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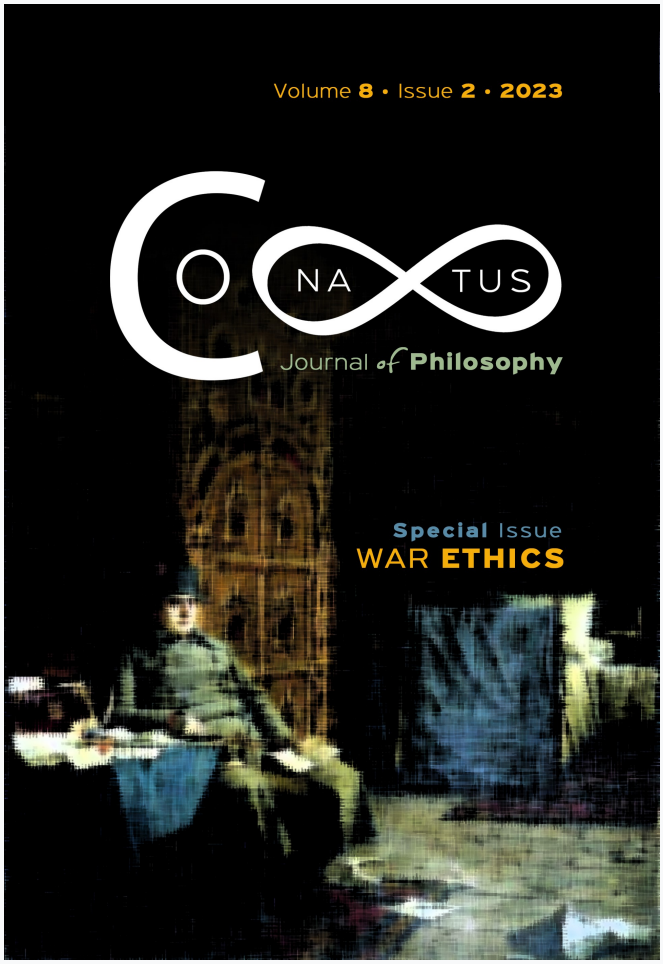

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Doctors with Borders

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Abstract

This paper presents the real case of a military surgeon who is the only one working at a small hospital in Iraq. The military surgeon can only operate on one wounded soldier due to limited medical resources. The first wounded soldier to arrive is the enemy. The second wounded soldier to arrive shortly after the enemy is a compatriot. Both soldiers will die without lifesaving surgery. The military surgeon is ordered by his superior not to operate on the enemy. Under the Geneva Conventions, physician-soldiers are legally required to give medical attention impartially. The only exception is urgent medical need. Both soldiers, friend and foe, have an urgent medical need. Dual-loyalty dilemmas such as this one can arise for military medical practitioners when loyalty to patients comes into conflict with loyalty to third parties such as the state. In this paper, several solutions to the dual-loyalty dilemma are considered and rejected. Solutions to the dual-loyalty dilemma ultimate fail because they rest on the physician-as-healer model which grounds contemporary medical ethics. The view that the ultimate objective of physicians and medicine is winning battles is defended. Physicians are non-neutral and partial fighters who sometimes must do harm. Medicine is a weapon that physicians use to fight an enemy. The only relevant differences between a soldier and physician are the kind of enemy, location of the enemy, and the type of weapons used against the enemy. The paper concludes that physician-soldiers are doctors with borders. There is no dual-loyalty dilemma on the physician-as-fighter model. The military surgeon should obey his orders and not operate on the enemy. Implications of the physician-as-fighter model for mass casualty triage and physician-soldier participation in non-lethal weapons development are considered.

Keywords: *dual-loyalty dilemma; medical ethics; military ethics; non-lethal weapons development; neutrality; impartiality; physician-as-fighter; mass casualty triage*

I. Introduction

There is a painting called "Hippocrates refusing the gifts of Artaxerxes" (1792). It tells the story of the emissaries of Artaxerxes II (405-358 BC), King of Persia, who were sent to Greece to persuade Hippocrates to save Persian soldiers suffering from the plague. The emissaries are depicted offering Hippocrates great gifts and placing a large heap of gold coins at his feet. Hippocrates' head is turned away from the emissaries with his left hand stretched out toward them in a sign of rejection. His left leg is also stretched out with his foot bearing down on the heap of coins. Hippocrates is reported to have said, "Tell your master I am rich enough; honor will not permit me to succor the enemies of Greece."

Hippocrates' rejection to help the Persians may seem surprising given that his Oath can be interpreted as forbidding physicians from discriminating between patients on the basis of political affiliation: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice."[1]

The sick could include friend and foe. What is even more surprising is that this painting of Hippocrates served as the model for a commemorative stone commissioned by the American Medical Association (AMA) and placed in the staircase at Washington Monument in 1855 as a tribute to President George Washington. The stone bears the inscription "Vincit Amor Patriae" (Love of Country Prevails). Did the AMA at one time prioritize *patria* over patient in times of conflict? When the AMA published its first code of ethics in 1847, it discussed many things including a physician's responsibilities to his patient and a patient's responsibility to her physician. But the code never explicitly mentions where a physician's loyalty should lie in times of conflict. Yet in the *Introduction* to the 1847 code of ethics, the AMA states that a physician should not withhold his services from an individual or his community except under rare circumstances in which doing so would be unjust to himself or his fellow physicians.[2] At least until 1855, giving medical attention to the enemy was for the AMA one of those rare circumstances.

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[1] Edmund D. Pellegrino, "The Moral Foundations of the Patient-Physician Relationship: The Essence of Medical Ethics," in *Military Medical Ethics*, Volume 1, eds. Thomas E. Beam and Linette R. Spracino, 3-21 (Washington, D.C.: Office of the Surgeon General, Department of the Army, and Borden Institute, 2003), 6.

[2] American Medical Association, *Proceedings of the National Medical Conventions* (Philadelphia, PA: AMA, 1847), 85, http://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id=6863b9b4-a8b5-4ea0-9e63-ca2ed554e876%2Fama_arch%2FAD000001%2F0039PROC&pg_seq=85.

Today, the AMA marches to a quite different tune. According to Principle IX of the AMA Code of Ethics, "A physician shall support access to medical care for all people."[3]

The AMA notes in a discussion of Principle IX that "the medical profession has no commitment to political advocacy because civic virtues are outside the professional realm."[4] In the case of an American physician-soldier, upholding Principle IX of the AMA Code of Medical ethics may call for supporting the enemy's access to medical care. After all, "for all people" includes the enemy. Yet upholding Principle IX can, under certain circumstances, generate a serious conflict between a physician-soldier's loyalty to his patient according to his medical ethical code and his loyalty to the state according to his military ethical code. This conflict of loyalties is called the dual-loyalty dilemma. The International Dual Loyalty Working Group defines the dual-loyalty dilemma as follows:

> Clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state.[5]

Edmund Howe recounts the following true story of a dual-loyalty dilemma faced by a military surgeon in Iraq:

> Military Surgeon
>
> A military physician was the only surgeon working in a small clinic in Iraq when a wounded enemy soldier was brought in. He was so badly injured that he needed immediate abdominal surgery to survive.
>
> At the same time, a U.S. soldier also was wounded and was reported inbound by helicopter evacuation from the battlefield. He, too, needed immediate lifesaving surgery that only this sole surgeon at this same clinic could provide.
>
> The highest-ranking officer in the clinic was not a physician.

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[3] American Medical Association, *AMA Code of Medical Ethics* (2015-2016), Principle IX, Preamble, XV, www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview.

[4] American Medical Association, *Code of Medical Ethics of the American Medical Association*, Principle IX, Preamble, XXX, 2014-2015.

[5] Dual Loyalty Working Group, *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms* (Washington, D.C.: Physicians for Human Rights, 2002).

