Should medical ethics justify violence?

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Medical ethics needs to be on its guard against those in military or political power who would seek to subvert its most basic tenets in order to serve their own ends

Emergencies and warlike situations often force medical personnel to follow orders and perform actions or duties pertaining to their field of expertise in flagrant violation of their professional code of ethics. Opposing such orders may be contextually impossible, or elicit unduly high personal costs. Medical ethics, while lamenting these impositions, is often reduced to passive and silent disagreement. In recent years, however, biomedical ethics has become active in accepting and supporting these estrangements from accepted standards and values of the healthcare professions, coming up with justifications of torture; suggesting non-treatment of the wounded, depending on their combatant status; prompting collaboration in the development of biological weapons, and disregarding informed consent.

Physicians' participation in torture has been unanimously condemned and, although acknowledging that such conduct "is the result of the displacement of their medical vocation by the doctrine of 'national security'", such an "ideological substrate" has nevertheless been deemed untenable.¹ Perpetrators were found to have committed their deeds in an ethical void²; this was recognised, but in no way did it serve to excuse physicians from the duty of opposing induced suffering and assuaging its effects to the best of their abilities.

Torture in its "humane" form has been defended on utilitarian grounds,³ using weak arguments that are unable to justify physicians' active participation in torture. For the most part, professional ethics has remained adamant in its undaunted disapproval of medical non-therapeutic involvement in violent scenarios such as war, terrorism, and even torture. Nobody would have thought, in earlier times, that medical ethics could take any other position than to unrelentingly reject physicians' participation in torture, and to express regret whenever such participation took place under duress. Unfortunately, a new trend has opened up a debate about the medical ethics involved when

doctors participate in torture. The time honoured principle of "first do no harm" has been replaced by tendentious arguments, which attempt to explain why the medical profession has outgrown its traditional role of assisting the sick and why it must now adopt new social responsibilities in emergency situations.

JUSTIFYING VIOLENCE

The ethics of violence is based on the entrenched thomistic (from the work of St Thomas Aquinas) permission to kill in self defence, and the doctrine of "the just war" has been developed to make the case that just wars exist, albeit under very specific conditions. And yet, wars have been fought without any regard for the "reigning doctrines of just wars".⁴ The problem reaches the frontiers of bioethics when a "just war" position questions what can legitimately be done and by whom in a supposedly just war scenario. An unprecedented discussion ensues, leading to the claim that healthcare workers should deviate from the ethics of unrestricted commitment to their profession, and adapt their actions to the needs and benefits of military strategy.

In times of war and other emergencies, the legitimately installed government modifies its sovereignty by overriding the legal system and exerting power over human beings who cease to be citizens protected by civil rights and are now seen as biological units whose fate is dictated by a single trait, be that gender, race, or religion. Based on a concept first introduced by Foucault,⁵ the Italian philosopher Agamben has defined biopolitics as the increasing implication of natural human life in the functioning and strategies of power; that is, sovereignty is exercised upon human beings seen as monads—units of being—not as citizens. Medicine and science, he adds, have also come to think in biopolitical categories, as can be typically seen in the current debate on life and death issues.⁶

One of the tragedies of contemporary societies is that ethical perspectives are cancelled by biopolitical measures that

focus on persecuting people just because they belong to some suspected ethnic group. Tension mounts between different understandings of what constitutes the common good—however biopolitical power sees fit to define it—in times of war, especially when terror and threats are ill defined and the enemy becomes invisible. Medical ethics had up till now not been infected by such policies, with the infamous exception of fascism and other similarly vile dictatorships, but biopolitical thought is beginning to seep into the fabric of medical practice and to endanger its moral foundations. As Agamben perceptively writes: "Especially interesting is the biopolitical horizon, which is characteristic of modernity, where the physician and the scientist move in a no man's land that, in other times, only the sovereign could enter" (Agamben,⁶ p 202). Put more bluntly, medical ethics has surrendered to political considerations.

