Physicians at War: Reply to Critics

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At the 2009 Annual Meeting of the Association of Practical and Professional Ethics, Prof. Michael Davis organized a response panel to my edited volume, *Physicians at War: The Dual-Loyalties Challenge*;[1] in addition to Davis, Prof. Aine Donovan and Col. Thomas Jefferson offered comments. Subsequently, Prof. Griffin Trotter wrote a review of the book for this journal, and Davis and Donovan put their comments in writing. I am grateful to have this opportunity to respond to the three of them and further grateful for their thoughtful contributions to this volume. In what follows, I will recapitulate the core idea behind the project (§1)[2] and then present and respond to the critiques of my interlocutors (§2).

1. PHYSICIANS AT WAR: THE DUAL-LOYALTIES CHALLENGE[3]

The project began during the 2004-5 academic year, when I was on a research fellowship at the Institute for Ethics of the American Medical Association (AMA). Just after I began the fellowship, two articles were published in *The Lancet* by Steve Miles in which he discussed alleged violations of military medical ethics that may have transpired through physician involvement in hostile interrogations.[4] Then, right before the holiday break, we received notice that the *New England Journal of Medicine* would be publishing a similar essay by Gregg Bloche and Jonathan Marks, in its first issue of 2005.[5] The American Medical Association in general, and the Institute for Ethics in particular, was extremely concerned about Miles's papers and the forthcoming one by Bloche and Marks. Not only were these extremely visible publications, but many thought that the allegations they contained were of grave ethical concern. The AMA, which publishes *The Code of Medical Ethics*, takes very seriously the moral status of the medical profession and therefore was very interested in these articles. (The AMA's Council on Ethical and Judicial Affairs has gone on to publish an opinion on physician involvement in interrogation, which represents the culmination of its thinking on these topics.)[6]

Having already had a background in some elements of military ethics, and the torture debate in particular,[7] my fellowship year quickly evolved to explore physician involvement in interrogations. One element of this project was to research some of the underlying moral issues, though another was to talk to those responsible for military ethics (including military medical ethics) education. This research led me to speak with those teaching military ethics at the US Military Academy at West Point, the US Naval Academy, and the US Air Force Academy,

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as well as those teaching military medical ethics at US Army Medical Department Center & School (Fort Sam Houston) and the University Services University of the Health Sciences (Bethesda, Maryland). After I left the AMA, I was also able to spend some time at the Australian Defence Force Academy (Canberra, Australia). I was extremely impressed with the professionalism and commitment to ethics that was displayed at each of these training academies.

When starting the research, however, one of the first things that I noticed was how little academic work had been done in military medical ethics. The Borden Institute, an agency of the US Army Medical Department Center & School, had produced two outstanding books which were meant to be used as textbooks for the teaching of military medical ethics.[8] Steve Miles[9] and Michael Gross[10] have each written books about these topics, though these emerged, at least in part, from the previously-mentioned journal articles of 2004. Finally, a symposium was held in a prestigious bioethics journal, *Cambridge Quarterly of Healthcare Ethics* (2006).[11] The point, though, is that few discussions regarding military medical ethics had been held until the past few years.

The motivating premise behind the volume was that, in times of armed conflict, physicians can arguably be subject to dual-loyalties. This concept has been explored in greater detail elsewhere,[12] but, for present purposes, we might understand it as the existence of simultaneous obligations which might come into conflict. While dual-loyalties can generalize to all sorts of contexts, our present concern is with the ones that apply to physicians during armed conflict. In these scenarios, physicians have medical obligations to those in medical need. We could ground such obligations in various ways, but the most straightforward way is to acknowledge the medical duties of beneficence and non-malfeasance, both of which have been traditional foundations of medical ethics. According to these duties, physicians are morally bound to render aid insofar as they can and not to (intentionally) make anyone medically worse off.

