in an ethically sensitive culture, to want this to always be the case. Yet, it must be conceded that disobedience is the exception, not the rule.[269] Following orders is the norm and not simply an excuse for "wrong" actions when morally questionable consequences happen. In fact, in most situations, disobedience is discouraged, punished, or at least questioned. There are powerful institutional, cultural, and psychological incentives to obey orders from authority. Based on the principle "ought → can" this leads to at least three interpretations of the defense "I was just following orders."[270]

Consider the following three interpretations of the use of *Befehl ist Befehl* as a defense for a morally wrong action in the military. (1) **The Mechanistic Defense** – this defense relies on a claim that although the agent is the physical cause of a moral wrongdoing, he is not the efficient cause of the wrongdoing. The agent is nothing more, nor less, than a "cog in a machine." As such, he has no real autonomy, as no moral choice realistically exists to him in his actions. The agent is morally free from blame or condemnation. (2) **The Limited Autonomy Defense** – this defense relies on a claim that although the agent is not a "cog in a machine," he is nonetheless limited in his autonomy

[269] It is important, whenever considering applied ethics, to establish the baseline or norm that is typically accepted. For example, discussions of capital punishment, or justifiable homicide such as self-defense, start with the norm that killing is, under most circumstances, morally wrong. The burden of proof lies in establishing the legitimacy of killing. Likewise, when it comes to disobeying orders, whether it is from those in authority or from the laws of the land, it is reasonable to suggest that the burden of proof lies in establishing the legitimacy of not following orders.

[270] See previous appendix for discussion on "ought→can".

due to the lack of autonomy enabling information.[271] This lack of information dictates that the agent must rely upon others for information used in deciding what to do. As such, although the results of his action may elicit morally heinous consequences, he is himself motivationally blameless in the activity. Arguably, had the agent known otherwise he could have acted differently. A severe limitation on autonomy can push this defense into the mechanistic defense. (3) **The Practical Defense** – failure to promptly and diligently follow orders can result in swift and sometimes harmful consequences to the agent such as verbal criticism, or forfeiture of pay and allowances. In the Military punishment may also include confinement, reduction in rank, bad-conduct discharge, death, or other such punishment as a court-martial may direct.[272]

Individuals might reject the Mechanistic Defense unless they have a solid commitment to materialistic, deterministic, or otherwise mathematical-mechanical metaphysics. Yet, the mechanization of an individual's actions is the desired goal of some types of training. There are good aspects of training people to act automatically without the need for conscious thought. The goal of such training can be to establish quick and accurate action. Mechanization is an approved way of training for certain aspects of personnel response such as for medics, doctors, pilots, policemen, and firemen. In these cases, the individuals are not just cogs in a machine. They are well-trained to automatically respond to certain situations.

[271] I'm using Mappes and DeGrazia's notion of autonomy as (a) liberty of action, (b) freedom of choice, and (c) effective deliberation. In the Limited Autonomy Defense, the agent is not constrained in his actions and is free to make choices. However, he lacks the knowledge to effectively deliberate his actions.
[272] See USMJ Articles 90, 91, 92.

Part of this training involves following orders. Without a doubt, following orders can have advantages. Following orders instills cohesion in a military unit that allows the unit to achieve mission objectives. Likewise, in emergency situations following orders allows for swift and efficient mobilization, containment, and resolution of an emergency. There is a relative degree of limited autonomy which may impact the evaluation of the results of an individual's following orders.

Psychologically we know that in certain situations with enough pressure almost any individual will lose personal volition. Consider that fraternal organizations routinely engage in behavior designed to persuade pledges to conform to the group values and structure. Anecdotal stories suggest that public schools are sometimes perceived to operate under "Ford factory models" which, consequently, encourage group-think and obedience to society. Cults and gangs engage in sophisticated psychological techniques to isolate individuals from their support networks to brainwash them into being willing servants of the cult or gang. Corporate atmospheres are known to encourage what might be considered by some people to be unethical climates.

In many cases, the mechanization of individuals is the desired goal of some types of training. However, the degree of mechanization and the ethical application of mechanization can vary from institution to institution. In some cases the mechanization may be restricted to simple tasks, e.g., quickly moving to suppress an ambush, quickly reacting to initiate CPR, or instinctively moving to avoid confrontation. In other cases, the degree of mechanization seeks a deep and total control of an individual.

As an extreme case, consider claims made by Chris White relating his experiences with Marine Corps indoctrination. Mr. White claims that his recruiter told him that the purpose of the 12-week boot camp was "to produce the most efficient, disciplined, and gallant, killing machine…by removing my undesirable civilian traits, such as individuality and the inhibition against killing other human beings, and inserting Marine Corps traits, such as anti-individuality for the sake of a team work ethic, and, more importantly, the ability and even desire, to kill other human beings."[273]

According to White, intense mental and physical indoctrination is used towards the goal of producing "troops capable of following orders with minimal agency of their own, efficiently enough to be utilized as a tool of the state, whether the Marine agrees with the orders or not."[274] Indoctrination is mostly about control:

> They control everything you do, from the order and speed of getting dressed, to the way you eat, sleep, and use the bathroom, to the way you walk, to the way you talk, to the way you sit, to the way you stand, to the way you worship, to the amount of water you drink, and so on, until you only do and think what is ordered of you…At a certain point, you lose that nasty civilian trait of individuality mentioned by your recruiter, and you accept, nay, enjoy, the fact that you [are] under their control. You signed on the dotted line, you came here of your own free will, it makes sense to go along to get along.[275]

White further claims that the constant lessons are "Don't stray from the mainstream. You are not you anymore. You are part of a machine…This does not necessarily translate into a submissive mind outside the realm of battle…they are controlled during battle, regardless of their political or moral views, on the whole."[276]

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[273] Chris White, "The Bedrock of the Marine Corps Indoctrination," Counterpunch, July 13, 2004. n.p.
[274] Ibid. n.p.
[275] Ibid. n.p.
[276] Ibid. n.p.

It is an empirical question as to how deeply individuals can be rendered automatons. Yet, the degree to which an individual loses autonomy in these situations should be relevant and taken into consideration when deciding the degree to which moral responsibility is assigned to that individual for an action. That is, the closer someone is to being "a cog in the machine," the more justification there may be in pleading "*Befehl ist Befehl*." Thus, moral responsibility may not be a binary assignment, but rather something to be placed on a sliding scale of "more-or-less" responsibility. Consequently, an individual should still be held accountable for his actions, but those who caused, allowed, or advocated immoral actions should also be accountable.

For individuals who are not sufficiently indoctrinated into mechanical reactions, limited autonomy may also explain or justify their defense. In this case, consider the situations in which autonomy is limited due to problems with justifiably limited knowledge including, but not limited to, lack of information and false or misleading information.[277]

Institutions often institute policy that individuals should follow only legal or moral orders. This can serve several purposes. A positive purpose is to provide protection for the individual who is confronted with an illegal or immoral act. In any organization, there is the potential for wrongdoing by an individual who may give an illegal order. Therefore, the organization can grant individuals the right to act on their moral judgment, as long as they are willing to be responsible for the consequences of their actions.

There may be a more nefarious purpose for providing a policy stating that individuals should follow only legal or moral orders. For organizations that are actively

[277] A discussion on what constitutes justified limited knowledge is beyond the scope of this dissertation. These issues are not dealing with simple cases of lack of knowledge where the individual agent is held responsible for a lack of knowing.

engaged in illegal or immoral goals this policy provides the institutions a shield from criticism by offering an illusion of agent autonomy. Those policies may ignore institutional pressures that attempt to regulate individual autonomy and overstate the belief that individuals are capable of choosing appropriate action.

Policy that allows for obeying only legal and moral orders may actually provide protection for the individual as it implies and the policy does reinforce a belief in personal responsibility. Yet there are situations of moral uncertainty where individuals may be unable to differentiate between illegal versus legal orders or moral versus immoral orders. In such cases, it seems disingenuous to insist that it is the individual agent who has *sole* responsibility for any illegal or immoral action.

Consider the following cases. A military physician is ordered to evaluate and treat a prisoner. The military police report that the prisoner was involved with a prison riot, and suffered his injuries from other inmates. As part of the evaluation, the physician is requested to include a medical opinion as to whether or not the prisoner could survive similar encounters. The military police indicate that this will determine whether the prisoner will be returned to the general population or placed in special quarters. The military physician is not provided with the information that in reality the prisoner is being interrogated and possibly tortured. The intelligence officers in charge of the interrogation have sent the prisoner to the medical facility hoping to (1) help conceal the signs of improper interrogation and (2) ensure that the prisoner will be ready for future interrogation sessions. Should the military physician have any legitimate reason to suspect that he was given an illegal or immoral order?

Alternatively, consider the case of a soldier driving a superior officer through unfriendly territory. The officer is on a personal phone, presumably talking to command staff. He tells his driver that there are reports of a terrorist attack at a local hospital. An ambulance races past the jeep. The officer suddenly orders the soldier to intercept the ambulance, force it off the road, and shoot anyone who tries to escape. The soldier has no way to determine if the ambulance is part of the terrorist plot, or if his superior issued an illegal order.

While professionals must be familiar with rules, laws, and ethical codes of their profession, it is a fair question to ask whether busy professionals have the time, experience, or knowledge to investigate every possible contingency of illegal or immoral action.[278] The presence of legal departments and ethics committees indicates that these are specialized services that professionals require precisely because professionals need guidance in some situations.

People do not always have adequate time, knowledge, and resources necessary to evaluate and to make appropriate legal and moral choices. Education, training, and development in these matters are important so that people can react quickly and appropriately when confronted with moral dilemma. The twin by-products of this are that we train people to react mechanistically to situations and we train people to obey orders. Yet we sometimes neglect the educational and developmental components of moral deliberation, especially about how to determine whether an order is legal or moral.

[278] As an example of how daunting this task may be, Department of the Army Field Manual FM 27-10, "The Law of Land Warfare" is over 190 pages long. Lawyers in the military may have over four years to study law, but the typical soldier in the military does not have the resources to gain such a large amount of legal expertise.