> He ordered the surgeon not to begin surgery on the enemy, but to wait until the U.S. soldier arrived and then to operate on him first. The military surgeon saw an ethical dilemma: should he ignore this order and follow what he saw as his medical, professional obligation to operate immediately on the patient before him, though he was a member of an enemy force, or should he wait as he was ordered knowing that if he waited, the patient before him would die?[6]

What should the military physician do? Like Howe, I will reveal what this military physician chose to do later. What I will reveal now is what I think the military physician should do. I think he should not operate on the enemy. To support this view, I will argue that physicians are fighters, just like soldiers, who wield weapons – the weapons of medicine – to win battles against obstacles to health. That is, I claim that physician-soldiers are *doctors with borders*. The only important differences between a soldier and a physician are the kind of enemy they fight, the location of the enemy, and the types of weapons used to fight the enemy. There are several implications of this view. First, if physicians are fighters, then there is no dual-loyalty dilemma because, as fighters, a physician's loyalty is always on the side of those who fight against the enemy. Second, if physicians are fighters, then we should shift our view away from medical ethics grounded in healing towards medical ethics grounded in fighting. This is not as difficult as it may seem. Third, the physician-as-fighter model creates a new model for mass casualty triage. Finally, if medicine is a weapon, then physician-soldiers may be morally required to participate in military weapons development.

The paper proceeds as follows. In Section II, I discuss and reject two prominent types of solutions to the dual-loyalty dilemma. In Section III, I argue that neutrality, impartiality, and the "do no harm" principle are not desirable medical values and should be rejected. This is important because these principles are at the foundation of a medical ethics grounded on the physician as healer. In Section IV, I argue that medicine is a weapon just as guns and bombs are weapons. Section V concludes with a discussion of Howe's case of the military surgeon and implications of the physician-as-fighter model for mass casualty triage.

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[6] Edmund G. Howe, "When, If ever, Should Military Physicians Violate a Military Order to Give Medical Obligations Higher Priority?" *Military Medicine* 180, no. 11 (2015): 1118.

II. Solutions to the dual-loyalty dilemma

Solutions to the dual-loyalty dilemma fall roughly into two categories: commensurable and incommensurable.[7] On one side is the view that military and medical loyalties are *commensurable* but pull in different directions. The challenge for those who adopt this type of solution is figuring out how to determine when the pull of one loyalty should trump the other loyalty. On the other side is the view that military and medical loyalties are *incommensurable*. As long as military and medical loyalty is in play, only one loyalty has pull. The incommensurability view breaks down into two further positions. One position is that extra-medical considerations are never relevant to medical decision-making. If one adopts this position, the challenge is to explain why military necessity always plays second fiddle to medical need. The second position is that only extra-medical considerations are relevant. Proponents of this position must explain why military necessity always outweighs medical need.[8]

a. Commensurability

Solutions in this category reflect a positive view of the physician-soldier role. As Michael E. Frisina points out,

> Military medical personal (sic) are highly decorated for their courage and bravery in assisting their fallen comrades and list among the highest number of recipients of the Congressional Medal of Honor for their actions above and beyond the call of duty.[9]

On this view, physicians can become soldiers, but a commitment to both medical and military loyalties will sometimes come into conflict.

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[7] Fritz Allhoff, ed., *Physicians at War: The Dual-Loyalties Challenge* (Dordrecht: Springer, 2008), 7.

[8] Allhoff, *Physicians at War*, 7. Allhoff mentions another option but admits that he is not sure how it is a *solution*. This option entails that military and medical values are intractable, but both apply in the same context. But see Howe for a discussion on how the military physician might meet the mutually exclusive needs of the military and a soldier patient in the case of reporting homosexual behaviour in the US military. Edmund G. Howe, "Mixed Agency in Military Medicine: Ethical Roles in Conflict," in *Military Medical Ethics*, Volume 1, eds. Thomas E. Beam et al., 331-365 (Washington, D.C.: Office of the Surgeon General, Department of the Army, and Borden Institute, 2003), 335.

[9] Michael E. Frisina, "Guidelines to Prevent the Malevolent Use of Physicians in War," in *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff, 39-52. (Dordrecht: Springer, 2008), 40.

When they do, military physicians, nurses, and other health care practitioners sometimes make questionable choices. For example, human rights violations perpetrated at Abu Ghraib and Guantanamo Bay that included the participation of medical practitioners have cast a long shadow over the role of the medical profession and its participation in conflict situations. But instead of leaving medical practitioners in a moral black hole to fend for themselves, Greg Bloche and Johnathan Marks believe we should acknowledge "the tensions between their Hippocratic and national service commitments" and assist doctors and nurses "by working with them to map a course between the two."[10] Consider the following attempts to map a course through the dual-loyalty dilemma.

i. Moral problem-framing

Rather than think of dilemmas as threats to be avoided, Rebecca Johnson argues that they are challenges to be embraced.[11] This view is based on two beliefs. First, ethical dilemmas are opportunities for personal growth; second, life is complex enough that if we take the time to look closely, we will see that there are "multiple roads to faithful and loyal service."[12] For Johnson, moral dilemmas contain the seeds of their own resolution. For instance, Johnson discusses the case of a devout Christian and pro-life platoon leader who is approached for advice by an enlisted pregnant female in her unit. The platoon leader is required to counsel the pregnant Marine on all her options, including termination. The platoon leader cannot ignore her religious convictions, but she also cannot ignore her duty to the Marine. What should the platoon leader do? To assist physician-soldiers in finding a third path through polarized options, Johnson recommends a four-step approach to "moral problem-framing that seeks to open, rather than close, courses of action" so that soldiers can honour both their personal and professional commitments.[13] Johnson admits that while moral problem-framing

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[10] Gregg M. Bloche and Jonathan H. Marks, "When Doctors Go to War," *The New England Journal of Medicine* 352, no. 1 (2005): 5.

[11] Rebecca J. Johnson, "Serving Two Masters: When Professional Ethics Collide with Personal Morality," in *Routledge Handbook of Military Ethics*, ed. George R. Lucas, 266-277 (Abingdon: Routledge, 2015), 271.

[12] Ibid.

[13] Ibid., 266. According to Johnson's four-steps to moral problem-framing, the platoon leader should (1) clarify the various moral and ethical actors and issues involved in the situation, (2) identify different options that meet her various moral and ethical responsibilities, (3) weigh the real, not perceived, implications of potential options, and (4) valuate which of the options identified open new ground for moral and ethical service. See Johnson, "Serving Two Masters," 272-273.

may not help military personnel in every case, such an approach opens a space for new pathways to a resolution, which in turn create new opportunities for moral growth and improved leadership.[14]

ii. Discretion

Johnson's moral problem-framing approach sees ethical dilemmas as opportunities for military personnel to find a course through what often just appear to be diametrically opposed options. But what about cases in which there really are only two options? For example, Howe recounts that during World War II, military commanders in Burma decided that combatants who contracted malaria and suffered from high fevers should return to battle. The long-term consequences of malaria include liver abscesses and tuberculosis. Military physicians complied with their commander's orders. Later, that judgement was called into question. Some claim that the medical officers were "robbed of sacred duties and rights to which their professional knowledge and service entitles them."[15] What was the right decision?

Howe argues that physicians should follow a discretion guideline when a conflict exists between the needs of the military and those of the patient. According to Howe, the physician-soldier must choose either to exercise discretion when the needs of the military are not absolute, or to exercise no discretion when the needs of the military are absolute.[16] After all, when a physician enlists in the military, she "at least implicitly, promises to support the mission or greater good when and if this is necessary, even if this requires subordinating the medical well-being of the individual soldier."[17] According to Howe, the military physicians in Burma were right not to exercise discretion. Military necessity was absolute in this case because the military physicians lacked the information necessary to clearly understand the battlefield situation, lacked battlefield expertise to win the war, and were not in a position to determine the level of battlefield effectiveness of soldiers suffering the flu from malaria.[18] However, when the gain to the military is negligible and the harm to the soldier is significant, Howe claims medical physicians should exercise discretion. Such cases include evaluating pilots and commanders for impairment, treating soldiers with

[14] Ibid., 266.