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

Of course, these non-medical obligations could precisely oppose the medical obligations previously mentioned. Consider, for example, physician participation in weapons development, which is covered in the third unit of the volume. We can easily imagine cases wherein physicians are operating on the just side in a conflict against an evil regime and that their expertise could be applied to chemical or biological weapons; we could further imagine that such weapons would

be effective against the enemy and lead to a quicker dissolution of the conflict. With such weapons, it could be the case that there would be fewer casualties overall—perhaps by shortening the war—or even that the existence of such weapons would be psychologically debilitating enough to the enemy that the conflict could rapidly come to an end. If this is a terrorist regime, then national security could legitimize the development of the weapons or, regardless, such weapons might serve the greater good—including the citizenry, present and future, which falls under the dissolved evil regime—and therefore be morally justified. But, despite the moral considerations that would count in favor of such weapons development, there are contrary considerations that would inveigh against it. In particular, the development of weapons could violate the physician's obligation of non-malfeasance since those weapons would be used to harm some individuals.[13] What, then, should physicians do? Are they morally permitted to participate in weapons development?

Before moving on to a more general discussion of these challenges, let me point out some other specific contexts in which such challenges arise. Many of these are covered in the volume, but I will briefly mention them in this section. In particular, we could see the above frameworks also applying in the following: physician involvement in torture (Unit 2) and battlefield triage/medical neutrality (Unit 4). Starting with torturous interrogations, it could easily be the case that such interrogations serve important military objectives, and that medical knowledge could make the interrogations more expedient, perhaps by conducting them in ways that invoke physical or psychological vulnerabilities of the detainee. Again, though, any application of medical knowledge that makes the detainee worse off than s/he otherwise would have been could be viewed as problematic when viewed through the lens of medical ethics.[14] Therefore, this is another instance of the dual-loyalties conundrum.

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

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

Given dual-loyalties challenges, how can they be resolved? There are four basic options. First, we could hold that medical and non-medical values are *commensurable* and that, in any given case, we just have to make adjudications about which pull more strongly. Second and third, we could hold that these values are *incommensurable*, but that one or the other set of values does not apply. One option is that non-medical obligations are patently irrelevant to medical decision making; the other is that medical obligations are inappropriate in these contexts. Fourth, we might say that the values are incommensurable, yet all apply. It is not clear to me how this fourth option is a *solution* to the challenge as it merely posits intractability. And I think, therefore, that it is simply implausible: most of us believe that there are right and wrong courses of action in situations where we countenance dual-loyalties challenges, and I want to suggest that we all believe this because one of the first three options listed must be correct.

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

This line is not without problems, both epistemic and metaphysical. Regarding the epistemic ones, we simply do not *know* how many lives might be at stake, or what the consequences will be of us having (or not having) chemical or biological weapons. Metaphysically, we might meaningfully ask how many lives are *worth* a single transgression against non-malfeasance, and thence beckons the specter of incommensurability. The epistemic worries, though, are just that, epistemic: whether we *know* the relevant stakes, it hardly follows that there does not *exist* some proper course of action, and we then have to do the best we can to determine what it is. The commensurability problem is a difficult one as well, and people choosing this approach to resolving the challenge will surely owe us an account of their thinking in this regard.

Let me also point out another answer that might present itself here, which is more empirical than conceptual. In setting up examples of dual-loyalties challenges, I made various suppositions, and people might simply deny that any

of these is reasonable. For example, in the torturous interrogation case, I asked that we consider an interrogation that advanced the greater good, despite its transgression of medical virtues. It is certainly an open possibility here to deny that such an interrogation is *possible*, perhaps by denying the plausibility of any sort of utility forecast that would justify the interrogation. In the torture debate more generally, this is a common line,[15] though I think that there are responses.[16] This approach, then, admits of the commensurability of the conflicting obligations while, at the same time, denying that there will ever be much pull coming from one of the directions; a quick look at the literature would suggest that the non-medical obligations are more commonly thought to be the impotent ones. Regardless, I think that this is the approach that it most intuitive, though there is some work to be done regarding how to understand the commensurability.