A third defense of following orders is the Practical Defense. Some ex-soldiers related that they only vaguely remember lectures on the Geneva Conventions, but they all knew that if they disobeyed orders they could be court-martialed. This is understandable given that large organizational structures have found that it is prudent to have a policy that allows for, or even demands, that people follow orders when someone with legitimate authority over them tells them what to do. Moreover, people may argue that such a policy is, overall, good for individuals and society. Over the long-run, it is claimed, the good outweighs the bad. Even in situations with limited information, an individual must sometimes act. In some cases, this conceivably means following orders without determining if they are legal, proper, or even moral. Precisely because information is limited, agents may have a valid defense of "*Befehl ist Befehl*." Once again, the individual retains some level of responsibility for his actions, but those *giving* the illegal, improper, or immoral orders must be held accountable to a high degree.

In conclusion, there may be times in which "following orders" is sometimes justified; in some situations in which an individual is acting as an automaton or when his autonomy is significantly limited. The issue is whether the need to follow orders establishes that military duties *always* override medical duties. This cannot be concluded unless following orders is always a justification, or at least always a justification in the military. It cannot be concluded that following orders establishes that military duties should always override medical duties unless the "following orders" defense is wholeheartedly accepted. The case of Karl Brandt demonstrates the problems with accepting this defense.

§1.2: Karl Brandt – Nazi Medical Doctor

Karl Brandt was one of the dominant medical figures in Nazi Germany.[279] Doctor Brandt was Hitler's personal physician and as a member of the *Schutzstaffel* (SS) was involved in many activities which eventually led to his execution after the Nuremburg Medical Trials.[280] Brandt was responsible for formalizing a program of the medical killing of children, expanding this program to a focus on adult chronic patients in the T4 program, advocating the use of carbon monoxide poisoning as a "humane" form of killing, and working with medical experiments.

Paradoxically, Brandt was considered by many Germans as "a highly ethical person" and was generally well regarded within Germany as a humane idealist.[281] He was angered at some of the brutal handlings of some medical patients and allowed some groups of people to be spared. Brandt's extensive use of the "following orders defense" during the Nuremburg Trials relating to medical experiments is particularly illuminating.[282]

Brandt claims that "There are three aggravating factors with respect to the question of the criminal element in experiments: their involuntary character, the lack of necessity for them, and the dangers involved."[283] The President of the Tribunal, Justice Beals, questioned Brandt. "I would ask counsel if by his question he intends to ask the witness whether the

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[279] Background information on Karl Brandt is taken from Robert J. Lifton's work *The Nazi Doctors: Medical Killing and the Psychology of Genocide.*

[280] The SS originated as a civilian paramilitary group, but eventually developed into both a state organization and a recognized branch of the government. It take control of state security and the secret state police. The SS was sometimes considered to be a second military within Germany as it sometimes worked along with military units. Yet, branches of the SS were formally considered not as a second military but as branches of the German military.

[281] See Lifton's *The Nazi Doctors*.

[282] Brandt was among 23 physicians and administrators tried for (1) the common design or conspiracy, (2) war crimes, (3) crimes against humanity, and (4) membership in a criminal organization.

[283] Alexander Mitscheerlich, *Doctors of Infamy: The Story of the Nazi Medical Crimes*, Knickerbocker Printing Corps, New York, 1949.

experiments . . . would be objectionable or illegal if carried on by a physician upon persons in civil life disconnected with the military service."[284] Brandt claims that under war conditions certain experiments may be deemed ethical and necessary.

To argue for this claim, Brandt classifies experiments as voluntary and involuntary, each of which can be further classified as dangerous or non-dangerous. Considering the notion of following orders Brandt says, "If there is a danger, the physician must be relieved of all responsibility for the danger that is involved. This is possible only by way of an official order on the part of some superior authority, or some government dispensation, the interests of the state being capable of varying interpretation in time of war."[285] This underscores a direct claim that responsibility for some actions may be assumed by some higher authority.

When asked about the ethical evaluation of physicians experimenting upon people, Brandt continues:

> May I first of all repeat, so that I am sure I have understood correctly. In the conduct of the experiments it is assumed that they are of the highest military importance, that the test persons have not given their consent, and that the experiments are dangerous, with death the possible outcome. In such a case I am of the opinion, considering the war situation, that the individual or government institution determining their importance must also undertake to relieve the physician of responsibility in the event of a fatal outcome of the experiment.[286]

Trying to evaluate what the implications of the "*Befehl ist Befehl*" defense implied, Judge Sebring asked, "Now, does it take away the responsibility from the physician, in your

[284] Ibid. 157.
[285] Ibid. 160.
[286] Ibid. 161.

view, or does it share the responsibility with the physician in your view?"[287] Brandt made what may have appeared to be a mechanistic defense, quickly followed by a limited autonomy defense:

> In my opinion it removes it from the physician, for from this moment on the physician is *only an instrument*, in about the same way as is an officer in the field who is ordered to take a group of three or five soldiers without fail to a position where they will perish, fall. When I apply the relationship of our German conditions during war, it is basically the same. I do not believe that the physician on his own would or could conduct such an experiment by his medical ethics or his moral sense, unless *he had immunity* from the authoritarian state, which would give him, on the one hand, security under formal law, and on the other hand, *a direct order* to carry out.[288]

This prompted Judge Sebring to ask Brandt about following orders. "Would you conceive that such an order would authorize the medical officer to whom the order was addressed to select subjects involuntarily and subject them to experiments, the execution of which that officer absolutely knew or should have known would likely result in death of the subject?"[289] Brandt responded by appealing to limited autonomy. "It depends on the clear chain of command that would apply in such a case."[290] Brandt elucidated this by appealing to an analogy of soldiers following orders in the military—soldiers follow orders even when (or especially when) they have imperfect knowledge of the situation.

Likewise, according to Brandt, physicians must follow orders. Failure to follow orders, for soldiers and physicians, means being held accountable for disobeying orders. According to Brandt, "Had this physician refused to carry out the experiments [as ordered to by the state], he would have surely been called to account for his failure. In such a case . . .

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[287] Ibid. 161.
[288] Ibid. 162. Emphasis added.
[289] Ibid. 162.
[290] Ibid. 162.

personal response to a code of ethics peculiar to a specific profession had to give way to the total character of this war."[291] Brandt thus seems to base his final appeal on the practical defense, where failure to obey orders results in personal hardship for the soldier who disobeys.

§1.3: Lessons from Brandt's Defense

During the Nuremburg Medical Trials, Nazi medical doctors often used the "*Befehl ist Befehl*" defense coupled with two further notions. The defense claimed that military necessity and ethics during times of war were different from ethics during times of peace and that certain actions, such as euthanizing selected populations or engaging in medical experiments "for the greater good," were justified. These Nazi defense arguments have been solidly rejected.

The basis of rejection of these defense claims is compiled in the indictments of the Nuremberg Medical Trials.[292] The indictments state that the defense of following orders does not apply in the following four situations: (1) Principals who took a consenting part in planning and executing a conspiracy to commit War Crimes and Crimes Against Humanity, (2) Principals who took a consenting part in planning and executing War Crimes, (3) Principals who took a consenting part in planning and executing Crimes Against Humanity, and (4) Membership in a criminal organization.

Examples of the first three indictments include performing medical experiments upon human subjects without their consent, during which murders, brutalities, cruelties, tortures, and other inhumane acts are performed; participating in mass murder of civilians;

[291] Ibid. 163.
[292] See Appendix 4 for Indictment List.

and performing euthanasia on human subjects, without their consent. The fourth indictment lists Die Schutzstaffelnder National Sozialistischen Deutschen Arbeiter-Partei, the SS, as an illegal organization. The eventual rulings in these trials add support to the implications in these charges that there seems to be a threshold past which military necessity, changing ethics, or following orders no longer apply as reasonable or moral.

Once an individual reaches this threshold, they must assume individual moral responsibility for their actions. In extreme cases, such as occurred in the Holocaust, the mechanization of an individual and the cultivation of limited knowledge reduced autonomy and resulted in immoral actions and moral irresponsibility. What is apparent from the indictments is that in these instances, the wrongness in these situations lies not only with the individual following orders, but in the fact that such orders should not have been issued. Moral condemnation must also rest upon those who initiate illegal or immoral orders, and upon those who enforce the ideals that lead to morally questionable practices as well as upon the individual who performed the act.

In conclusion, there are instances in which claiming "*Befehl ist Befehl"* is justifiable, though it does not absolve an individual of all moral responsibility for his actions. "Just following orders" can provide a legitimate defense and can provide relevant information that should be taken into consideration in a defense. On a practical and moral level, "*Befehl ist Befehl*" is a significant part of military training and tradition. In many cases, following orders in the military is justified. When the complexities of war, human psychology, and individual moral responsibility are examined, it is plausible that soldiers may be justified in following some orders even when they have difficulty determining if the order is legal and

moral and even when such orders may appear to conflict with personal or professional non-military duties.

Because of the horrifying results of blindly following orders, as seen by the atrocities committed by Nazi Doctors, Japanese researchers in Unit 731, and the soldiers who participated in the My Lai Massacre, one needs to understand and evaluate the appropriateness of "just following orders." Since we, as a society, hold individuals responsible for their actions, we need to provide training, education and development necessary for individuals, especially soldiers, to explore and to determine what constitutes a legal, valid, and proper order. We must also provide the training, education and development necessary to foster appropriate responses to moral dilemma. Part of this education should indicate that it is not always the case that military duties ought to override other duties. Sometimes other moral and ethical duties, such as those of military physicians, must take priority. As the Nuremburg Medical Trials indicate, military duties no longer have priority beyond a threshold of reasonable or moral actions.

§2: Nazis Revisited - Professional Subversions

There are various attempts to claim that successful conflict resolution is achieved if physician duties are allowed to override competing military duties. Some of the claims advocate a total separation of duties, such that physicians should never involve themselves with military duties. Other claims are based on the idea that professional autonomy, biased towards physician duties, would ensure ethical practices.