[15] Howe, "Mixed Agency in Military Medicine," 339.

[16] Ibid., 355.

[17] Ibid., 333.

[18] Ibid., 339.

minor issues such as substance abuse, and meeting the clinical needs of soldiers with psychological disorders.[19]

iii. Coleman supreme emergency in military medical settings framework flowchart

Some views are even more specific than Howe's physician-discretion guideline or Johnson's moral problem-framing approach. For example, Nikki Coleman creates a framework flowchart to assist physician-soldiers and ethics committees to make informed decisions in challenging operational situations such as administering an experimental anthrax vaccine to coalition forces during the Gulf War.[20] The issue in this case was not just the administering of unproven pharmaceuticals but the suspension of the bioethical principle of informed consent by mandating the vaccine. Coleman argues there are situations in which bioethical principles must be suspended. These include cases when a patient is unconscious, a danger to himself and others due to a mental health condition, or public health concerns.[21] By drawing on bioethical principles, the Siracusa Principles, and the concept of supreme emergency, Coleman develops a supreme emergency in military medical settings framework flowchart to support informed and consistent decision-making and balance the operational needs and risks to military personnel.[22] The Siracusa principles are an essential part of the framework because they were created to balance the suspension of individual rights and a need to protect the wider community from health threats such as a pandemic.[23] They are intended to prevent the risk of all bioethical principles being suspended when the operational situation may only require the suspension of one, such as the principle of autonomy in the case of a mandatory anthrax vaccine for soldiers before deployment to a conflict setting.

Commensurability solutions to the dual-loyalty dilemma are attractive for several reasons. First, they support physician participation

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[19] Ibid., 344-355. For similar views, see Michael L. Gross, "Military Medical Ethics in War and Peace," in *Routledge Handbook of Military Ethics*, ed. George R. Lucas, 248-264 (Abingdon: Routledge, 2015), 260; William Madden and Brian Carter, "Physician Soldier: A Moral Profession," in *Military Medical Ethics*, Volume 1, eds. Thomas E. Beam and Linette R. Spracino, 269-291 (Washington, D.C.: Office of the Surgeon General, Department of the Army, and Borden Institute, 2003).

[20] Nikki Coleman, "When to Suspend Bioethical Principles in Military Medicine for Operational Purposes: A Framework Approach," in *Health Care in Contexts of Risk, Uncertainty, and Hybridity*, eds. Daniel Messelken and David T. Winkler, 221-234 (Cham: Springer, 2022), 233.

[21] Ibid.

[22] Ibid., 221.

[23] Ibid., 224.

in the military. Advances in medicine have made physician participation a crucial component of winning contemporary wars. Commensurability means the physician-soldier is not a morally impossible role. Second, a commensurability approach might alleviate the additional problem that different people deal with the same ethical tensions in different ways. Two military physicians may come to opposite conclusions on how to resolve the same ethical dilemma. Commensurability solutions to the dual-loyalty dilemma generate guidelines, frameworks, and flowcharts that can not only save time in the field hospital and on the battlefield but also foster consistency in ethical decision-making across people, countries, and services.[24] Finally, a more consistent approach to resolving ethical dilemmas may go some way to relieving military medical practitioners of the pain they may feel when they must follow military necessity knowing it will cause harm to individual soldiers.[25]

Adopting a commensurability approach to solving the dual-loyalty dilemma faces an obstacle. Commensurability views make a crucial assumption, namely that using medicine, medical knowledge, and medical skills for non-medical ends is morally unproblematic. However, several of the world's medical ethical codes unequivocally reject this assumption. Consider the following examples:

> World Medical Association (WMA) Declaration of Tokyo: The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective, or political, shall prevail against this higher purpose.[26]

> The International Dual Loyalty Working Group of Physicians for Human Rights: Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment [is a human rights violation].[27]

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[24] Ibid., 228.

[25] Howe, "Mixed Agency in Military Medicine," 356.

[26] World Medical Association, *WMA Declaration of Tokyo – Guidelines for Physicians concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment* (WMA, 2022), https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/.

[27] Dual Loyalty Working Group. *Dual Loyalty and Human Rights in Health Professional Practice. Proposed Guidelines and Institutional Mechanisms* (Washington, D.C.: Physicians for Human Rights, 2002).

> American Medical Association: Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened. Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat *individuals to verify their health* so that torture can begin or continue.[28]

The only way for the commensurability view to respond to these ethical injunctions to put medicine and patient before *patria* is to assert that military necessity and safeguarding the community may need to take priority over these medical ethical codes in times of conflict. But what justifies a medical professional prioritizing the security concerns of the group over the autonomy and medical needs of the individual? For some theorists, the answer is "nothing" because the role of physician and soldier are incommensurable.

b. Incommensurability

One way to solve the dual-loyalty dilemma is to grab one horn and spurn the other. Either non-medical considerations in medical decision-making are irrelevant (physician-first) or non-medical considerations are the only ones that are relevant (soldier-first). The most common horn to grab is the physician-first horn. This can be done in two ways. The first option is to segregate the role of the physician and soldier. Physicians should not become soldiers and soldiers should not become physicians. This will prevent the two loyalties from coming into conflict. The second option is to agree that physicians can become soldiers, but they should always prioritize medical need over military need.

i. Segregation

Victor Sidel and Barry Levy believe the tension between a physician's loyalty to her medical code of ethics and a soldier's loyalty to her military code of ethics is all too frequent and creates an "inherent moral impossibility" to carry out both roles.[29] Due to the conflict in loyalties,

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[28] American Medical Association, "Opinion 2.067: Torture," in *AMA Code of Medical Ethics* (2015). Emphasis added.

[29] Victor W. Sidel and Barry S. Levy, "Physician-Soldier: A Moral Dilemma," in *Military Medical Ethics*, Volume 1, eds. Thomas E. Beam and Linette R. Spracino, 293-231 (Washington, D.C.: Office of the Surgeon General, Department of the Army, and Borden Institute, 2003), 296.

physician-soldiers frequently violate bioethical principles while also failing to fulfill the expectations and responsibilities of the Geneva Conventions.[30] When the practice of medicine comes under military control, it becomes "fundamentally dysfunctional and unethical."[31] Sidel and Levy's view is that "combining combat capabilities with medical skills [perverts] medical care into a 'weapon.'"[32] Thus, it is wrong for physicians to serve as physician-soldiers because the overriding ethical principles of each profession are incompatible. A physician is a physician, a soldier is a soldier, and never the twain shall meet.

ii. Physician first, soldier second

Most theorists that grab the physician-first horn of the dilemma would disagree with Levy and Sidel that combining the role of a physician and a soldier creates an "inherent moral impossibility."[33] Physicians may become soldiers, but medical ethics nevertheless takes priority over military ethics. Edmund Pellegrino considers different models of the patient-physician relationship and concludes that the model of *physician as healer* lies at the heart of the Hippocratic Oath and serves as the foundation for medical ethics.[34] Many agree with Pellegrino that "medical ethics begins and ends in the patient-physician relationship."[35]

Medicine is defined by its "end" and that end is helping and healing; the end of medicine as medicine is what distinguishes it as "a special kind of human activity with its own internal morality."[36] As such, the internal morality of medicine demands its own loyalty which can come into conflict with competing commitments. When loyalties conflict or a case is morally ambiguous, physician as healers should put their medical ethics code first.[37]

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[30] Ibid., 303. Usually, physicians in a civilian practice have ways around such ethical conflicts by referring the patient to a different physician or resigning from their position. This option is not usually available to physician-soldiers.

[31] Ibid.

[32] Ibid., 304.