Second, we could resolve the challenge by saying that one of the two directions (necessarily, as opposed to contingently) exerts no pull. The more common direction that this would take is to deny that extra-medical considerations can have any import on medical considerations. This strategy is one that we might appropriate, in a different context, from Michael Walzer.[17] Walzer has postulated the existence of "spheres of justice" such that we can only distribute resources within some sphere based on considerations internal to it, rather than from some distributive logic that would be motivated from some other sphere. In applying that structure to our context, it would therefore be inappropriate to make decisions regarding *medicine* by appeal to *extra-medical* considerations: medicine occupies its own sphere of justice and, therefore, medical decisions must be based on medical considerations alone. Note, then, that this view is patently one of incommensurability: it does not *ma t er*, for example, whether there are tremendous extra-medical benefits to be gained through some action that violates tenets of medical justice since the former are inadmissible regarding considerations of the latter. On this view, there is no dual-loyalties challenge since there are no *dual* loyalties in the first place: physicians must make medical decisions based *solely* on medical considerations and chains of command, national security, and the greater good are impotent against such considerations. While Walzer did not explicitly apply his framework to this present context, such an application is nevertheless fairly straightforward.

This view is not without problems, though many people will nevertheless find it compelling. As far as I can tell, the most pressing objection would have to do with how we individuate different spheres. As I laid it out in the previous paragraph, the medical sphere was conveniently insulated from the non-medical realm, and this insulation provided a solution to the dual-loyalties challenge. However, this structure could receive pressure in either of two directions. First, we might wonder whether this medical sphere is *too small*. In fact, the reason it offers a solution to the dual-loyalties challenge is that it is precisely of the scope that would do so and, therefore, might be thought to be idiosyncratic or *ad hoc*. What is so special about medicine such that it gets its own sphere of justice? The postulation of such a sphere almost seems to be question-begging against "greater good" considerations, since it eliminates those considerations out of hand (e.g., by asserting a sphere which they cannot penetrate). We could certainly carve up

the spheres differently, and maybe "greater good" could be some such sphere, of which medicine were a proper part. Regardless, it would seem that the postulation of some sphere needs to be *motivated* in some way, and it is not clear to me what the motivation for a medical sphere would be. Conversely, maybe the medical sphere is *too big* (as opposed to too small). If there is a medical sphere, there could very well be sub-medical spheres: just as some features set off the medical sphere from others, features within it might be used to set off facets of it from itself. The problem would then be that this conception of spheres could lead to a sufficiently high number of them such that they would not be useful in particular cases. At any rate, the proponents of spheres will have to say something about *why* there is a sphere of medicine and why it does not either get subsumed under a bigger sphere or fracture into multiple smaller ones; only such a compelling story here would preserve the merits of this answer.

Finally, we could resolve the dual-loyalties challenge in the third way, which is again to deny that there are dual loyalties at all. While the spheres of justice approach negates the relevance of extra-medical obligations, a converse approach holds that *only* extra-medical obligations are admissible and that medical obligations do not apply. Again, this line would deny that there is a dual-loyalties *challenge* since there would not be competing obligations at all. This is undoubtedly the least popular of all the options and, as far as I can tell, I am the only person who defends it.[18] The idea here is that medical obligations apply only to *physicians* and that there is conceptual space for medically-trained military functionaries who are nonetheless not physicians.[19] Physicians are members of the medical *profession*, and this carries with it various moral features. For example, they have taken an oath to abide by various features of that profession, including providing care for those in need. But we could easily imagine medically-trained personnel who are not members of this profession: they may never have taken the oath nor ever planned to provide positive medical services. Rather, they could use their medical training in an adversarial way, such as through the development of weapons or through participation in hostile interrogations.

I want to suggest that medical obligations do not apply to these people, whom I take to be something other than physicians. The contrary view would have to hold that, *regardless* of these people's non-participation in the medical profession, the obligations nevertheless attach to them. I think that this line is problematic for various reasons, and have argued for it elsewhere.[20] A second critique of this position—which came out as a response to that work and is therefore not considered within it—is that the people that I would otherwise exempt from medical obligations are, *in fact*, physicians: they *have* taken the associative oaths and *are* members of the medical profession. I do not disagree with this claim, but it does nothing to erode the conceptual space that I aim to delimit. Rather, it seems completely possible to me that military physicians could *opt out* of the profession, and that some of their obligations would thereafter dissolve. (Some, however, would not, such as the obligation to preserve confidences obtained through participation in the profession.) Furthermore, there is no reason that these personnel had to take whatever oaths would ground medical obligations: we could easily imagine a medically-trained force that completely rejects these values altogether.