A common theme for the claim that physician duties ought to override military officer duties is that physicians should be allowed to exercise professional autonomy when deciding how to handle situations of ethical conflict and moral dilemma. It is argued that without this provision physicians may be forced to act in ways that cause harm to individuals, the overall mission of the military, and to the medical institution. It is suggested that when physicians are not allowed professional autonomy in the zealous pursuit of military objectives we risk destroying them as healers, undermine trust in physicians, and undermine trust in the medical institution.

In this section, I explore my interpretation of why these approaches are not satisfactory, despite the insights that they provide. In previous approaches there is an underlying implication that suggests professionals, such as physicians, are unquestionably moral when acting as professionals or that somehow a profession is independent from societal influences. The claims suggest that conflict exists when physicians are forced to mix their duties with non-physician activity and suggest that if physicians are allowed to act with full autonomy, that moral action ensues.

Given that many physicians are excellent role models for moral behavior, this impression is understandable as this is a testament to the many physicians who are above reproach in their professional and personal conduct. The danger is that the impression may blind us to the possible insidious ways in which professionals may be led to immoral practices. It may blind us to the possibility that sometimes "bad" people are in positions of trust and authority, allowing them to influence and tarnish the reputation of others.

Because of the potential for abuse, several claims have been made that suggest that physicians should not be left to their own devices when trying to adjudicate conflicts in duties. In this section, Nazi Germany is revisited to examine one possible motivation for this suggestion. This examination shows Nazi Germany as a historical example of what happens when (1) physician ideals shift from concentrating on individual patients to concentrating on societal needs, (2) physicians are allowed both unrestricted managerial and expertise autonomy and (3) language is used to transform the values and socially accepted ideals of medicine and ethical conduct.

§2.1: Barondess

Barondess presents an account of the rise of physician involvement with Nazi Germany. Barondess' account will help explain how physician duties, values, and activities radically shifted with the rise of the Third Reich.

According to Barondess, Germany was considered one of the most sophisticated countries in the world, leading in science and technology. Support for Nazism grew along with various social factors such as the eugenics movements of the 19th century, restructuring post-World War I society, social unrest and state regulations. As a consequence, "These

forces culminated in the restructuring of German medicine, making it an arm of the state policy."[293] Biomedicine became largely identified with National Socialism. As biomedicine became focused on state issues, there developed a conflict between the new state focus and that of the tradition of medicine. "But medicine differed from these in its explicit commitment to an ethical basis, to a humanitarian stance, and to a 2000-year-old Hippocratic ideal that placed the sufferer first and did not stratify the responsibilities of the physician on the basis of the social priorities of the state."[294]

In the late 19th and the early 20th centuries, there was a boom of using scientific theories to serve political and social prejudices. In particular, by 1920 "racial hygiene" was widely accepted as valid medical science. In Nazi Germany "medical metaphors increasingly emerged in efforts to justify the activities of National Socialism in 'treating' the country with 'applied biology.'"[295] Medical training became increasingly influenced by this applied biology. "By the end of 1934 the Kaiser Wilhelm Institute had trained 1100 physicians in what came to be called 'genetic and racial care.'"[296]

The medical profession was heavily involved with the Nazi movement, National Socialism, and Socialized Biology. "Physicians joined the Nazi Party not only earlier but in greater numbers than any other professional group. By 1937, physicians were represented in the *Schutzstaffel* [the infamous SS] 7 times more frequently than the average for the

[293] Jeremiah A. Barondess, "Medicine Against Society: Lessons from the Third Reich," JAMA 276 (1996): 1657.
[294] Ibid. 1657.
[295] Ibid. 1658.
[296] Ibid. 1658.

employed male population. By 1942 more than 38,000 physicians were party members, nearly half of all physicians in Germany."[297]

Various aspects of the Nazi movement appealed to the biomedical community. Nazi racial hygiene was perceived as an extension of social Darwinism. Physicians felt that they were now in a better position to help society. Professionally, physicians felt as if they were helping to return honor and dignity to Germany, and physicians felt that they were helping to prevent unemployment. Additionally, "there was a broad climate of dissatisfaction with the structure of the profession, based on concerns that medicine was becoming too business-like, overly scientific, and overly specialized."[298]

As anti-Semitism grew, these attitudes would have a profound impact on the changing role of medicine. In particular, there was a growing sentiment that society needed to rid itself of "burdensome" or "useless" lives. To accomplish this, Germany enacted a series of laws and programs to promote racial hygiene.[299]

The Sterilization Law in July of 1933 called for the "involuntary sterilization of anyone suffering from disease thought to be genetically determined."[300] Under this law, between 350,000 to 400,000 people were sterilized. The law gained wide appeal, including an endorsement by the American Eugenics Society, as it "established the political, legal, and operational feasibility of a massive program of eugenic control."[301]

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[297] Ibid. 1658. For comparison, reports suggest that currently about one-third to one-half of the physicians in the U.S. are members of the American Medical Association.
[298] Ibid. 1659.
[299] Ibid. 1659. See *Gesetz zur Verhutung erbkranken Nachevuchs von 14 Juli, 1933, mit Ausfuhrungsverordnung, Erlauterunger*, etc. Pp. 272. Munich, J.F. Lehmann's Verlag, 1934. For an English translation see Paul Popenoe, "The German sterilization law," Journal of Heredity 25:7 (1934), 257-260, on 259-260.
[300] Barondess, "Medicine Against Society," 1659.
[301] Ibid. 1659.

The next step of the racial hygiene program was the Nuremberg Laws of 1935. These laws were largely based on U.S. laws prohibiting marriages between whites and non-whites. They were also defended by the American Medical Association's practice of not admitting blacks into their organization. The Nuremberg Laws excluded Jews from citizenship and prevented marriage between Jews and non-Jews.[302]

The racial hygiene program continued with the T-4 program in October of 1939. Hitler ordered "mercy deaths" for patients "incurably sick by medical examination." This program began with children, expanded to include adults in mental institutions, and then steadily increased its "patients" until it included Jews, homosexuals, communists, Gypsies, Slavs, and prisoners of war. "By 1940 euthanasia had become part of normal hospital routine" and even when not under direct orders physicians and hospitals were empowered to act and received full support for acting on their own initiative.[303]

With the growing "success" of the racial hygiene movement, biomedical research began to organize around state and military interests reaching into such areas as brain studies, sterilization, execution, assassination, typhus treatment, rapid decompression techniques, freezing, seawater poisoning, transplants, burn treatments, radiation, twin studies, and congenital defects. Physicians were widely complicit concerning Nazi activities with physicians deciding who were subjects for experimentation, who died, and who remained prisoners.[304]

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[302] See, "The Nuremberg Laws," located at the Jewish Virtual Library: http://www.jewishvirtuallibrary.org/jsource/Holocaust/nurlaws.html for additional information.
[303] Barondess, "Medicine Against Society," 1659. The quote in this statement is also from Barondess.
[304] Ibid. 1659.

Physicians also oversaw executions and certified deaths. They were instrumental in administering the Nazi camps. "In short, the medical profession served not only as an instrument of Nazi mass murder, but was involved in the ideological theorizing and in the planning, initiation, administration, and operation of the killing programs."[305]

Part of the subversion of the medical profession in Nazi Germany was due to overwhelming social-political pressure. "The German medical profession had been indoctrinated for more than a decade by the Nazi Party apparatus, with relation to its special role in healing the country and in applying a radicalized eugenics to cleansing the *Volk* of inferior elements."[306] According to Barondess, after the war many physicians returned to practice as if nothing wrong had happened. It was relatively easy for them to reintegrate into society and the scientific community. Against this backdrop, Barondess offers a final thought. "For biomedicine a central lesson from the Nazi era is that the medical ethos is not immutable, but can be severely distorted by social and political forces and by perversion in the application of science and technology. The core values of medicine require protection, especially by an informed, engaged, and concerned profession."[307]

To help understand why many physicians thought that their actions were professionally sanctioned, consider Caplan's account of Nazi doctors.

§2.2: Caplan

Caplan's project is an inquiry into actions and the attempted defenses of biomedical professionals' practices under Nazi Germany. According to Caplan, "It is necessary to

[305] Ibid. 1660.
[306] Ibid. 1660.
[307] Ibid. 1661.

understand how those who committed horrific crimes on a mass scale were able to persuade themselves that what they were doing was ethically correct. Those who carried out mass murder, sterilization, and cruel experiments did so for reasons they believed were moral. This fact is difficult to accept for those who take ethics seriously."[308]

According to Caplan, "Rather than see Nazi biomedicine as morally bad, the field of bioethics has generally accepted the myths that Nazi biomedicine was either inept, mad, or coerced."[309] The "myth of incompetence" is the common belief "that only madmen, charlatans, and incompetents among doctors, scientists, public health officials, and nurses could possibly have associated with those who ran the Nazi party."[310] However, as Caplan observes, most medical personnel involved with the Nazi leaders were well trained in medicine and were often highly regarded within German society.

The "myth of madness" draws upon the vision of the "mad scientist," perhaps a Frankenstein, who must be psychologically unhinged, or mad, to have participated in the Nazi programs. Yet, Caplan counters, the logistics of running mass murder camps needs a vast support system. More than just madmen would have to be involved. "The technical and logistical problems of collecting, transporting, exploiting, murdering, scavenging, and disposing of the bodies of millions from dozens of nations required competence and skill, not ineptitude and madness."[311] Possibly unique in the history of genocide, "The Holocaust differs from other instances of genocide in that it involved the active participation of

[308] Arthur L. Caplan, "How Did Medicine Go So Wrong?" in *When Medicine Went Mad: Bioethics and the Holocaust.* (Totowa, NJ: Humana Press, 1992), 54-55.
[309] Ibid. 59.
[310] Ibid. 55.
[311] Ibid. 56.

medicine and science."[312] Quoting Lifton, Caplan claims that the medical involvement was necessary to allow Nazis to carry out their goals:

> Elite SS Troops, specially trained in mass killing, found it psychologically impossible to, on a daily basis, use machine guns and pistols at point blank range to kill tens of thousands of persons and dump their bodies in mass graves….It would not have been possible to achieve genocide on the desired scale and at the desired pace without the willing assistance of competent technological and biomedical expertise.[313]

The "myth of coercion" is the common belief that those who participated in the Nazi programs were coerced and unwilling participants. Although it is true that there was coercion and unwilling participation, the evidence suggests, according to Caplan, that most mainstream biomedicine professionals willingly joined the Nazi party and shared with its ideology. Many physicians, according to Caplan, willingly and enthusiastically embraced the Nazi vision.