[33] See Howe's rebuttle in "Point/Counterpoint – A Response to Drs Sidel and Levy," in *Military Medical Ethics*, Volume 1, eds. Thomas E. Beam and Linette R. Spracino, 312-320 (Washington, D.C.: Office of the Surgeon General, Department of the Army, and Borden Institute, 2003).

[34] The other models include physician as clinical scientist, businessman, body mechanic, and social servant. Pellegrino, 9-10.

[35] Ibid., 5.

[36] Ibid., 10.

[37] See Daniel Zupan, Gary Solis, Richard Schoonhoven, and George Annas, "Case Study: Dialysis for a Prisoner of War," *The Hastings Center Report* 34, no. 6 (2004): 12; Tom Koch,

Grabbing the physician-first horn is the most common approach to solving the dual-loyalty dilemma and has much to recommend it. In most cases, it is easier navigating the edicts of one ethical code than navigating two. The various guidelines, frameworks, and flowcharts offered by proponents of the commensurability approach are proof of how difficult it is to find a path through the moral maze in which military medical practitioners may find themselves. Giving primacy of position to one ethical code or loyalty allows one to act with a clear conscience. Moreover, the moral dictates of the many contemporary medical ethics codes are reflections of the principles found in the Hippocratic Oath, parts of which are recited by most U.S. medical students on the occasion of "white coat" ceremonies. Furthermore, a physician-first approach to resolving the dual-loyalty dilemma aligns with contemporary secular and religious sentiments regarding the inherent dignity or sanctity of all human life and the medical practitioner's unique role in preserving it in times of medical need.

Yet, there are at least three reasons that speak against grabbing the physician-first horn of the dual-loyalty dilemma. First, it is very important to note that medical ethical codes are not laws but standards of honourable conduct. As Fritz Allhoff correctly points out, the AMA does not offer arguments but "merely statements."[38] This is also true for the WMA and other medical ethical codes. What we need, however, are arguments to give us "reasons (as might be offered by premises and a purported inferential structure) to accept them aside from the fact that medical associations endorse them."[39]

Second, the segregation solution proposed by Sidel and Levy is problematic because it would require calling on civilian physicians who would not have the necessary military training to provide medical services on the battlefield.[40]

Third, the physician-first view suffers from what I call the *McCoy Complex*. In the original Star Trek television series, the character Dr. Leonard McCoy, also known as "Bones," is the chief medical officer on the Federation Constitution-class starship USS Enterprise. One of the

"Editorial: Weaponising Medicine: 'Tutti Fratelli,' No More," *Journal of Medical Ethics* 32, no. 5 (2006): 249-252.

[38] Fritz Allhoff, "Physician Involvement in Hostile Interrogations," in *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff, 91-104 (Dordrecht: Springer, 2008), 98.

[39] Allhoff, "Physician Involvement in Hostile Interrogations," 98.

[40] Michael L. Gross "The Limits of Impartial Medical Treatment During Armed Conflict," in *Military Medical Ethics for the 21st Century*, ed. Michael L. Gross and Don Carrick, 71-84 (Abingdon: Routledge, 2016), 82.

most iconic catchphrases from the original Star Trek series is the line "I'm a doctor, not an X," which McCoy usually uttered to express his frustration when anyone questioned his authority in medical matters or when he was asked to perform tasks in which he did not specialize. Examples include "I'm a doctor, not an engineer,"[41] "I'm a doctor, not a bricklayer,"[42] "I'm a doctor, not an escalator,"[43] and sometimes in reverse order as in "I'm not a magician, Spock, just an old country doctor."[44]

McCoy's often cranky but humane character made him one of the most enduring examples of the honourable medical doctor on television and in film. Yet, we can question his resistance to combining his medical skill and knowledge with any other profession. Is medicine a special kind of human activity with its own internal morality that precludes its practitioner from using it for non-medical ends? Is the profession of healing a higher calling that requires a doctor to refrain from engaging in activities that she knows may harm others? If one could show that the military and medical professions shared fundamental values, aims, and duties, then the role of physician-soldier would not be an "inherent moral impossibility" as Sidel and Levy claim. Moreover, it could go some way to showing that the physician-soldier does not have a higher calling. Finally, it may follow that it is morally permissible for a physician-soldier to use her medical skills and knowledge for non-medical ends.

iii. Soldier first, physician second

Another way to solve the dual-loyalty dilemma is to argue that extra-military considerations are irrelevant to military decision-making. One way to support this claim is to denude medicine of its sanctified role by reducing it to a certification of skill. The most succinct statement of this approach comes from Dr. David Tornberg, former Deputy Assistant Secretary of Defense for Health Affairs. Gregg Bloche and

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[41] *Star Trek: The Original Series,* Season 2, Episode 4, "Mirror, Mirror," directed by Marc Daniels, aired on October 6, 1967, on NBC, https://www.primevideo.com/detail/0I3S517SCXAFEUZ0M8P0NY3PFA/ref=atv_dp_season_select_s2.

[42] *Star Trek: The Original Series*, Season 1, Episode 26, "The Devil in the Dark," directed by Joseph Pevney, aired on March 9, 1967, on NBC, https://www.primevideo.com/detail/0RLGFOASUIWE2L5OM3DG8CJO83/ref=atv_dp_season_select_s1.

[43] *Star Trek: The Original Series*, Season 2, Episode 11, "Friday's Child," directed by Joseph Pevney, aired on December 1, 1967, on NBC, https://www.primevideo.com/detail/0I3S517SCXAFEUZ0M8P0NY3PFA/ref=atv_dp_season_select_s2.

[44] *Star Trek: The Original Series*, Season 2, Episode 12, "The Deadly Years," directed by Joseph Pevney, aired on December 8, 1967, on NBC, https://www.primevideo.com/detail/0I3S517SCXAFEUZ0M8P0NY3PFA/ref=atv_dp_season_select_s2.

Jonathan Marks provide a good summary of Tornberg's view of the military physician:

> A medical degree, Tornberg said, is not a "sacramental vow" – it is a certification of skill. When a doctor participates in interrogation, "he's not functioning as a physician," and the Hippocratic ethic of commitment to patient welfare does not apply.[45]

Stripping medicine of its ethic by reducing the medical practitioner to the role of technician may have unacceptable consequences. Marks laments the following:

> health professionals – whether physicians, psychologists, nurses, medics, or others – who have served or now serve at Guantanamo Bay, have become pawns in the mistreatment of detainees and in the debate over their treatment.[46]

Psychiatrists and psychologists at Guantanamo Bay and Abu Ghraib were considered behavioral scientists who advised military intelligence on interrogational torture.[47] Military officers had access to detainee medical records, and medics and doctors cleared detainees for interrogation. Reducing the medical practitioner to a technician also creates a space where "physicians are free to apply their skill to maximise the goals of military necessity irrespective of the effect on patients."[48]

Despite these serious concerns, Allhoff argues that the physician-first solution to the dual-loyalty dilemma fails because it requires that one hold dubious metaphysical commitments. According to Allhoff, the physician-first solution holds the unjustified assumption that having medical knowledge and skills confers moral duties. But this, Allhoff argues, is a false assumption. Assuming that hostile interrogation is morally permissible, is there any reason to bar medically-trained soldiers from using their medical skills to facilitate the interrogation process? Allhoff helpfully translates the physician-first solution into argument form as follows:[49]

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[45] Bloche and Marks, 4.

[46] Ibid.

[47] Ibid.

[48] Koch, 251.

[49] Allhoff, "Physician Involvement in Hostile Interrogations," 99.

P1. The medically-trained interrogator has medical knowledge.
P2. If the medically-trained interrogator has medical knowledge, then she has certain moral duties.
C. The medically-trained interrogator has certain moral duties.