In this preliminary section, I introduced the notion of the dual-loyalties challenge, which is further elaborated in Unit 1 of the volume. I also introduced some particular issues in which this challenge is manifest: physicians and torture (Unit 2), physicians and weapons development (Unit 3), and physicians on the battlefield (Unit 4). Each of these units comprises papers which explore the associative dimensions in greater detail and display a range of different perspectives thereof. I also discussed various options to resolve the dual-loyalties challenge; these are also variously considered throughout the included essays. At the end of the volume, I included three appendices, which are statements published by the World Health Organization and the American Medical Association regarding physician involvement in armed conflict. Having now laid out the motivation for the project and the coverage therein, let us turn to the respondents.

2. RESPONSE TO CRITICS

In this section, I will consider the responses to the book offered by Davis, Donovan, and Trotter. From the outset, I should note that the book is an edited volume: one of my essays was reprinted in it, but everything other than the introduction was contributed by others. Some of the respondents make comments about individual essays but, insofar as I did not write those essays, I will largely pass over such comments. In this regard, I commend the individual essays to the interested reader and encourage direct correspondence with the authors; it falls beyond my purview to engage their essays on their behalf. Rather, my strategy here will be to defend the core project espoused in the book, particularly insofar as that project is challenged by the critics. As appropriate, I will also make comments about the book's organization and/or the contributing cast; obviously I bear responsibility in these regards as well.

As a second preliminary comment, there is little overlap in the feedback offered by the commentators; given that they are responding to an edited volume, this is probably not surprising. In other words, different commentators have chosen different essays to emphasize, as well they should. But insofar as the volume lacks any sort of core argumentation—again, because it is a collection of disparate essays—the responses to it are highly varied. My original strategy had been to distill core themes that run throughout the various responses; this seemed more philosophically interesting and less pedantic in mode of presentation. However, after reading the comments in detail, I simply do not think that there is a fruitful way to do this, so I will therefore just address the commentators individually.

2.1 Trotter

As mentioned from the outset, Trotter was originally commissioned to write a review of the book; this review was commissioned before the journal decided to turn Davis and Donovan's APPE presentations to print. Trotter's contribution is therefore of a necessarily different sort insofar as his goal is different: rather than comment on some particular theme in the book, his task is more or less to provide a comprehensive overview and assessment. And, in this regard, he offers a valuable service, carefully detailing the contents of the book and providing short abstracts

of each essay. I highly commend this review to the interested reader, particularly as it can be used to determine which essays could be most profitably read.

Let me first register Trotter's praise for the book:

> Overall, *Physicians at War* is a well-organized, tightly edited, very readable anthology that will be accessible and interesting to a wide range of readers, including both content experts and the general public. It would serve well as required reading in undergraduate and graduate courses on military ethics, medical ethics and military tactics, and would also be valuable as supplemental reading in a wide range of courses dealing with international ethical or legal norms.[21]

Not surprisingly, I agree with this assessment, though I appreciate his unbiased corroboration.

As I said above, though, the bulk of the review offers direct engagement with individual essays, so I shall pass over that here. Rather, let me focus on a criticism that Trotter makes, namely that "[t]he single most apparent weakness of the book is that the first section is almost entirely one-sided (to the editor's credit, in a way that mostly opposes his view) and contains no comprehensive, philosophically sophisticated account of the dual-loyalties problem or of a general approach to it."[22] I think that this is right, and Trotter does well to seize on it. As I said in §1, I think that the dual-loyalties problem can be approached either in general or else in regards to particular issues (e.g., torture and weapons development). For whatever reason, the literature is a lot more rich when it comes to the particular issues, though those discussions should be able to generalize, even if not overtly presented in that way. In other words, whether physicians can be complicit in torture or weapons development depends on general structural features of the medical profession; the presentation of particular contexts is at least somewhat derivative on the broader conception.

That said, comparatively little theoretical work has been done to articulate this broader conception and, when it has, that work has not been done by philosophers. And the volume offers no improvement in that regard insofar as none of the contributors to Unit 1 (i.e., the unit on the theoretical basis of the dual-loyalties challenge) is a philosopher and none of the discussions on offer in that unit is particularly interested in the underlying philosophical foundations of dual-loyalties. To some extent, this is covered in the volume introduction, but Trotter is correct that more could be offered here. As hinted at above, I think that insights can be extracted from the essays on particular topics, but more could be done theoretically. With edited volumes, though, one can only commission what people are willing to write, so volume editors are at least limited in that regard. I remember even searching the literature for something to reprint on this topic, and the literature really is deficient; there simply is not much there. That said, I do think that the contributions to Unit 1 are useful, even if a philosophical perspective could be added. And, should any reader of this essay be inclined, there is a good opportunity to make an impact by working on this topic.