"The Holocaust occurred," says Caplan, "with the intellectual support and the involvement of the medical and scientific establishment of the most scientifically and technologically advanced society of its time. The Holocaust, unlike many other instances of mass killing, was scientifically inspired, supervised, and mediated genocide."[314] Caplan claims that biomedicine was heavily involved with Nazism through direct involvement, providing the means, motives, and support for furthering Nazi goals. Biomedicine was complicit in a general failure to protect or resist the immoral actions of Nazi politics.

Consider what is known about experimentation in the Nazi camps. Medical personnel conducted approximately twenty-six types of "medical" experiments upon non-

[312] Ibid. 56.
[313] Ibid. 57.
[314] Ibid. 63.

consenting, coerced human beings. The "medical" or "scientific" merits of the experiments are questionable. As was explicated at the Nuremburg trials, "The evil inherent in Nazi medical experiments was not simply that people suffered and died but that they were exploited for science and medicine as they died."[315] Some of the suffering was so great, and some of the practices were so disturbing, that people recruited to help researchers with the experiments refused to help.[316]

Caplan's central question is "How did physicians and scientists convince themselves that murderous experimentation was morally justified?"[317] Caplan identifies six defenses used by biomedical professionals.

First, biomedical and military personnel claimed that test subjects were volunteers and might be freed if they survived. This is, as we know, simply false. The test subjects were not "volunteers" in any morally relevant sense. Additionally, many of the testing activities were "terminal experiments," meaning that death had to occur for the experiment to "succeed."

Second, the biomedical and military personnel claimed that only people "doomed" to die were used. By "doomed" they seem to have meant criminals sentenced to die or people with terminal conditions close to death. Again, this is known to be untrue. Even in the cases where a test subject was sentenced to die, standard ethics suggest that it was not legitimate to use them as experimental instruments in goals they did not actively endorse.

Third, biomedical and military personnel claimed that participation in Nazi experiments was offered as expiation to subjects, that is, participation was offered as a

[315] Ibid. 65.
[316] See Caplan or Lifton for details.
[317] Caplan, "How Did Medicine Go So Wrong?" 70.

"cleansing" of their crimes. This was false since most people used in medical experiments were considered "guilty" because of "crimes" related to race, political views, or genetics. As with the previous defense, even if someone were legitimately guilty of a crime, it is implausible to suggest that victims in the atrocities of Nazi experimentation would in some sense be "cleansed" of their guilt.

Fourth, biomedical and military personnel claimed that since medicine and science are value neutral, then medical and scientific experiments are also value neutral. Additionally, they claimed that since they were acting under state authority they were not themselves responsible for their actions. This is the familiar "I was following orders" defense. Interestingly, Caplan does not refute this claim. However, we can readily see that even if it is true that medicine and science are value neutral, that does not necessarily mean that experiments done in the pursuit of medical or scientific knowledge are also value neutral.

Fifth, biomedical and military personnel claimed that when working for the defense and security of the state, there was a different morality during war. Again, this claim is not really addressed by Caplan. However, the claim is closely related to the next one, which Caplan does refute.

Sixth, biomedical and military personnel claimed that it was reasonable to sacrifice the interests of the few for the benefit of the society. An analogy is made with this defense with respect to common practices of the Allied armies. Nazis claimed that given the Allied practice of drafting soldiers then using these soldiers as experimental subjects, it seemed similarly justified to "draft" test subjects into their medical programs. Caplan counters this

by claiming that "in the context of the Nazi regime, it is fair to point out that sacrifice was not born equally by all as is true of a compulsory draft that allows no exceptions. It is also true that many would argue that no degree of benefit should permit intrusion into certain fundamental rights."[318]

Based on his analysis of these six defenses, Caplan concludes that:

> Time and again physicians and public health officials at the [Nuremburg] trials refer to the threat posed by 'inferior races' and 'useless eaters' to the welfare of the Reich. The paradigm of the state metaphorically facing a biological threat to its overall well-being that could only be alleviated by the kind of medical interventions doctors would use to fight disease within the body is reflected in the medical literature and training of health care professionals both before and during the war.[319]

The concern, when considering the relationship of physician duties to other duties, is that "The biomedical paradigm provided the theoretical basis for allowing those sworn to the Hippocratic principle of nonmaleficence to kill in the name of the state." Caplan ends his article by stating that "…those who teach bioethics in the hope that it can effect conduct or character must come to terms with the fact that biomedicine's role in the Holocaust was frequently defended on moral grounds."[320]

The next section illustrates how language is used to transform the values and ideals of medicine and ethical conduct. Lifton's account of "socialized biology" which details a paradigm shift in medical duties—a shift in focus from individual patients to social groups which involves a role change from medical healer to medical killer—provides the key to understanding the role of language.

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[318] Ibid. 76.
[319] Ibid. 77.
[320] Ibid. 78.

§2.3: Lifton

According to Lakoff and Johnson, "The people who get to impose their metaphors on the culture get to define what we consider to be true—absolutely and objectively true."[321] Robert Jay Lifton's *The Nazi Doctors: Medical Killing and the Psychology of Genocide* provides an insight into how Nazi Germany used biological and medical metaphors to institute a program that most people agree is highly unethical—Genocide. This section reviews some of the metaphors used by the Nazis to define social-political-medical "truth." This review will show how biological ideology and metaphor was used to undermine and subvert the role of the physician. This will, in turn, be used to suggest why, and under what circumstances, it is best to not suggest that physician duties should *always* override military duties. As will be seen, there is a danger in uncritically suggesting that professional medical autonomy, in the guise of pursuing professional ideals, should override military duties just as there is a danger in uncritically suggesting that military duties should override professional medical duties.

How can language, and in particular metaphor, influence the practice of a profession? Consider two basic questions in medical ethics; "What is the role of the physician?" and "What is the physician's relationship to his patient?" As previously indicated, physicians are typically seen as healers and caretakers of their individual patients. James F. Childress and Mark Siegler discuss five contemporary metaphors used to understand the physician-patient relationship.[322]

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[321] George Lakoff and Mark Johnson, *Metaphors We Live By*, Chicago: The University of Chicago Press, 1980. 160.

[322] James Childress and Mark Siegler, "Metaphors and Models of Doctor-Patient Relationships: Their Implications for Autonomy." Reprint in: Mappes and DeGrazia's, *Biomedical Ethics*, 64-72.

The first metaphoric relationship is "Parental" or "Paternalism." This relationship is one in which the physician assumes the role of a parent, while the patient is either a passive infant or a guided adolescent. This metaphor stresses that the physician knows best, while the patient has few rights and little or no autonomy in determining appropriate treatment plans. The parental model assumes ignorance on the part of the patient and does not consider that the physician and patient may have differing views, and values, when it comes to health care.

The second metaphoric relationship is that of "Partnership." This relationship stresses that both physician and patient are partners in a shared value of health. This adult-to-adult model highlights the equal power between patient and physician and downplays the assumed ignorance of the parental metaphor. There is not an automatic assumption that the physician initially knows what is best for the patient. However, it presupposes a trust that may be unjustified. It assumes that the patient must trust the physician to act in the patient's best interests, and the physician must trust that the patient will participate in knowledgeable health care decisions.

The third metaphoric relationship is that of "Rational Contracts." This relationship stresses a compromise between the ideal partnership and the realization that trust is not immediately possible between a physician and a patient. It highlights two possible misleading ideas: (a) sick people view health care as an exchange in goods and services; (b) sick people are always able to make rational choice. The rational contract downplays the ideas of physician benevolence, care, and compassion.

The fourth metaphoric relationship is based on "Friendship." This relationship is based on the role of the "good old country doctor" or "friend." Friendship stresses how one person, the doctor, assumes the interest of the other, the patient. Although a common metaphor for areas with low populations, the metaphor becomes strained in areas with high populations, HMOs, and doctors with conflicting interests. It can also become strained as the "friendship" is somewhat based on payment for services.

The final metaphoric relationship is that of a "Technician." This relationship treats the doctor as a plumber, engineer, or body mechanic – merely fixing what is broken or contracted for. This model highlights the new advanced technology that medicine depends upon, yet downplays the social status traditionally given to a physician.

These five metaphors capture the most common views of the relationship of the physician to their patients. In particular, each metaphor highlights a relationship between a doctor and his individual patient, but also downplays the relationship of a physician to the general public or society-at-large. Although Nazi doctors practiced with certain elements of the parental and technician models, the Nazi party incorporated new metaphors that radically changed the physician-patient dynamic and the traditional role of the physician as healer.

The Nazi doctors worked under biological and medical metaphors that (1) changed the physician-patient relationship to focus on society and (2) systematically made acceptable a different metaphor for the physician—from Physician Healer and Caretaker to the Physician Healer and Killer. This changing role of the physician was partially the result of misguided social and biological ideology that was advanced and made acceptable partly by medical metaphor.

The social and biological ideology the Nazis used was a combination of pseudoscientific genetics and eugenics. From genetics, the Nazi leaders instilled the ideas of "racial purity" and the "inherent Aryan virtue." These ideas prompted a rationalization to adopt a program of eugenics in which the Nazis hoped to achieve direct control over human progress. Lifton speaks of this Nazi state as a "biocracy" which models itself from "theocracy, a system of rule by priests of a sacred order under the claim of divine prerogative…of cure through purification and revitalization of the Aryan race."[323] The Nazi leaders made use of both a divine mission, part of a cultural obsession with anti-Semitism, and misguided, although scientific sounding, biological ideals.