Allhoff argues that the argument is unsound because P2 is false. It is not the case that "knowledge of P is *sufficient* to obligate an agent to ϕ."[50] Normative principles can obligate an agent to ϕ, i.e., maximize happiness, but knowledge of non-moral propositions cannot. Knowledge and technical skill are value-neutral. Therefore, "[m]edical knowledge alone is not sufficient to create moral obligations absent some moral principle that would yield those obligations."[51] If Allhoff is right that P2 is false, this lends support to Tornberg's claim that a physician-soldier is not functioning as a physician when he participates in interrogation. Accordingly, the various medical ethical codes and bioethical principles would not apply. Allhoff concludes that medically-trained interrogators act as soldiers, not physicians, and are therefore not bound by medical ethical codes or bioethical principles.

Some will see this as a positive development. There will be times when the welfare of a physician-soldier's community should be prioritized over her patient. Physician-soldiers may rightly be called on to use their medical expertise in the service of their community, and this service may include participation in hostile interrogations or weapons development.[52]

The greatest weakness of Allhoff's soldier-first solution to the dual-loyalty dilemma is that it dodges the issue. Allhoff asks whether medical knowledge or skill is not sufficient for conferring the moral duties of a physician onto a medical technician. But that is not the right question. We are not interested in figuring out how to circumvent using a Hippocratic Oath card-carrying physician with a McCoy Complex in hostile interrogations, assuming such interrogations are permissible. What we want to know is whether participation in interrogations or weapons development is morally permissible for someone with *a medical degree*. If it is, then *a fortiori* it is also morally permissible for medical technicians and Allhoff's solution is unnecessary.

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[50] Ibid., 100.

[51] Ibid.

[52] Michael L. Gross, "Is Medicine a Pacifist Vocation or Should Doctors Help Build Bombs?" in *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff, 151-166 (Dordrecht: Springer, 2008).

Commensurability and incommensurability approaches to solving the dual-loyalty dilemma share a major assumption. They all assume the model of the physician as helper. This model generates the conflicts and tensions that these solutions attempt to resolve. I do not deny that physicians heal. But this is not all they do, and the physician-as-healer model is not only model available to us.

III. Neutrality, impartiality, do no harm

Madden and Carter argue that "[Physician and soldier] are two very different professions, yet societies, if they are to survive, need both of them, just as they need laws and moral direction. The physician-soldier bridges these two professions."[53] Some theorists attempt to bridge the gap between the military and medical professions by showing that there is a great deal of overlap between their respective ethical codes, values, and ideals.[54] Hence, the military and medical professions are not fundamentally opposed.[55] This is good news for commensurability but bad news for segregation. However, "not fundamentally opposed" does not mean "fundamentally supportive." Shared principles, values, and aims only take us so far because there are three crucial differences between the physician and soldier that cast them apart. These differences are neutrality (not taking sides), impartiality (medical attention without discrimination), and the "do no harm" principle. Recently, there has been pressure on the idea that neutrality, impartiality, and "do no harm" principle are realistic values for the medical profession to uphold. The next three sections intend to place even greater pressure on these values.

a. Neutrality

Neutrality is one of the seven fundamental principles of the International Committee of the Red Cross (ICRC). The ICRC declares that "In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature."[56] However, we have good reasons to doubt

[53] Madden and Carter, 279.

[54] Frisina, 51; Madden and Carter, 281.

[55] Cristiane Rochon and Bryn Williams-Jones, "Are Military and Medical Ethics Necessarily Incompatible? A Canadian Case Study," *Journal of Law, Medicine and Ethics* 44, no. 4 (2016): 649.

[56] International Committee of the Red Cross, *The Fundamental Principles of The International Red Cross and Red Crescent Movement* (Switzerland: ICRC, 2015), https://www.icrc.org/sites/default/files/topic/file_plus_list/4046-the_fundamental_principles_of_the_international_red_

the positive association of the physician as healer with neutrality. Consider that it would be *perverse* to be neutral in the face of genocide or other grave human rights violations. The ICRC was aware of the concentration camps in WWII but remained silent to avoid compromising its neutrality. The result was disastrous. This is why some members of Médecins Sans Frontières (MSF)/Doctors Without Borders question the status of neutrality in its own charter.[57]

This criticism of neutrality is compelling. It gives us a reason for believing that, at least sometimes, physicians should not be neutral. More than that, we also have a reason for thinking that neutrality is fundamentally opposed to what it means to be a physician.

Notice that neutrality is only discussed when viewing the physician-soldier in relation to the enemy, i.e., states, guerilla groups, or terrorist organizations. These are large or small groups that consist of members who fight against another group. But this is the wrong level of analysis with respect to physician neutrality. If we want to determine whether neutrality is essential to medicine, we must consider the physician in peacetime as a civilian in relation to her patient and whatever is causing her patient's suffering.[58] This is the correct level of analysis because the civilian physician in peacetime is the starting point for medical ethics. Medical ethics was not born from the context of warring groups of people. Hippocrates did not create the Oath because his nation frequently went war. So, we should consider physician neutrality at the level of the civilian physician in peacetime.

Imagine a patient has ocular melanoma that can be defeated if his ophthalmologist uses high-energy x-rays to kill the cancer. When considering physician neutrality, we should be clear about who or what a civilian doctor in peacetime is neutral. The first thing to do is specify the relevant "sides." In the ocular melanoma case, there is the patient on one side and the ocular melanoma on the other. The patient has sought out her ophthalmologist to help her kill the cancer that has besieged her eye. This is a case of patient versus cancer. Now imagine what our reaction would be if we overheard the ophthalmologist saying to his colleague that he was neutral between the patient defeating the melanoma or the melanoma defeating the patient. I suggest that we would be deeply disturbed by the ophthalmologist's disinterestedness. Just as it would be perverse to

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cross_and_red_crescent_movement.pdf.

[57] Fiona Terry, "The Principle of Neutrality: Is It Relevant to MSF?" *Les Cahiers de Messages* 113 (2000): 1-6.

[58] When I say "peacetime," I am referring to a state or condition of no conflict or war at the level of groups of people.

remain neutral in the face of gross human rights violations, such as genocide, it would be perverse if the ophthalmologist were neutral between his patient and the melanoma. Disinterested medical care seems wrong. The ophthalmologist should choose a side, and we would expect him to choose his patient's side! If patients did not know whether they would be seen by a doctor who was on their side when they go to the hospital, the whole medical profession would collapse. There is an implicit agreement between doctors and patients that doctors are on the side of the patient, not whatever is beleaguering the patient. So, neutrality is neither intrinsic to the medical profession nor is it advisable or desirable. Physicians are not neutral actors. The essence of medicine is non-neutrality and that means choosing to side against whatever is afflicting a patient.

An objection would be to argue that the ocular melanoma is not the sort of thing that one can be neutral about in the way Switzerland was neutral in WWII. Cancer is a disease not a person, a group of people, or a state. Discussions of neutrality must take place in the domain of human relations, not relations between humans and non-human entities. Therefore, my argument for the inherent non-neutrality of physicians is misguided. I would respond that, whether cancer is a person or not is irrelevant. The key point is that a doctor can *choose a side*. This was the case in WWII with the Nazi doctors and Japanese experiments performed by Unit 731. If doctors can choose between reducing their patients' suffering or helping a disease to manifest or progress in a certain way in an experimental subject, then whether ocular melanoma is a person or not is irrelevant. All that matters morally is which side a physician chooses to help. Novels and film are replete with evil doctors who choose the object of their scientific interest over their patients. These famously include Doctor Moreau who created human-animal hybrid beings using vivisection (*The Island of Dr. Moreau*, 1896) and the synthetic science officer Ash who secretly allowed crew members of the commercial space craft Nostromo to become impregnated with an alien as a means for transporting it undetected back to earth (*Alien*, 1979). These characters are evil because civilian physicians in peacetime should not only be non-neutral between their patients and the enemy, they should always choose the side of their patients.

b. Impartiality

Impartiality is also one of the seven fundamental principles of the ICRC. The ICRC declares the following:

> The Movement makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeav-

> ours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.[59]

Regarding impartiality, Article 12 of Geneva Convention I (1949) states the following:

> Members of the armed forces who are wounded or sick shall be treated humanely and cared for without any adverse distinction founded on sex, race, nationality, religion or any other similar criteria [...]. Only urgent medical reasons will authorize priority in the order of treatment to be administered.[60]

The ICRC and Article 12 both state that urgent medical need is the only legitimate criterion for discriminating between patients. No other criteria will enter into the determination of who receives medical attention. For example, although the conditions for mass casualty triage (a shortage of medical supplies, overwhelming casualties in a short time and the immediate threat of troop degradation) rarely come together in the theatre of war today, such urgent medical emergencies do occur. On these occasions, Michael Gross argues that military necessity takes priority over Article 12.[61] Asking physician-soldiers to be truly impartial or give medical attention only on the basis of urgent medical need may result in helping the enemy return to battle. This could lengthen the conflict and increase the risk of more harm to soldiers and civilians on both sides.[62] Furthermore, diverting scarce medical resources to enemy wounded turns impartial medical care into an unreasonable burden on a state's ability to wage war effectively.[63]

Gross nevertheless maintains that rare cases *do not invalidate* the Geneva Conventions rule on impartiality. He takes it that military ne-

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[59] International Committee of the Red Cross, *The Fundamental Principles of The International Red Cross and Red Crescent Movement* (Switzerland: ICRC, 2015).

[60] API, *Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts* (Protocol I), 8 June 1977, Geneva: ICRC.

[61] Gross, "The Limits of Impartial Medical Treatment," 74.

[62] Justin List, "Medical Neutrality and Political Activism: Physicians' Roles in Conflict Situations," in *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff, 237-253 (Dordrecht: Springer, 2008), 242.

[63] Gross, "The Limits of Impartial Medical Treatment," 74.

cessity is only a defensible *exception* to Article 12.[64] Thus, he claims that rare exceptions only *set aside* the underlying principle of medical impartiality.[65] Instead of considering that we may need to update to Article 12 (after all, the Geneva Conventions are not set in stone like the Ten Commandments), Gross chooses to reaffirm the image of the physician as an *impartial* healer.

In peacetime, the patients that doctors see generally are not opposing forces as they sometimes are in a wartime field hospital. But even if a patient and physician are not enemies, there is an important sense in which a physician should not be impartial. Imagine two patients who go to the same medical clinic. The doctor can only add one more patient to her family practice before she is overburdened. Patient X has a medical condition and Patient Y does not. In this situation, the doctor should not be impartial between X and Y. If she can only see one more patient, she should be partial to Patient X who has a medical need. So, the medical profession is not intrinsically impartial nor is it advisable or desirable for individual physicians to be impartial between patients.

Doctors do more than just give medical attention at the very moment a patient has been gripped by illness. They also try to *prevent* illness just as political representatives use preventative diplomacy as a tool to prevent war. Preventative medicine is just one facet of medicine in which physicians work to prevent obstacles to health such, as illness and disease, before they occur. Medical partiality means giving preventive medicine only to those who have a medical need such as children who should be vaccinated against chickenpox or vaccinating soldiers against infectious diseases specific to their assigned geographic locale.

Now consider how medical non-neutrality and partiality function together when a physician becomes a physician-soldier. A civilian physician is not an impartial agent with respect to her patients. When a civilian physician becomes a physician-soldier, she remains partial to those patient-soldiers or non-combatants who require medical attention. This is just a physician exercising her skills on people who need it now or for the future rather than those who do not. All the patients she sees have a medical need. Medical partiality actually says nothing about who among those that need medical attention should gain access to it, when, and in what order. We need a different principle to decide how to triage. As for neutrality, a civilian physician is non-neutral

[64] Ibid.

[65] Ibid.

because she chooses her patient over whatever is causing her patient's suffering. A doctor should not choose to side with the enemy within, whether it is syphilis, the plague, or the coronavirus. When a civilian physician becomes a physician-soldier, she becomes doubly non-neutral because she also enlists on the side that is against the enemy without, whichever state, guerilla group, or terrorist organization that may be.

c. *Primum non nocere* (above all, do no harm)

The "do no harm" principle as a medical value is also questionable. If the physician is primarily a healer, then it appears that the "do no harm" principle may be an unbridgeable difference between the military and medical professions. Soldiers are licensed to kill while doctors are licensed to heal. However, Rochon and Williams-Jones note that issues such as euthanasia, assisted suicide, and abortion are increasingly being recognized in medicine as deeply connected to the bioethical principles of beneficence and autonomy.[66] This view raises the question of whether the "do no harm" principle in medicine is as absolute or fundamental as it once was. The same is true of soldiering. The principle of beneficence is intimately connected to the legitimate use of force. For example, soldiers on international peace-keeping missions are restricted from intervening with force to stop human rights violations like genocide (e.g., Rwanda) if they are not operating under Chapter VII of the UN Charter.[67] This view of "peace-keeping" as synonymous with "do no harm" deserves as much criticism as the ICRC's absolute neutral stance in WWII with respect to their knowledge of the concentration camps. Harming to prevent harm is not by definition wrong.[68]

During the COVID-19 pandemic, the number of patients who needed ventilators far exceeded availability. Imagine this hypothetical case. Two patients who both need a ventilator due to COVID-19 have the same clinical condition and expected outcomes. Patient A is a nurse and patient B is a non-medical worker. There is only one ventilator. Who should receive this scarce resource? If A is given the ventilator, then B loses out. If B is given the ventilator, then A loses out. Either way, someone loses. But if we have enough ventilators for everyone, then no one will lose out. Patient A and Patient B will both have access to a ventilator, not based solely on medical need, but also on availability. If all hospitals had enough doctors, nurses, and resources, triage would not be necessary.

[66] Rochon and Williams-Jones, 648.

[67] Ibid.

[68] Ibid.

Anyone who entered an emergency room, whether for a heart attack or a hang nail, would be attended to in good time.

This example is intended to illustrate that harming is not intrinsic to medicine. Below, I will also show that harming is not intrinsic to the military. For the moment, assume this is true about the military. Nevertheless, it is a fact that physicians and soldiers must sometimes do harm to achieve good ends. The reason is because we have not figured out how to achieve our medical or military goals without causing harm. So, harm is not intrinsic to medicine or the military but is currently unavoidable. If one doubts this claim about medicine, then consider why we bother improving surgical techniques. Doctors participate in the design and development of new medical procedures, better equipment, and safer pharmaceuticals with fewer side effects. Why do they bother? They bother in order to reduce harm and suffering *caused by medical treatment*. Sharper scalpels, better anesthetics, and robot-assisted surgery all lead to better outcomes. Better medical outcomes mean more effective and *less harmful* medicine. Imagine we could remove an appendix without disturbing any of the surrounding tissue to extract at it. No one would ever countenance a scar! But anyone who has had an appendectomy has a scar because physicians have not yet figured out how to perform this surgery without leaving a mark, although scars are becoming smaller and less visible thanks to improved surgical practices. Of course, this would not be possible if physicians refrained from participating in the development of better medicine.

When harm is necessarily unavoidable, as it is in medicine today, the "do no harm" principle cannot be interpreted as an absolute prohibition on causing harm. Instead, the "do no harm" principle should be understood as "do as little harm as possible" to get the job done, and this begins to sound strikingly similar to the *jus in bello* principles of proportionality and necessity that constrain the use of force in war.

Harming is not intrinsic to the military either. Someone might argue that this is false because the military uses weapons and weapons are inherently harming. According to Vivienne Nathanson, "Weapons always do harm; it is the essential element of their nature."[69] So, how could harm not be intrinsic to the military which uses weapons? Consider the prospects for reducing harm in war with "non-lethal weapons" (NLWs). The US Supreme Court defines NLWs as follows:

[69] Vivienne Nathanson, "The Case Against Doctor Involvement in Weapons Design and Development," in *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff, 167-177 (Dordrecht: Springer, 2008), 174.