As a second point, Trotter characterizes the contributions in Unit 1 as mostly ones that oppose my view, so let me say something about that. While I thought it would be heavy-handed to defend a substantive view in a volume introduction, I at least gesture toward what my view is; such a view also readily comes out of

other writing.[23] To wit, I deny the pre-eminence of medical values and think that dual-loyalties challenges should be adjudicated in ways that respect a pluralistic set of commensurable moral values as opposed to being adjudicated in ways that merely assert the pre-eminence of medical values (cf., Walzer). As a utilitarian, medical values do not occupy any privileged status in my own moral thinking, but, suffice it to say, the consensus view is diametrically opposed to that approach. The contributions to Unit 1 really are representative of the literature, which is to say that the literature is mostly one-sided. Again, there is an opportunity to make a contribution here, but I have to admit that my editorial responsibilities precluded me from making that contribution in the volume.

Before moving on, let me reiterate that Trotter's review provides a valuable resource for quickly apprehending both the contents of the book and the approach that its constitutive contributions take. While I have not engaged his comments on each of the essays, those comments are fair and insightful; I am grateful to him for offering such a conscientious review.

2.2 Donovan

Unlike Trotter, Donovan's comments have little to do with any essay in particular, but rather develop a theme implicit in the book; she does a fantastic job and I wish I would have been able to recruit her from the outset. Her general contention is that military physicians are not, in fact, subject to dual-loyalties challenges and that "the reality is that military personnel generally report no conflict at all with their Hippocratic oath."[24] She goes on to argue that as recently as WWII, military physicians were curiously dispassionate toward their medical duties. To make this claim, she draws from her own research regarding a group deployed to Japan in order to study the effects of radiation disease of the atomic bombs the US dropped on Hiroshima and Nagasaki. Donovan claims that the associated physicians were specifically sent "to observe and to document but not to intervene"[25] and she cites this as an example of battlefield neutrality: the physicians took no side in the conflict, nor any personal interest vis-à-vis the victims. She concludes that: "[t]he moral duty to heal was replaced with the military mission to document these physicians saw themselves as acting in a role outside of their medical duties, they were military officers first and physicians second."[26]

Donovan then goes on to characterize the second half of the 20th century as one in which military medicine made progress, strengthening the "professionalism of the military medical corps."[27] As examples, she points to both the way that physicians were used and the way in which they saw themselves during use in Bosnia and, twice, in Iraq. Donovan's narrative and details are insightful; I will not rehearse them here but rather direct the interested reader to her excellent commentary. Her ultimate point is that the dual-loyalties conception is simply not a useful one to foist upon a medical military largely unencumbered with such conflict, particularly given its evolution over the last several decades.

In response, let me grant that the vast majority of military medicine does not encounter dual-loyalties challenges in its regular operation and most of its medical personnel do nothing different than their civilian counterparts. For example, consider high-profile groups like the so-called Behavioral Science Consultation

Teams (BSCTs) that developed detention and interrogation strategies for captives at Guantánamo Bay; the medical personnel in these groups comprise a very small percentage of the military's medical expertise. That said, it hardly seems surprising that there has been a moral outrage over the BSCTs, with the accompanying investigative reporting, coverage in academic (esp. bioethics) journals, and so on: the interestingness of the associated moral issues far outstrips their frequency. But so what? Many of the interesting moral issues that applied ethicists confront take place at the margins, mostly removed from common experience.

Consider some of the most profound moral debates, such as capital punishment and human cloning. Last year, there were about 50 executions in the US,[28] and there has never been a case of human (reproductive) cloning. Or consider the moral status of interrogational torture, another lightning rod for moral debate: nobody would seriously argue that there are more than a handful of cases in which such torture should be seriously countenanced.[29] This is not to deny that there are issues in applied ethics of more thoroughgoing frequency: abortion, animal rights, pornography, and so on are just a few examples. Rather, the point is that we can have meaningful moral discourse about reasonably circumscribed practices, and that such discourse can be interesting and worth pursuing.