The eugenics program in Germany began much as other eugenics programs in Western Europe and the United States. Negative eugenics was practiced by prohibiting marriage between individuals with mental illness or retardation, and by prohibiting marriage between members of different races.[324] Negative eugenics was also practiced by instituting forced sterilization laws for the criminal or insane.[325]

Positive eugenics was practiced by actively encouraging specific marriages, or rewarding individuals who contributed to the state ideal of socialized medicine. In an attempt to create a pure and perfect race, the Nazi Party carried the theories of eugenics to the extreme, eventually leading to Nazi Germany's involvement in genocide. In this respect, Lifton identifies a 5-step progression to mass murder within the Nazi biocracy: (1) Sterilization, (2) Child Euthanasia, (3) Adult Euthanasia, (4) Direct Medical Killings, and

[323] Lifton, *The Nazi Doctors*. 17.
[324] Ibid. 23.
[325] See United States Supreme Court case Buck v. Bell, 274 U.S. 200 (1927) or Steven Jay Gould's "Carrie Buck's Daughter" for more information regarding sterilization laws in the U.S.

(5) Mass Murder. The Nazi justification and promotion of this process relied, in a large part, on using biological metaphors.

The first step in promoting the justification of mass murder, in a biological context, was to destroy the distinction between healing and killing. That is, the Nazis needed to undermine the popular beliefs that healing, by a physician, is automatically morally praiseworthy while killing, again by a physician, is automatically morally reprehensible. To undermine these beliefs, Nazi propagandists initiated a notion of *medicalized killing*—killing understood as both a surgery and a therapeutic imperative.[326] From the Nazi military point of view, this understanding had positive effects. Nazi command was aware that the *Einsatzgruppen* troops[327] were suffering from psychological problems due to the nature of their executions. Interpreting these executions as necessary to protect the health of the state would lessen the stress felt by the troops.

The troops suffered signs of what we now know as moral distress: anxiety, nightmares, and tremors. In a desire to decrease moral distress and, more importantly to the Nazi scheme, increase the effectiveness of mass killings, Nazi command needed to find a "surgical" means of killing. A "surgical" distinction would allow soldiers in the trenches, so to speak, to mentally distance themselves from the psychological horror of murder by adding a patina of legitimacy to the mass killing of innocent people.

The idea of "medical killing" would justify mass murder because the killing would then be a "therapeutic" imperative for the German (Aryan) people. This was accomplished by first dichotomizing humans into either the "racially pure Aryan Volk" or into "the Impure

[326] Lifton, *The Nazi Doctors*. 15.
[327] These troops were special units of soldiers responsible for face-to-face killing of Jews in Eastern Europe.

Other." By means of metaphors, the Nazis then re-conceptualized the Aryan race into a "pure" biological organism. Simultaneously, the Nazi Party re-conceptualized non-Aryans into "impure" biological organisms that presented a potential threat of disease to the Aryan organism. As this was now a "medical" situation, medical workers, including physicians, assumed new roles involved with "healing" the society by killing the "impure" elements of it. When a physician was confronted with the apparent contradiction between healing and killing, he could claim:

> Of course I am a doctor and I want to preserve life. And out of respect for human life, I would remove a gangrenous appendix from a diseased body. The Jew is the gangrenous appendix in the body of mankind.[328]

Physicians were transformed from serving the individual patient to serving a social organism, a transformation which included assuming the dual role of healer and killer.

The Nazis were masters of using metaphors to manipulate the cognitive understanding of the German people to influence how "Germans" viewed groups the Nazis wanted to eliminate. There were many metaphors that the Nazis used to describe the Jewish people. One group of metaphors focused on the organism metaphor and medical notions used for treating illness and disease: the Jews are agents of racial pollution and racial tuberculosis; the Jews are parasites and bacteria causing sickness, deterioration, and death; the Jews are eternal bloodsuckers, vampires; the Jews are germ carriers, maggots in a rotting corpse. This new Nazi medical reasoning promoted the idea that it was of biological or medical importance to eliminate the Jewish people.

Another group of metaphors were employed to focus the Nazi perception that the Jewish people were less than human: the Jews are ants – thus they must be exterminated

[328] Lifton, *The Nazi Doctors*. 16.

before they overrun the country; the Jews are wild dogs – thus they are dangerous and should be killed, and can be used in medical experiments to better society.

The underlying ideology of the mass-killings relied upon pseudoscientific ideas of racial purity, genetics, and eugenics.[329] The justification further painted a picture of the German Volk as a biological organism that was threatened by disease. This conception invited the idea of a medical solution which, in turn, tried to justify mass killing as analogous to killing the cancer of humanity. This further changed the role of the physician from a healer to a killer.

By utilizing and imposing certain metaphors, the Nazi leadership was able to cognitively alter belief structures which transformed physician professionalism and the physician-patient relationship. The conceptual structures convinced people that there was a need for a national "cure" for "the Jewish problem." The Nazis heavily pushed the idea of the Regime as a Healing Movement, or as Rudolf Hess declared, "National Socialism is nothing but applied biology."[330]

Within the Nazi medical community there were many metaphors the doctors used to justify their participation in murder. The underlying metaphor justifying sterilization and medical killing was *lebensunwertes Leben*, "life unworthy of life." This phrase permeates the entire five-step program to genocide: Sterilization → Child Euthanasia → Adult Euthanasia → Direct Killing → Mass Murder.

Sterilization started with cases of the criminally insane. It then included the hereditary sick: congenital feeblemindedness, schizophrenia, epilepsy, manic-depressive

[329] Genetics itself is a science; the Nazi application of it was not. The Nazis taught that the Aryan race was descended from Atlantis while non-Aryans were descended from monkeys and apes.
[330] Lifton, *The Nazi Doctors*. 129.

insanity, Huntington's chorea, hereditary blindness, hereditary deafness, grave bodily malformation, hereditary alcoholism, and so on. The Nazis attempted to justify sterilization by claiming that people with those medical conditions represented a threat to the organic body of the pure German Volk. Continued reproduction, so their fears ran, represented the threat of spreading more of "their kind" like a cancer, sucking nourishment from society until the social organism died.

The medical metaphor of group X as a cancer was quickly assimilated by the Nazi culture, thereby increasing the belief that group X was consuming valuable limited public resources. For many Germans this seemed unfair. "The best young men died in war, causing a loss to the Volk of the best available genes. The genes of those who did not fight then proliferated freely, accelerating biological and cultural degeneration."[331] These hereditary sick were further made less human by being identified by metaphors such as "this person is mentally dead," "that person is merely human ballast," or "that group represents empty shells."[332]

The Nazi party, including the medical profession and military profession, made use of metaphors at three levels. First, there was the ever-present biological assumption of an organism, the German Volk, protecting itself from a biological harm, such as the spread of cancer. This gave rise to the idea that the cancer must be stopped from spreading. Second, there was an idea that the organism, the German Volk, was being crowded in its natural environment and unable to continue its genetic heritage because there was a direct threat to its genetic future. Third and most important for people who must work directly with the

[331] Ibid. 47.
[332] Ibid. 47.

hereditary sick, were the dehumanizing metaphors. The metaphorical beliefs contributed to feelings of resentment and the changing attitude towards non-Aryans. The metaphors further represented the cognitive transition to the next level of the Nazi eugenics program – medical killings disguised as euthanasia.

The Nazis instituted two distinct programs of euthanasia, one for children and one for adults. Once more playing to the influence of the organic metaphors and the biological threat to the body, to the Nazi mindset, people with hereditary sickness where using valuable resources. Sterilization was not doing enough to combat the problem of dwindling resources. This became seen as a large scale triage problem at a society level. Not only did the Nazis feel that they had to stop the cancer from spreading, they felt the need to remove the cancer from the body.

The next step of the eugenics program involved killing children (newborns to approximately five-year olds) with hereditary conditions. Doctors used pseudo-biological reasoning to justify their actions. "These creatures [the children] naturally represent for me as a National Socialist only a burden for the healthy body of our Volk."[333] Although a person would think that the systematic killing of children would be a difficult and horrifying task for a doctor, many Nazis used the organic and health metaphors to lessen the difficulty. The psychological burden was further lessened as doctors used metaphors as euphemisms for killing, for example "putting-to-sleep," or "slow withdrawal of rations."

The adult euthanasia program followed similar reasoning and justification—protect the race while putting sick people out of their misery. The adult program, named T4,

[333] Ibid. 62. The speaker is Dr. Hermann Pfannmuller, one of the Nazi doctors who developed various "Special Diets" that starved patients to death.

extended the medical oversight of killing to include (1) patients suffering from specific disease, (2) patients institutionalized for more than five years, (3) the criminally insane, and (4) non-German citizens.[334] The doctors' involvement with this program of killing included: (1) identify people to be given "Special Treatment," (2) perform the actual killing by injecting lethal medication, by ordering "special diets," or by experimenting with gasses to come up with a more "humane" way of killing, (3) calm the patients who were to be killed, (4) disguise the killing process, (5) falsify the death-certificate, and (6) develop new technology to increase the killing process. By participating in the "euthanasia" programs, the doctors had redefined their roles from "medical healer" to "medical killer."[335]

The T4 program officially ended around August 24, 1941. The Nazi regime, however, made it clear to physicians that medical killing should continue. With no official policy of medical killing, individual doctors were left to their own discretion to select and administer killings. Physicians continued to use metaphors, such as calling mental patients "useless eaters," to justify their actions. Moreover, physicians had more freedom to experiment with killing techniques. For example, the "useless eaters" were given special, totally fat free diets to ensure that they died.[336]

As new technology was developed to kill patients, concepts of the T4 program were extended to the concentration camps under code 14f13. In the camps, people were selected to die with emphasis based on crimes, political views, and race. Yet, the selection process

[334] Lifton, *The Nazi Doctors*. 65-66.
[335] Ibid. n.r.
[336] Ibid. n.r.

still continued to use medical myth and metaphors of health. The 14f13 program "provided two crucial bridges between existing concepts and policies and unrestrained genocide."[337]

The first bridge was "the ideological bridge from the killing of those considered physiologically unworthy of life to the elimination, under the direction of doctors, of virtually anyone the regime considered undesirable or useless: that is, from direct medical to medicalized killing."[338] The second bridge was "the institutional bridge from the T4 project to the concentration camps."[339] The camps themselves provided insight into medical action that was influenced by metaphor.