> Weapons, devices and munitions that are explicitly designed and primarily employed to incapacitate targeted personnel or materiel immediately, while minimizing fatalities, permanent injury to personnel, and undesired damage to property in the targeted area or environment. NLW are intended to have reversible effects on personnel or materiel.[70]

NLWs are not intended to kill, maim, or permanently disfigure. Unlike ordinary weapons used in war that can do a great deal of harm, "non-lethal weapons offer the prospect of reducing casualties and protecting civilians during asymmetric war."[71] I would add that the benefits of NLWs also apply to soldiers in asymmetric and conventional warfare. The whole point behind the development of NLWs is to reduce harm in war just as physicians seek to reduce harm caused by medical treatment by participating in the design and development of more effective and less harmful medicine. If the military can achieve its ends with NLWs, then they should be considered.

NLWs give us a good reason to believe "that the use of lethal or deadly force per se is not the *raison d'être* of the military or of military operations."[72] Yet, one could argue that even if NLWs reduce harm, they still cause harm. So, harming is intrinsic to the military.

To see why this is false, consider that a weapon is an instrument or object of offensive or defensive combat; it is an instrument used in fighting. Next, consider the essential purpose of weapons in the context of war: "Weapons are developed to be more efficient at their essential purpose – removing obstacles from the way of an advancing military force."[73] The objects to be removed in battle could include buildings, people, or tanks. However, "removing obstacles" does not entail that harming is *necessary* to achieve that goal. The reason soldiers still cause harm is for the same reason physicians still cause harm. They have yet to discover how to develop and design harmless weapons (although sticky foam is a good example of a less-than-lethal weapon). But harming is not an *essential element* of weapons. So, although it is

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[70] United States Department of Defense, *Non-Lethal Weapons (NLW) Reference Book* (Joint Non-Lethal Weapons Directorate, 2012), https://www.supremecourt.gov/opinions/URLs_Cited/OT2015/14-10078/14-10078-3.pdf.

[71] Michael L. Gross, "Medicalized Weapons Modern War," *The Hastings Center Report* 40, no. 1 (2010): 35.

[72] Pauline Shanks Kaurin, "Non-Lethal Weapons and Rules of Engagement," in *Routledge Handbook of Military Ethics*, ed. George R. Lucas, 395-405 (Abingdon: Routledge, 2015), 396.

[73] Gross, "Pacifist Vocation," 169.

true that militaries currently use weapons that do harm, that does not mean the military is by necessity a harming profession.

In the previous sections, I tried to show that neutrality, impartiality, and the "do no harm" principle are not medical values that physicians should hold. The physician is a non-neutral and partial agent who sometimes unavoidably does harm to remove obstacles to health. The physician is beginning to sound like a soldier, another non-neutral and partial agent, who must sometimes do harm to remove obstacles to peace. But even if many were to agree with this much, I suspect there would still be resistance to the idea that a physician really is a fighter, a warrior in a white coat, and the further inference that the foundation of medical ethics should be a fighting ethics. The reason for this resistance, I think, is a reluctance to take the final step and acknowledge that if a physician is a fighter, then medicine must be a weapon. And if medicine is a weapon for fighting, then we have good reasons for reconsidering or, as I shall suggest, abandoning the physician as healer model.

IV. Medicine as a weapon

There is no question that medicine is used as a weapon. Military medical professionals have been called on to lend their medical expertise for the development of chemical and biological weapons. But even if it is true that medicine is a weapon, should it ever be used for non-medical ends? Currently, the Chemical Weapons Convention (2020) prohibits the use of chemical weapons in armed conflict but excludes "law enforcement, including domestic riot control purposes" [article II.9 (d)].[74]

I argued above that weapons are not inherently harming. This means that, if medicine is a weapon, it is not inherently an instrument of harm, even if its current use cannot avoid causing patients harm to remove obstacles to health. To reduce medicalized harm, physicians participate in the design and development of more effective and less harmful medicine.

Madden and Carter seem to implicitly assume that medicine is a weapon:

> It is not an accident that many words of clinical medicine are the words of war. For instance, a *war* is being waged against cancer, diseases *attack* the body, and the physician

[74] Organization for the Prohibition of Chemical Weapons, *Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on Their Destruction* (OPCW, 2020), https://www.opcw.org/chemical-weapons-convention/articles/article-ii-definitions-and-criteria.

> *aggressively* uses everything in his *armamentarium* to claim *victory* for his patient over the disease. "We will defeat cancer in our lifetime," was a long standing pledge of the American Cancer Society. Tumors invade tissue. They are destroyed by radiation or chemotherapy. Antibiotics kill bacteria. These are not the words of passive exercises. They are the words of battle, a battle that can result in the death or debilitation of the patient if not successfully fought. This vocabulary is appropriate because for many patients and medical professionals who help them, the perceived *ultimate responsibility* of the practitioner is to defeat death.[75]

I suggest that the words of war are appropriate because cancer, malaria, and coronaviruses pose serious threats to the bodies they invade. Just because the enemy during the COVID-19 pandemic was a virus (SARS-CoV-2) this no less diminishes the fact that a global war was taking place against an invisible enemy that only doctors and nurses could fight. As resources quickly became scarce in the early days of the pandemic, mass casualty triage was the new normal in emergency rooms all over the world. The principle of salvage was the operational determinant of who gained access to ventilators in very short supply. Medicine was used as a *weapon* to fight the enemy.

An objection would be to accept that the vocabulary of war is appropriate because it can have positive effects on efforts to deal with the pandemic but reject my claim that the coronavirus or any other disease, such as Ebola, HIV/AIDS, or Zika, is an enemy properly speaking. People are enemies, not viruses. To be a fighter properly speaking, one needs to be fighting another human being. Doctors and nurses do not fight people in their clinics and hospitals. They treat people. Therefore, doctors and nurses are not fighters like soldiers fighting in Iraq or Afghanistan. If doctors and nurses are fighters, they are so only metaphorically. Referring to doctors and nurses as we did during the pandemic as warriors on the frontlines putting their lives at risk in the battle against COVID-19 may boost morale and courage among medical practitioners, but it does not make them fighters. Once again, my argument is misguided.

I would respond that whether an enemy is human or not is irrelevant. An enemy is anything that is hostile to some person or some thing. The hostile entity need not be a person. For example, it is common to refer to an environment as being "hostile" to human life such

[75] Madden and Carter, 279-280.

as the hostile planetary surface of Mars or Venus. Back on Earth, Death Valley in California is a hostile environment for human life with average temperatures in July of 48°C (116.6°F). The East Antarctica Plateau is an extremely hostile environment where temperatures can drop to -98°C (144°F). Environments are not human but can be hostile to humans because they can pose a serious threat to human and non-human survival.

Disease and sickness are the enemies of health and physicians are fighters who combat them. It may sound like metaphor, but this is only because we continue to be gripped by the physician-as-healer model. Pandemics, whether past or present, greatly strain the notion that doctors and nurses are simply helpers and healers. They do help. They do heal. And thank goodness they do. But they do so by fighting. Physicians are fighters.

I suggest the real issue goes even deeper than just using medicine as a weapon for non-medical ends. No one has an issue with using medicine to exterminate or completely eradicate cancer, COVID-19, or chickenpox from the face of the planet. Of course, these are cases of using medicine as a weapon for medical ends (removing obstacles to health) against non-human enemies. The deeper concern, I think, is using medicine as a weapon against human enemies for non-medical ends. The concern is completely justified. Frisina explains:

> Since the victims of the Nazi medical horrors were defined out of a class of human beings protected by codes of conduct, rule of law, and rudimentary elements of conventional decency, the behavior and conduct of these nefarious medical professionals was not construed in their minds as a violation of ethical duty and obligation.[76]

How do we prevent the malevolent use of medical knowledge and skill if medicine is stripped of its healing ethic and reduced to a mere means for military ends? The concern is real. The actions of Unit 731 and the Nazi doctors, Dr. Moreau, and science officer Ash are not about healing or improving the health and well-being of patients. These are actions to improve medical science for the sake of science and a misguided interest in an alien entity. NLWs development is not about improving health; it is about improving security. So, when we think about using medicine as a weapon to make a human enemy unconscious (calmatives) or hallucinate (psychotropic drugs), it feels like we are treating

[76] Frisina, 41.

humans like a disease or bacteria, something nonhuman we lose no sleep over destroying, just as most doctors in Nazi Germany and Unit 731 lost no sleep over experimenting on or exterminating their human subjects.