STRATEGY PREVAILS

Our customary understanding of the common good as a corporate, impersonal, and ill defined entity tends to exacerbate conflicts between public and private interests. The vagueness of the corporate conception of the common good makes it easier to override individual rights and allows the powerful to manipulate the definition of the common good in accordance with their own interests.^{7 1}

To avoid these pitfalls, London suggests replacing the corporate conception with a "generic interests view" of the common good, where each individual identifies with those interests she shares with every other member of the community without losing sight of, and control over, particular ends and projects, thus in this way personalising the diffuse concept of the common good. His proposal leaves many loose ends, but what appears somewhat troubling is the belief that the common good, understood from a generic interests view, will be more efficient in persuading individuals to set aside personal goals in favour of shared public interests. They might thus be more easily convinced to accept that "[S]ecrecy could be justified [albeit] only if it is absolutely necessary to safeguard the efficiency of counter-measures" [against chemical and biological weapons]" (London,⁷ p 24) (My own interpolations are shown in square brackets). Supported by additional examples, London concludes that "the generic interests conception of the common good provides a framework within

¹"Corporate", as used by London, is "the collective agent or the body politic" (London,⁷ p 21).

which we can debate what substantive constraints are appropriate for biomedical civil defence research" (London,⁷ p 24). In other words, a semantic turn serves to introduce morally suspect terms such as "secrecy" and "constraints".

Up to this point, London has carefully avoided questioning the substance of medical ethics, but his proposed strategy does pave the way for the moral acceptance of hitherto unjustified, "absolutely necessary" constraints on professional autonomy. Conscription; civil service duties; expropriations, and harsh penalties for deserters and traitors are all examples of extraordinary strategic impositions that have been grudgingly noted by prevailing ethical codes. Strategic emergencies in wartime may override professional ethics, but the new and disturbing feature seeping into medical ethics is the willingness to modify some of its precepts in order to render medical professionals more likely to acquiesce to military demands.

PRESSURE ON PROFESSIONAL HEALTHCARE RELATED ETHICS

In the initial phases of the Gulf War, previously untested drugs and vaccines were to be delivered to servicemen without resorting to the informed consent normally required for investigational substances.⁸ Supportive arguments suggested that the known benefits of the compounds under scrutiny rendered their non-investigational in character and that therefore it was legitimate to authorise their being registered as mandatory protective measures for service people. Furthermore, it would be impracticable to obtain consent signatures from all soldiers.⁹ In opposition to this stance, it was argued that "troops retain a degree of moral agency"¹⁰ and, by being denied the opportunity of informed decision, they were "stripped of one of the few basic rights that American soldiers had previously retained" (Annas,¹⁰ p 27).

Counting on the discipline of enlisted men to blindly comply and recruiting benevolent ethical opinions, informed consent was clearly breached. This was one of the first papers in which research medical ethics accepted the violation of an essential bioethical precept for the benefit of military demands.

Biotechnologists have also been summoned to take "responsibility for the detection of the intentionality of a bioterrorist in the making and before that individual actually perpetrates a harm".¹¹ Consequently, "whistleblowing on fellow biotechnologists", reporting malfeasance, nosiness, and CCTV are encouraged, because "[i]f this should

constitute 'spying', then it is clearly spying in a good cause" (Spier,¹¹ p 584).

PUBLIC HEALTH AND BIODEFENCE

Bioterrorism poses threats that go way beyond the battlefield and present a real menace to civilian populations, comparable to the sudden outbreak of a lethal epidemic. The expertise that is required of public health bodies in dealing with such contingencies is unparalleled by that required of any other organised institution, and the plea to provide appropriate funding and reinforcement of public health bodies' infrastructure are both pertinent and urgent.¹² Unfortunately, well reasoned arguments to this effect are marred by ambiguous statements such as: "The public health infrastructure is the 'nerf de la guerre' (the essential basic component to waging war or mounting a public health campaign...)"¹³ In a similar vein, the need to develop collaboration between police, criminologists and epidemiologists has been in some minds.¹⁴

In 2002 President G W Bush proposed mandatory vaccination of all health professionals and of half a million military personnel—a plan that was greeted with massive opposition. In one bioethical commentary the idea is put forward that healthcare professionals have no obligation to be vaccinated before an actual bioterrorist attack, whereas during the brief period "post-event but pre-epidemic, healthcare professionals would have an obligation to be vaccinated against smallpox".¹⁵ This may be a solid defence of autonomy, but has it been reasonably balanced against the benefits of well designed epidemiology programmes? If philosophers consider themselves authorised to discuss the technicalities of epidemiology and the soundness of military strategies, one must expect that ethics will undermine itself in the name of contingent arguments and situational considerations. The mutual infection between ethics and tactics has imposed contingent considerations on the ethics of biomedical disciplines to the point of distorting their internal morality.