The Nazi camps represented the "final solution to the Jewish question." The Nazis employed very powerful metaphors to try to justify their actions. From the Nazi point of view, the "Jewish question" was: Given that the German Volk is a body and the Jews are a disease that threatens the Volk, how do we protect the body? Using medical metaphors, the solution was to rid the body of the disease. Genocide became legitimized as a medical procedure as "A[n] image of curing a deadly disease, so that genocide may become an absolute form of killing in the name of healing."[340]

Within the Nazi camps, selections for death were perceived as similar to medical triage in war.[341] Inhumane medical experiments were viewed either as necessary duties to the military state or as "hobbies."[342] Gas chambers were sometimes referred to as "The Central Hospital."[343] Prisoners were often called "The Living Dead."[344]

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[337] Lifton, *The Nazi Doctors*. 138.
[338] Ibid. 138.
[339] Ibid. 138.
[340] Ibid. 467.
[341] Ibid. 173.
[342] Ibid. 201.
[343] Ibid. 244.

Lifton's book provides insight into how extensive medical metaphors were utilized by the Nazis, including both medical and military professionals. One pattern that emerges is that the Nazis used *organic* metaphors to attempt to justify what they did, yet used *mechanical* metaphors to carry out the medicalized killings. Both types of metaphors were also used as part of the Nazi defense in attempts to justify why they did not try to stop the killings.

During the Nuremburg Trials, the defense attempted to justify the actions of the physicians by claiming that the procedure at the camps was very mechanical. The selections and killings were constantly pushed to be faster. The camps were ran like manufacturing plants, with an assembly line precision which made the Nazi killing machine cold and lifeless. Even if a participant thought that something was immoral about the process, they felt helpless to change the process. Many participants described feeling as mere cogs in the machine, or like simple tools in the apparatus, with no idea what the rest of the machine was doing. The final defense argument was that the defendants were "just following orders."

The Nazis used organic and mechanical metaphors to shape and define the perception of the nature of reality. From what we have seen, some of the atrocities committed by doctors can be partially attributed to the physicians' belief in the metaphorical reality of the society to which they belonged. They believed that the metaphors accurately described the state of affairs of the world. Physicians embraced activities which we now perceive as highly unethical and contrary to all moral belief.

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[344] Ibid. 425.

Appendix 4: Nuremburg Charges[345]

COUNT ONE -- THE COMMON DESIGN OR CONSPIRACY

1. Between September 1939 and April 1945 all of the defendants herein, acting pursuant to a common design, unlawfully, willfully, and knowingly did conspire and agree together and with each other and with divers other persons, to commit War Crimes and Crimes against Humanity, as defined in Control Council Law No. 10, Article II.

2. Throughout the period covered by this Indictment all of the defendants herein, acting in concert with each other and with others, unlawfully, willfully, and knowingly were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the commission of War Crimes and Crimes against Humanity.

3. All of the defendants herein, acting in concert with others for whose acts the defendants are responsible unlawfully, willfully, and knowingly participated as leaders, organizers, instigators, and accomplices in the formulation and execution of the said common design, conspiracy, plans and enterprises to commit, and which involved the commission of, War Crimes and Crimes against Humanity.

4. It was a part of the said common design, conspiracy, plans and enterprises to perform medical experiments upon concentration camp inmates and other living human subjects, without their consent, in the course of which experiments the defendants committed the murders, brutalities, cruelties, tortures, and other inhumane acts, here fully described in Counts Two and Three of the Indictment.

5. The said common design, conspiracy, plans and enterprises embraced the commission of War Crimes and Crimes against Humanity, as set forth in Counts Two and Three of this Indictment, in that the defendants unlawfully, willfully, and knowingly encouraged, aided, abetted, and participated in the subject[ing] of thousands of persons, including civilians, and members of the armed forces of nations then at war with the German Reich, to murders, brutalities, cruelties, tortures, atrocities, and other inhumane acts.

COUNT TWO -- WAR CRIMES

6. Between September 1939 and April 1945 all of the defendants herein unlawfully, willfully, and knowingly committed War Crimes, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving medical

[345] Nuremburg transcripts are from the University of Missouri-Kansas City (UMKC) School of Law collection "Famous Trials." Access to the Nuremberg Trials is available at http://www.law.umkc.edu/faculty/projects/ftrials/nuremberg/nuremberg.htm

experiments without the subject's consent, upon civilians and members of the armed forces of nations then at war with the German Reich and who were in the custody of the German Reich in exercise of belligerent control, in the course of which experiments the defendants committed murders, brutalities, cruelties, tortures, atrocities, and other inhumane acts. Such experiments included, but were not limited to, the following:

(A) HIGH ALTITUDE EXPERIMENTS. From about March 1942 to about August 1942 experiments were conducted at the Dachau Concentration Camp for the benefit of the German Air Force to investigate the limits of human endurance and existence at extremely high altitudes. The experiments were carried out in a low-pressure chamber in which the atmospheric conditions and pressures prevailing at high altitude (up to 68,000 feet) could be duplicated. The experimental subjects were placed in the low-pressure chamber and thereafter the simulated altitude therein was raised. Many victims died as a result of these experiments and other suffered grave injury, torture, and ill treatment. The defendants Karl Brandt, Handloser, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Ruff, Romberg, Becker-Freyseng, and Weltz are charged with special responsibility for and participation in these crimes.

(B) FREEZING EXPERIMENTS. From about August 1942 to about May 1943 experiments were conducted at the Dachau Concentration Camp primarily for the benefit of the German Air Force to investigate the most effective means of treating persons who had been severely chilled or frozen. In one series of experiments the subjects were forced to remain in a tank of ice water for periods up to three hours. Extreme rigor developed in a short time. Numerous victims died in the course of these experiments. After the survivors were severely chilled, rewarming was attempted by various means. In another series of experiments, the subject[s] were kept nake[d] outdoors for many hours at temperatures below freezing. The victims screamed with pain as parts of their bodies froze. The defendants Karl Brandt, Handloser, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Becker-Freyseng, and Weltz are charged with special responsibility for and participation in these crimes.

(C) MALARIA EXPERIMENTS From about February 1942 to about April 1945 experiments were conducted at the Dachau Concentration Camp in order to investigate immunization for and treatment of malaria. Healthy concentration camp inmates were infected by mosquitoes or by injections of extracts of the mucous glands of mosquitoes. After having contracted malaria the subjects were treated with various drugs to test their relative efficacy. Over 1,000 involuntary subjects were used in experiments. Many of the victims died and others suffered severe pain and permanent disability. The defendants Karl Brandt, Handloser, Rostock, Gebhardt, Blome, Rudolf Brandt, Mrugowsky, Poppendick, and Sievers are charged with special responsibility for and participation in these crimes.

(D) LOST (MUSTARD) GAS EXPERIMENTS. At various times between September 1939 and April 1945 experiments were conducted at Sachsenhausen, Natzweiler, and other concentration camps for the benefit of the German Armed Forces to investigate the most

effective treatment of wounds caused by Lost gas. Lost is a poison gas which is commonly known as Mustard gas. Wounds deliberately inflicted on the subjects were infected with Lost. Some of the subjects died as a result of these experiments and others suffered intense pain and injury. The defendants Karl Brandt, Handloser, Blome, Rostock, Gebhardt, Rudolf Brandt, and Sievers are charged with special responsibility for and participation in these crimes.

(E) SULFANILAMIDE EXPERIMENTS. From about July 1942 to about September 1943 experiments to investigate the effectiveness of sulfanilamide were conducted at the Ravensbruck Concentration Camp for the benefit of the German Armed Forces. Wounds deliberately inflicted on the experimental subjects were infected with bacteria such as streptococcus, gas gangrene, and tetanus. Circulation of blood was interrupted by tying off blood vessels at both ends of the wound to create a condition similar to that of a battlefield wound. Infection was aggravated by forcing wood shavings and ground glass into the wounds. The infection was treated with sulfanilamide and other drugs to determine their effectiveness. Some subjects died as a result of these experiments and others suffered serious injury and intense agony. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Gen[z]ken, Gebhardt, Blome, Rudolf Brandt, Mrugowsky, Poppendick, Becker-Freyseng, Oberheuser, and Fischer are charged with special responsibility for and participation in these crimes.

(F) BONE, MUSCLE, AND NERVE REGENERATION AND BONE TRANSPLANTATION EXPERIMENTS. From about September 1942 to about December 1943 experiments were conducted at the Ravensbruck Concentration Camp for the benefit of the German Armed Forces to study bone, muscle, and nerve regeneration, and bone transplantation from one person to another. Sections of bones, muscles, and nerves were removed from the subjects. As a result of these operations, many victims suffered intense agony, mutilation, and permanent disability. The defendants Karl Brandt, Handloser, Rostock, Gebhardt, Rudolf Brandt, Oberheuser, and Fischer are charged with special responsibility for and participation in these crimes.

(G) SEAWATER EXPERIMENTS. From about July 1944 to about September 1944 experiments were conducted at the Dachau Concentration Camp for the benefit of the German Air Force and Navy to study various methods of making seawater drinkable. The subjects were deprived of all food and given only chemically processed seawater. Such experiments caused great pain and suffering and resulted in serious bodily injury to the victims. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Becker-Freyseng, Schaefer, and Beiglebock are charged with special responsibility for and participation in these crimes.

(H) EPIDEMIC JAUNDICE EXPERIMENTS. From about June 1943 to about January 1945 experiments were conducted at the Sachsenhausen and Natzweiler Concentration Camps for the benefit of the German Armed Forces to investigate the causes of, and inoculations against, epidemic jaundice. Experimental subjects were deliberately infected

with epidemic jaundice, some of whom died as a result, and others were caused great pain and suffering. The defendant[s] Karl Brandt, Handloser, Rostock, Schroeder, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Rose, and Becker-Freyseng are charged with special responsibility for and participation in these crimes.

(I) STERILIZATION EXPERIMENTS. From about March 1941 to about January 1945 sterilization experiments were conducted at the Auschwitz and Ravensbruck Concentration Camps, and other places. The purpose of these experiments was to develop a method of sterilization which woul[d] be suitable for sterilizing millions of people with a minimum of time and effort. These experiments were conducted by means of X-Ray, surgery, and various drugs. Thousands of victims were sterilized and thereby suffered great mental and physical anguish. The defendants Karl Brandt, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Brack, Pokorny, and Oberh[e]user are charged with special responsibility for and participation in these crimes.