The focus of the book does not deny the quotidian nature of much of military medicine; instead, the point is simply that there is little of ethical import to talk about in this regard. Or, if there were, it would not be significantly different from civilian medicine, so nothing would be gained by appealing to the military context. Military medicine does confront challenges that distinguish it from civilian medicine, and we can usefully think about how to consider these challenges. It further bears notice that some of these challenges—even if infrequently articulated—can have tremendous upshot. Consider, for example, physician complicity in weapons development: the efficacy of chemical and biological weapons portends grave impact on myriad populations. Even if it is a small number of physicians involved in these projects, the consequences could be substantial. And this is not to prejudge the immorality of such an association insofar as chemical or biological weapons might shorten a just war against an unjust regime, thus staving off a greater overall loss of life; for reasons like this, the challenge must be taken seriously. So, while I agree with Donovan that military medicine is not often burdened with dual-loyalty challenges, I think that those burdens can be philosophically interesting in and of themselves and, furthermore, while infrequent, can nevertheless manifest a moral urgency.

2.3 Davis

Finally, let me consider Davis; while Donovan took issue with the empirical basis of the project, Davis challenges its theoretical execution. In particular, he identifies five sorts of arguments that can be "used to move from the facts of a specific situation to the claim that a member of a certain profession should, all things considered do such-and-such:" theoretical, casuistical, technical, social, and professional. I will direct the reader to Davis's essay for an explication of the different modes of argumentation, but his ultimate point is that *Physicians at War* presents positions couched in the first four modes while largely excluding

his preferred, the last. Professional arguments emphasize the distinctiveneses of professional roles and places codes of ethics—whether implicit or explicit—at the fore of moral reasoning with regards to those professions.

Davis sees the issue as follows:

> *Physicians at War* [asks] us what a physician is to do when she owes loyalty *both* to her employer (the military, government, or country) *and* to her profession (medicine) [when] these loyalties *seem* to clash in a systematic way. My answer is that the military physician should do that her profession requires—which is all the military asks of her. . . . There is no problem of dual loyalties here, only a misunderstanding of what the military asks of a military physician.

Davis goes on to say that military physicians are obligated to follow legal orders only and that, for example, an order for a military physician to effect a hostile interrogation runs afoul of various codes of ethics and international declarations and treaties. Any order to contravene law—or even a professional code of ethics—does not even have any *prima facie* purchase upon the physician and therefore there is no dual-loyalties conflict at all (i.e., only the professional obligations exist). Or, to put it another way, there cannot be a conflict between the physician's medical obligations and her military obligations since her obligation to the military would have her refuse the order in the first place insofar as one of her professional duties is to refuse illegal orders. Again, there is no conflict since the non-professional obligations cannot get off the ground.

This is a clever argument; Davis's own work on the moral status of the professions has been extremely influential and deserves much respect. In this response, I cannot fully articulate my (contrary) view of the professions, but at least a few remarks should be sufficient to indicate the sources of our disagreement. However, even some of those may be bypassed by mentioning a couple ways in which I think Davis's comments miss the mark. The first issue is what the competing sources for the dual-loyalties are meant to be, and I was admittedly quick in this regard. For example, I above—and in the introduction to the book—characterized the tension as being between medical obligations and military chain of command, national security, and/or the greater good; I then went on to offer some clarification as to why the military chain of command could be understood as having moral value.

Davis then goes on to pick on the idea that medical obligations could compete with military obligations insofar as military obligations cannot suggest illegal action; insofar as they might, those military obligations have no moral force and the dual-loyalties challenge is therefore abrogated. So my first response to Davis is simply that he has mis-identified the various foci that might oppose medical obligation insofar as military obligations was only one potential source. Granting—for now—that some orders would be illegal and therefore annulled, there are other sources for the conflict, such as the greater good. For example, suppose that a hostile interrogation would end up saving lives, but is nevertheless illegal: the would-be interrogator is still put in a position wherein she must decide between serving this greater good or else honoring her medical (and legal) obligations. To deny that such a clash is possible is an empirical one—not a moral one—and just denies the supposition meant to motivate the discussion.