The deep-seated worry is that we will not be able to control medicine once we accept its use as a weapon. But that is a legitimate concern for all weapons use. This is why we have crafted conventions and laws of war to constrain kinetic weapons use in times of conflict. The use of kinetic force in war is highly circumscribed. The use of medicine in peacetime is also highly circumscribed. A physician cannot use radiotherapy to no end to kill the ocular melanoma that has besieged his patient's eye. It will probably kill his patient. A physician may not prescribe a pharmaceutical at a dosage that exceeds safe levels. It could kill or seriously harm his patient. The use of medical knowledge, skill, and technology is already highly circumscribed to prevent harm. This is neither unique to the military nor foreign to the medical profession.

I have been defending a view of the physician as a fighter. An advantage of the physician-as-fighter model is that it can embrace the physician as someone who has the power to help and heal but understands that she does so by *fighting*. But engaging in battle comes with its own ethical code. Medical ethics and military ethics are both a fighting ethics. I suggest the only relevant differences between the civilian physician as a fighter and the soldier as a fighter are the kind of enemy they fight, the location of the enemy, and the type of weapons they use to fight the enemy. The military uses guns and bombs. The medical profession uses medicine. And as we already know, the location and kind of enemy and the type of weapons used to fight greatly constrain a physician and soldier's actions and choices. Neither the military nor the medical profession can use the weapons of medicine and arms without discretion. If the arguments above are sound, combing the role of physician and soldier is just as Frisina says: "this melding of professions does not make for such strange bedfellows as one might naively assume."[77]

V. Conclusion

At the beginning of this paper, I introduced the case of the military surgeon who had to choose between saving his compatriot or the enemy. I claimed that the military surgeon should save his compatriot. It should be clear why. The physician is not a neutral fighter. The phy-

[77] Ibid., 51.

sician should always side with his patient against the "enemy within" to fight whatever is causing him to suffer. But in the military surgeon case, the physician is also a soldier. While medical partiality, as I have argued, means a physician should only give medical attention to those who need it, and both his compatriot and the enemy combatant need medical attention, the military surgeon is also a soldier who has sworn to fight for his country against the "enemy without" to remove the obstacles to peace. The military surgeon picked his side. Only one of the two patients that needs lifesaving surgery is the "enemy without." The military surgeon only has time and resources to fight the "enemy within" for one patient. Given that he has sworn to defend his country from the enemy without, he should fight for his compatriot against the enemy within. The physician-soldier fights alongside his compatriots against the "enemy without" by fighting alongside them against the "enemy within." In this case, the military surgeon saved the wrong soldier.

It does not follow from medical ethics grounded in a fighting ethics that physician-soldiers should abandon wounded enemy combatants or enemy civilians who have a medical need. We are not Hippocrates. We no longer believe that giving the enemy wounded medical attention *necessarily* means we are increasing his chances of winning his war against us. But this crucially depends on which enemy wounded our physician-soldiers help. Although there is much more that needs to be said, I would like to offer a preliminary suggestion regarding mass casualty triage in war.

The usual rationale for mass casualty triage in war is that military necessity takes priority over medical impartiality. This is justified by arguing that diverting scarce medical resources to enemy wounded can impede a state's ability to wage war effectively. Gross argues that we should salvage our own combatants first to conserve the fighting strength of our military. The remaining wounded should receive impartial medical attention. Whether friend or foe, only urgent medical need can justify discriminating between the remaining wounded. But I have already argued against medical impartiality the way it is being used here. There is no conflict between military necessity and the medical partiality of the physician-soldier. The question is what precisely does "military necessity" mean for the *physician-soldier*?

The ultimate objective and responsibility of the physician-soldier is to win battles even if it is true that she save lives and eases the suffering of her patients in the process of fighting. Mass casualty triage grounded on the principle of winning battle means a physician-soldier will prioritize

her patients based on fighting the battles "within" that will best help her side win the battles "without." In most cases, this will mean giving medical attention first to her compatriots.[78] The direction of medical attention runs first from giving the least medical attention to those on her own side who can be salvaged (return to battle) and then, in increasing degrees of medical attention, to those on her side who need it most. Contra Gross, a physician-soldier does not fight for those on her side she can salvage and then treat the remaining wounded, friend or foe, impartially or based on medical need alone. The reason for prioritizing our all of our wounded first even if some or all are *less wounded* than the enemy is further justified on *jus post bellum* grounds. It is not just the fact that a soldier is wounded that determines whether she receives medical attention. The nature of the wound or illness is also important. Repatriating soldiers who otherwise would be able to return to the workforce, raise a family, or volunteer but cannot because they did not receive the necessary medical attention on the grounds of impartiality has serious implications for the survival of society. Not only does disease, disfigurement, and disability affect a soldier's self-confidence, pride, and dignity, but returning more soldiers as pensioners because they are not capable of participating in the workforce places an enormous economic and social burden on the state.[79] Military necessity includes considerations for the survival of society *post-bellum*.

Regarding the enemy, the direction of medical attention is reversed. The physician-soldier gives medical attention first to enemy wounded who need lifesaving medical attention and then in decreasing degrees to those who need it the least. The reason for this reversal is not based on medical need, as is usually argued. It is justified by the physician's legitimate and overriding objective of winning battles. Enemy wounded who need urgent medical attention are generally soldiers who cannot be salvaged. Prioritizing the battle within assists the physician-soldier's side with winning the war because these enemy soldiers are not likely to return to battle. One could make the argument that

[78] I say "in most cases" because there may be situations when saving the enemy first will best assist in winning the war. The enemy may have information that we could use to end the war more quickly or simply save more lives. But in such a case, we should only save the enemy over our own if the *chance* of getting the information is worth the risk of losing our compatriot. If the chance is very good then whether we fail or succeed, our soldier will not have died in vain. I think this is right. Imagine a father who has a good chance of saving his adult daughter's life but only if he donates his heart. Even if the operation failed and both died, it is easy to imagine the father thinking he did not die in vain so long there was a good chance that he could save his daughter. Of course, what counts as a "good" chance for the one willing to sacrifice his or her life will be highly subjective.

[79] Leo van Bergen, "For Soldier and State: Dual Loyalty and World War One," *Medicine, Conflict, and Survival* 28, no. 4 (2012): 321.

triage in war should also be sensitive to the *jus post bellum* principle of "compensation." While post-war restitution by an unjust aggressor may be warranted, a defeated country needs to have the resources for its own reconstruction and this would include healthy manpower.[80] A defeated state may be overburdened by the repatriation of diseased, disfigured, and disabled enemy soldiers whose condition makes them a burden on their state because they may be unable to care for their families or participate in the reconstruction of their society.

This is just one example of how medical ethics grounded in a fighting ethics may change how physician-soldiers should triage in war. There may be other changes to the patient-physician relationship as well. The contemporary physician-patient relationship is currently grounded in the physician-as-healer model. A physician and patient have reciprocal duties and responsibilities. I do not have the space to discuss those duties and responsibilities here but will just note that what they entail will change if the physician-patient relationship is grounded in a physician-as-fighter model. Patients are already expected to participate in their own healing but how the physician and patient fight together may require deemphasizing the significance of certain bioethical principles and emphasizing new ones.

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[80] Brian Orend, "*Jus post bellum*: The Perspective of a Just-War Theorist," *Leiden Journal of International Law* 20, no. 3 (2007): 580.

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