(J) SPOTTED FEVER EXPERIMENTS. From about December 1941 to about February 1945 experiments were conducted at the Buchenwald and Natzweiler Concentration Camps for the benefit of the German Armed Forces to investigate the effectiveness of spotted fever [i.e., typhus] and other vaccines. At Buchenwald numerous healthy inmates were deliberately infected with spotted fever virus in order to keep the virus alive; over 90% of the victims died as a result. Other healthy inmates were used to determine the effectiveness of different spotted fever vaccines and of various chemical substances. In the course of these experiments 75% of the selected number of inmates were vaccinated with one of the vaccines or nourished with one of the chemical substances and, after a period of three to four weeks, were infected with spotted fever germs. The remaining 25% were infected without previous protection in order to compare the effectiveness of the vaccines and the chemical substances. As a result, hundreds of the persons experimented upon died. Experiments with yellow fever, smallpox, typhus, paratyphus A and B, cholera, and diphtheria were also conducted. Similar experiments with like results were conducted at Natzweiler Concentration Camp. The defendants Karl Brandt, Handloser, Rostock, Schroeder, Genzken, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Rose, Becker-Freyseng, and Hoven are charged with special responsibility for and participation in these crimes.

(K) EXPERIMENTS WITH POISON. In or about December 1943 and in or about October 1944 experiments were conducted at the Buchenwald Concentration Camp to investigate the effect of various poisons upon human beings. The poisons were secretly administered to experimental subjects in their food. The victims died as a result of the poison or were killed immediately in order to permit autopsies. In or about September 1944 experimental subjects were shot with poison bullets and suffered torture and death. The defendants Genzken, Gebhardt, Mrugowsky, and Poppendick are charged with special responsibility for and participation in these crimes.

(L) INCENDIARY BOMB EXPERIMENTS. From about November 1943 to about January 1944 experiments were conducted at the Buchenwald Concentration Camp to test the effect of various pharmaceutical preparations on phosphorus burns. These burns were inflicted on experimental subjects with phosphorus matter taken from incendiary bombs, and caused severe pain, suffering, and serious bodily injury. The defendants Genzken, Gebhardt, Mrugowsky, and Poppendick are charged with special responsibility for and participation in these crimes.

7. Between June 1943 and September 1944 the defendants Rudolf Brandt and Sievers unlawfully, willfully, and knowingly committed War Crimes, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder of civilians and members of the armed forces of nations then at war with the German Reich and who were in the custody of the German Reich in exercise of belligerent control. One [h]under twelve Jews were selected for the purpose of completing a skeleton collection for the Reich University of Strasbourg. Their photographs and anthropological measurements were taken. Then they were killed. Thereafter, comparison tests, anatomical research, studies regarding race, pathological features of the body, form and size of the brain, and other tests, were made. The bodies were sent to Strassbourg and defleshed.

8. Between May 1942 and January 1943 the defendants Blome and Rudolf Brandt unlawfully, willfully, and knowingly committed War Crimes, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murder and mistreatment of tens of thousands of Polish nationals who were civilian and members of the armed forces of a nation then at war with the German Reich and who were in the custody of the German Reich in exercise of belligerent control. These people were alleged to be infected with incurable tuberculosis. On the group [sic; pretense] of insuring the health and welfare of Germans in Poland, many tubercular Poles were ruthlessly exterminated while others were isolated in death camps with inadequate medical facilities.

9. Between September 1939 and April 1945 the defendants Karl Brandt Blome, Brack, and Hoven unlawfully, willfully, and knowingly committed War Crimes, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the execution of the so-called "euthanasia" program of the German Reich in the course of which the defendants herein murdered hundreds of thousands of human beings, including nationals of German-occupied countries. This program involved the systematic and secret execution of the aged, insane, incurably ill, of deformed children, and other persons, by gas, lethal injections, and divers other means in nursing homes, hospitals, and asylums. Such persons were regarded as "useless eaters" and a burden to the German war machine. The relatives of these victims were informed that they died from [n]atural causes, such as heart failure. German doctors involved in the "euthanasia" program were also sent to the Eastern occupied countries to assist in the mass extermination of Jews.

10. The said War Crimes constitute violations of international conventions, particularly of Articles 4, 5, 6, 7, and 46 of the Hague Regulations, 1907, and of Articles 2, 3, and 4 of the Prisoner-of-war Convention (Geneva, 1929), the laws and customs of war, the general principles of criminal law as derived from the criminal laws of all civilized nations, the internal penal laws of the countries in which such crimes were committed, and of Article II of Control Council Law No. 10.

COUNT THREE -- CRIMES AGAINST HUMANITY.

11. Between September 1939 and April 1945 all of the defendants herein unlawfully, willfully, and knowingly committed Crimes against Humanity, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving medical experiments, without the subjects' consent, upon German civilians and nationals of other countries, in the course of which experiments the defendants committed murders, brutalities, cruelties, tortures, atrocities, and other inhumane acts. The particulars concerning such experiments are set forth in Paragraph 6 of Count Two of this Indictment and are incorporated herein by reference.

12. Between June 1943 and September 1944 the defendants Rudolf Brandt and Si[e]vers unlawfully, willfully, and knowingly committed Crimes against Humanity, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the murders of German civilians and nationals of other countries. The particulars concerning such murders are set forth in Paragraph 7 of Count Two of this Indictment and are incorporated herein by reference.

13. Between May 1942 and January 1943 the defendants Blome and Rudolf Brandt unlawfully, willfully, and knowingly committed Crimes against Humanity, as defined by Article II of Control Council Law No. 10, in that they were principals in, accessories to, ordered, abetted took a consenting part in, and were connected with plans and enterprises involving the murder and mistreatment of tens of thousands of Polish nationals. The particulars concerning such murder and inhumane treatment are set forth in Paragraph 8 of the Count two of this Indictment and are incorporated herein by reference.

14. Between September 1939 and April 1945 the defendants Karl Brandt, Blome, Brack, [and] Hoven unlawfully, willfully, and knowingly committed Crimes against Humanity, as defined by Article II of Control [sic] Council Law No. 10, in that they were principals in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the execution of the so-called "euthanasia" program of the German Reich, in the course of which the defendants herein murdered hundreds of thousands of human beings, including German civilians, as well as civilians of other nations. The particulars concerning such murders are set forth in Paragraph 9 of Count Two of this Indictment and are incorporated herein by reference.

15. The said Crimes against Humanity constitu[t]e violations of international conventions, including Article 46 of the Hague Regulations, 1907 the laws and customs of war, the general principles of criminal law as derived from the criminal laws of all civilized nations, the internal penal laws of the countries in which such crimes were committed, and of Article II of Control Council Law No. 10.

COUNT FOUR -- MEMBERSHIP IN CRIMINAL ORGANIZATION

16. The defendants Karl Brandt, Genzken, Gebhardt, Rudolf Brandt, Mrugowsky, Poppendick, Sievers, Brack, Hoven, and Fischer are guilty of membership in an organization declared to be criminal by the International Military Tribunal in Case No. 1 in that each of the said defendants was a member of DIE SCHUTZSTAFFELN DER NATIONAL SOZIALISTISCHEN DEUTSCHEN ARBEITER-PARTEI commonly known as the "SS" after 1 September 1939. Such membership is in violation of Paragraph I (d) Article II of Control Council Law No. 10.

Appendix 5: Just War Theory—Conditions

A full account of Just War Theory is beyond the scope of this paper. However, the basics are captured from a statement made by the National Conference of Catholic Bishops, *The Challenge of Peace: God's Promise and Our Response. Jus ad bellum* requires meeting the following conditions:

1. Just Cause: "War is permissible only to confront 'a real and certain danger,' i.e., to protect innocent life, to preserve conditions necessary for decent human existence, and to secure basic human rights."
2. Competent Authority: "[W]ar must be declared by those with responsibility for public order, not by private groups or individuals."
3. Comparative Justice: "In recognition of the fact that there may be some justice on each side, "[e]very party to a conflict should acknowledge the limits of its 'just cause' and the consequent requirement to use *only* limited means in pursuit of its objectives."
4. Right Intention: "[W]ar can be legitimately intended only for the reasons set forth above as a just cause."
5. Last Resort: "For resort to war to be justified, all peaceful alternatives must have been exhausted."
6. Probability of Success: This criterion is not precisely stated, but the bishops affirm that "its purpose is to prevent irrational resort to force or hopeless resistance when the outcome of either will clearly be disproportionate or futile."
7. Proportionality: "[T]he damage to be inflicted and the costs incurred by war must be proportionate to the good expected by taking up arms….This principle of proportionality applies throughout the conduct of the war as well as to the decision to begin warfare."[346]

Jus in bello requires the following conditions:

8. Proportionality: as above.
9. Discrimination: "[T]he lives of innocent persons may never be taken directly, regardless of the purpose alleged for doing so….Just response to aggression must be…directed against unjust aggressors, not against innocent people caught up in a war not of their making."[347]

[346] Robert L. Holmes, *On War and Morality*, (Princeton, New Jersey: Princeton University Press, 1989), 164.
[347] Holmes, *On War and Morality*,164.

Appendix 6: A Primer on Professionalism

§1: Understanding "Professionalism"

To grasp the theoretical and practical conflicting professional duties of the military-physician, we must understand the features of professionalism. In particular we can look at such features as how to identify a professional or how to identify an activity as a profession. Additional features of professionalism include identifying what qualities or characteristics are present when dealing with professionals or a profession, as well as what qualities or characteristics should be present when dealing with professionals or a profession. Typically, this is accomplished by first identifying professionals and professions, then extracting the characteristics that they share.

Initially it might seem to be an easy task to identify professionals and professions. Consensus within the literature of professionalism suggests that "white-collar" workers are professionals: physicians, lawyers, veterinaries, teachers, and so forth. Likewise, consensus suggests that "blue-collar" workers are not professionals: janitors, lifeguards, factory workers, and so forth.