Ultimately, we can allow everything that Davis has said while denying that his conclusion follows: the challenge still exists, but it is just located elsewhere (i.e., not in regards to military obligations).

The second approach, though, is less concessionary. Davis's argument is motivated by the illegality of hostile interrogation, but he simply does not argue for this conclusion; suffice it to say, I see it differently.[30] I will not pursue that discussion here, but the contents of codes of ethics and international declarations and treaties is simply not unequivocal on this issue, particularly regarding interrogations that fall short of torture. Regardless, even if it were, Davis's approach forces the entire dual-loyalties framework into the subset of issues that are circumscribed legally. Weapons development (Unit 3) would still be at least somewhat of an open question, and battlefield triage and medical neutrality (Unit 4) are clearly on the table. In other words, he assails the whole project by trying to indict only a part of it; this criticism does not go through. And, finally, the project is meant to be philosophical: even if the law did unequivocally decry some practice, it would still be an open question whether the law got the answer right. Pointing to laws as ways to close philosophical discussion simply does not work because those laws are subject to philosophical analysis as well; maybe legal reform is the right way to go. This is not to say that it is or is not in any particular case, but rather is merely meant to register a methodological objection to Davis's approach.

In closing, let me again thank my interlocutors for their dialogue and for their thoughtful consideration of *Physicians at War*. I also thank the editor of this journal, Elliot Cohen, for providing the forum for discussion.

Endnotes

1. Allhoff, *Physicians at War*.

2. For more detail and discussion, see Trotter, "Book Review," this volume, 81–86.

3. This section adapted from "Physicians at War: The Dual-Loyalties Challenge" in Allhoff, *Physicians at War*, 3–11.

4. Steven H. Miles, "Abu Ghraib: Its Legacy for Military Medicine," *The Lancet* 364.9435 (2004): 725–9; Steve H. Miles, "Military Medicine and Human Rights," *The Lancet* 364.9448 (2004): 1851–2.

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

6. The Council on Ethical and Judicial Affairs, CEJA Report 10, A-06, "Physician Participation in Interrogation" (American Medical Association, 2006). Reprinted in Allhoff, *Physicians at War*, 261–71.

7. Allhoff, "Terrorism and Torture." See also Allhoff, "A Defense of Torture." See also Allhoff, *Terrorism, Ticking Time-Bombs, and Torture*.

8. Office of the Surgeon General, *Military Medical Ethics*.

9. Miles, *Oath Betrayed*.

10. Gross, *Bioethics and Armed Conflict*.

11. I authored an essay in this symposium; Fritz Allhoff, "Physician Involvement in Hostile Interrogations"; reprinted in Allhoff, *Physicians at War*.

12. See, for example, Physicians for Human Rights, *Dual-loyalty & Human Rights in Health Professional Practice*; excerpts reprinted in Allhoff, *Physicians at War*, 15–38. See also Allhoff, *Physicians at War*, Unit 1.

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

14. In fact, this is precisely the view taken by the AMA (2006) in its report. Reprinted in Allhoff, *Physicians at War*, 261–71. For a dissent, see Allhoff, "Physician Involvement in Hostile Interrogations"; reprinted in Allhoff, *Physicians at War*, 91–104.

15. See, for example, Arrigo, "A Utilitarian Argument against Torture." See also Wynia, "Consequentialism and Harsh Interrogations."

16. See, for example, Allhoff, "A Defense of Torture." See also Allhoff, *Terrorism, Ticking Time-Bombs, and Torture*.

17. Walzer, *Spheres of Justice*.

18. See Allhoff, "Physician Involvement in Hostile Interrogations," 395–400.

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

20. Allhoff, "Physician Involvement in Hostile Interrogations."

21. Trotter, "Book Review," 85.

22. Ibid., 82.

23. See, for example, Allhoff, "Physician Involvement in Hostile Interrogations."

24. Donovan, "Military Physicians," 87.

25. Ibid.

26. Ibid.

27. Ibid.

28. http://www.deathpenaltyinfo.org/executions-year (accessed February 14, 2010).

29. See, for example, Allhoff, *Terrorism, Ticking Time-Bombs, and Torture*.

30. For more discussion, see ibid.

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