Yet, this consensus is not without controversy. Some activities, although not normally associated with professional activity, nonetheless contain people characterized as professionals: professional musicians, professional athletes, professional poker players, or even people who compete in eating competitions "professionally." Furthermore, the literature of professionalism contains debate regarding whether or not some jobs should properly be characterized as professional: paralegals, paramedics, nurses, or soldiers.

This essay addresses two of the more useful approaches to identifying professions and professionals – a mostly descriptive approach and a somewhat normative approach. The descriptive approach I will call "essentialism." Essentialism relies on identifying the necessary conditions that must be obtained for an activity to qualify as a profession or that an individual must meet to be properly identified as a professional.

The normative approach I will call "functionalism." Functionalism relies on identifying the appropriate function or role of an activity as it relates to society's needs. Professional norms are then defined as related to insuring these needs are met in morally appropriate ways. In either case, both essentialism and functionalism seek to answer two related questions for identifying professionalism: What characteristics are necessary for an activity to be considered a profession, or what characteristics are necessary for a person to be considered a professional?

§2: Essentialism

As the name suggests, essentialism seeks to answer the previous questions by identifying the essential features of professionalism. To this end, Michael Bayles, Bernard Barber, and Lisa Newton offer overlapping accounts of essentialism. I outline each account in turn.

According to Bayles almost every author in professionalism literature identifies three necessary features that characterize professionals: (1) a professional has acquired extensive training of a particular activity, (2) the activity of a professional emphasizes intellectual powers over physical ability, and (3) the professional performs an activity that is an important service to society.[348] Along with these essential characteristics, Bayles offers the following characteristics as common, but not necessary, to most professionals: (a) professionals are certified or licensed to practice, (b) professionals organize special memberships to promote the interests of their profession, and (c) professionals are autonomous in their work.[349] Finally, Bayles distinguishes between consulting and scholarly professions.

Consulting professions traditionally provided a fee-for-service practice in a client-practitioner relationship in which the professional acts as an agent for a specific client. Scholarly professions tend to operate on a salary with either many clients or no personal clients. These distinctions further demarcate the essential features, as well as generate various ethical issues. Consulting professionals, according to Bayles, possess several salient features, features which present possible conflicts of interests between the professional and a

[348] Michael D Bayles, *Professional Ethics*, (Belmont: Wadsworth Publishing Company, 1981), 7.
[349] Ibid. 8.

liberal democratic society: (i) consulting professionals provide services related to basic human needs, (ii) consulting professionals have a virtual monopoly on the services they provide and (iii) consulting professionals are not subject to much public control. Thus we can see that Bayles has a robust understanding of professionals. Barber and Newton have slightly different approaches to essentialism.

Whereas Bayles offers a discrete view of professionalism, Barber favors a continuous view of rating the relative degree of professionalism.[350] According to Barber, there are no absolute differences between professionals and non-professionals. Rather, there is a continuum between fully professional (doctors and lawyers), partly professional (paramedics and paralegals), and barely or not at all professional (garbage men and lifeguards).[351] The degree of professionalism depends upon the degree of involvement with four features of professionalism: (1) a professional has a high degree of generalized and systemic knowledge, (2) a professional is oriented towards public interest as opposed to self-interest, (3) a professional maintains self-control through codes of ethics, membership in professional organizations, and through training, and (4) a professional maintains a system of monetary and honorary rewards of achievement that reflect the above.

These criteria, according to Barber, are used to classify professional activity in one of three ways. First, they may be used to compare two or more different professions. Second, they may be used to compare professionals within the same occupation. And third,

[350] Discrete, from the language of mathematics, describes objects that are individually distinct or non-continuous. For example, when measuring time continuous units are used because they can always measure smaller units of time, but when counting the number of people who arrive to a party, discrete numbers are used because one should not say "Five and a half people came to the party." In the context of professionalism, then, if you suggest that either someone is professional or not, you are making a discrete claim. If you suggest that someone can be more or less professional, you are making a continuous claim.

[351] Bernard Barber, "Some Problems in the Sociology of the Professions," *Daedalus* 92 (1963): 669. Examples listed here are my own.

they can be used to evaluate with respect to differing criteria. For example, under Barber's system, a physician is more professional than a race-car driver; a teacher is more professional than a secretary; a physician at a teaching university is more professional than a "country doctor;" a Supreme Court justice is more professional than a newly graduated lawyer.

Newton presents the most complex account of professionalism. First, Newton suggests that professionals themselves claim that there are two criteria (which according to Newton are individually necessary and jointly sufficient conditions) that justify professionalism: (1) professionals are maximally competent in a specific area of knowledge, and (2) professionals are committed to public good in that area.[352] Newton identifies additional features that *some* professionals claim as justification for their professional status: (a) professionals attend to the welfare and interests of their clients, sometimes at the expense of the public good, and (b) professionals command large fees. Together with the first two criteria, I characterize these four criteria as Newton's "internal" characteristics of a profession, i.e., these are criteria which professionals often indicate as being qualifications that identify professionals.

In addition, Newton identifies what I refer to as "external" criteria, i.e., criteria that involve the historical development of a profession or a description of those criteria which actually appear to exist in a modern profession. There are three external characteristics, any one of which is a necessary component of professionalism: (1) professionals practice an

[352] Lisa H. Newton, "Professionalization: The Intractable Plurality of Values," in *Profits and Professions*. ed. Wade L. Robison, et al. (Clifton: Hurnana Press, 1983), 49. Newton does not offer an account of what she means by "maximally competent." My impression is that this is some standard of "above average" skill or ability, something that the average person would be unwilling or unable to accomplish.

activity to achieve excellence within that activity, (2) professionals practice an activity for profit, and (3) professionals practice an activity which is directed to benefit others.[353]

Although it is difficult to conclude exactly how the external characteristics relate to the internal characteristics, it appears that Newton is claiming that an activity is considered professional when it arises from one of the external criteria and conforms with, at a minimum, the first two internal criteria. This account seems to combine aspects of both Bayles and Barber's view. There are conditions which must be met to qualify as professionalism. This is consistent with Bayles discrete view. Once professionalism has been identified, professionalism may be evaluated as a continuum over a range of activity. This aspect is consistent with Barber's continuum view.

Taken together, the three accounts offered by Bayles, Barber, and Newton give a descriptive account of how to identify professionals and professions. One looks for combinations of the following features: providing an important service to either the public or individuals, containing a significant intellectual component, requiring extensive training, having a high degree of specific knowledge, orientation towards community interests (not strictly self-serving), having a code of conduct or some instrument of self-regulation, containing rewards and prestige, being very competent, providing a public good, or caring for people in their charge.

As useful as this list is, however, it is mostly a *descriptive* account of professionalism. A crucial part of granting "professional" status is in the profession being identified with serving the interests of the public good or the interests of one's client. However, essentialism seems to lack a certain normative element of identifying specifically

[353] Newton, "Professionalization," 55.

what professionals *ought* to do. How do they serve the public good? How do they work towards client interests? To capture this normative dimension, I now turn to functionalism.

§3: Functionalism

Functionalism relies on defining professional *norms* that an activity, organization, or person must meet in order to earn the benefits and obligations of public recognition as being a professional. As the name suggests, functionalism strives to explain professionalism in terms of function within society.

Ozar demarcates nine categories of professional obligation.[354] Like Bayles, Barber, and Newton, Ozar understands that there are features commonly associated with professionalism: a public oath, an ethical code, service to others, specialized knowledge and special moral commitments. These features are, however, based upon the collective profession's answers to nine categorical questions:

1. What is (are) this profession's chief client(s)?
2. What are the central values of this profession?
3. What is the ideal relationship between a member of this profession and a client?
4. What sacrifices are required of members of this profession and in what respects do the obligations of this profession take priority over other morally relevant considerations affecting its members?
5. What are the norms of competence for this profession?
6. What is the ideal relationship between the members of this profession and co-professionals?
7. What is the ideal relationship between the members of this profession and the larger community?
8. What ought the members of this profession do to make access to the profession's services available to everyone who needs them?
9. What are the members of this profession obligated to do to preserve the integrity of their commitment to its values and to educate others about them?[355]

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[354] David T. Ozar, "Profession and Professional Ethics," in *Encyclopedia of Bioethics*, 3d ed., ed. Stephen G. Post, vol. 4 (New York: Macmillan Reference USA, 2004), 2158-2169.

[355] Ozar, "Profession and Professional Ethics," 2158-2169.

Not every profession needs to answer these questions the same way; however each profession must identify an acceptable range of answers. The professional norms are established by (1) a profession establishing an agreed upon range of answers to the questions and (2) society's sanctioning of these answers. Thus, for example, defense lawyers may serve very different clients than public works engineers; priests may value sacrifice while advertising agents may value maximizing profit; politicians may serve their constituents while minimizing the needs of voters outside of their own districts.

Common usage of the concepts surrounding essentialism and functionalism often seems to follow the convention that the essentialism approach identifies whether or not we are dealing with professionalism while the functionalism approach provides details about a particular profession or professional's ideals. In the former case we are often dealing with more descriptive notions of professionalism, while in the latter case we are often dealing with more normative elements. Yet this is not an established rule. Both essentialism and functionalism can be used to identify descriptive and normative features of professionalism.

Vita

Kevin Michael Bond was born in Anchorage, Alaska on December 9, 1973. He was reared in Perry, Oklahoma and graduated from Perry High School in 1992. He attended the University of Science and Arts of Oklahoma, Chickasha, Oklahoma and received a Bachelor of Science degree in Mathematics in 1996. He continued his education at Oklahoma State University, Stillwater, Oklahoma where he earned a Master of Arts degree in Philosophy with a Graduate Minor in Mathematics in 2002. Kevin moved to Knoxville, Tennessee to continue his studies in Philosophy with an emphasis in Medical Ethics. While at Knoxville, Kevin also studied Satori Ryu Iaido, Isshin Ryu Karate, and Shindo Muso Ryu Jodo under Sensei Lance England. During his last year as a Ph.D. Candidate at the University of Tennessee at Knoxville, Kevin worked for the Department of Army as an Operations Research Analyst with the Army Center of Excellence for the Professional Military Ethic (ACPME), United States Military Academy, West Point, New York. Upon graduation Kevin plans on continuing his work and research with the ACPME.