Expenditure to "combat terrorism" tripled from 2001 to 2002, but even "greater funding" is warranted, says one author, considering that "biodefense" also addresses "decades of neglect of the public health infrastructure".¹⁶ Unfortunately this would mean funding public health for the wrong reasons and, in fact, with poor results,¹⁷ in part because efforts have been focused on presumed specific threats, and also because federal agencies have discouraged such "dual functionality" by demanding strict attention to and focus on bioterrorism. The medical

needs of the population had remained unattended till biodefence found reasons to pitch in, arguing that "[A] large uninsured population thus amounts to a substantial barrier to bona fide biopreparedness".¹⁸ Public health ethics will have a hard time understanding that if the uninsured finally receive medical coverage it will be for the sole reason that they are important elements in biodefence. The plea is then made that ethicists "address themselves not only to ethical problems *in* biodefence, but also to the ethics *of* biodefence".¹⁹

MEDICAL ETHICS IN A QUANDARY

Any kind of torture is unacceptable, with the exception of the most unusual situation where essential information could not be obtained otherwise.²⁰ Even then, torture could only be accepted under very strict conditions, stipulating that "antiseptic pain will carefully be increased only up to the point at which the necessary information is divulged, and the doctor will then administer an antibiotic and a tranquilizer" (Shue,²⁰ p 142). Does this mean that as long as the victim fails to break down the physician remains a passive bystander, and that he or she only ministers after torture is suspended? It may be that doctors are not allowed to behave otherwise, but it is not for ethics to uphold such practices.

Torture practices, also called "aggressive interrogation," are being replaced by "non-coercive interrogation [which] would not ordinarily implicate a detainee's health [and yet] there is a case for having an independent physician on standby".²¹ Why so, if supposedly no duress is being exerted? Or does it mean that innovative "interrogation stressors" are being applied, which are legitimated by the physician's presence?

According to Gross,²² torture is always illegal, but could be acceptable as "moderate physical pressure" to prevent imminent, grievous harm. Physicians, he says, should allow "collective well-being and state law to supersede 'their responsibility to' their 'patient's individual wellbeing'". Leaving aside that words such as "patient" and "well-being" are misplaced in a debate on torture, it is highly unsettling that the participation of physicians in torture practices should become more distinct "as we consider grounds that allow a physician to play a pivotal role in a criminal interrogation that utilises physical force". The author concludes that: "[T]orture requires medical assistance and the decision to use physical force always requires the physician's consent."²² The author also says that in a decent society, individuals may be

sacrificed to the common good even at the cost of this being illiberal and ignoring basic human rights. Depending who defines “decent society”, this argument could be employed to justify medical experiments in Nazi Germany, psychiatric commitment in the Soviet Union, and, outside the medical realm, suicide bombers inspired by the good of their religious community.

When physicians are called upon to perform their medical duties on the battlefield or in catastrophic scenarios, the ethics of health care are not jeopardised, for the physician continues to care for the sick and wounded, albeit in a different and not so freely chosen setting. Physicians in war are traditionally considered non-combatants who are told where to exercise their medical skills, but not how to do so. And yet, “[M]edicine in the trenches” should suspend its efforts to help the “Dynamic Object” (vague and indeterminate community goals) and give priority to the *telos* of “Immediate Object”, meaning that it is “good to save lives, and each individual life is regarded as good to save, even apart from...contextualized benefit-burden assessments”.²³ Sound though this paternalistic advice is, the text’s credibility is somewhat eroded when it states that: “[p]erhaps the most difficult problem facing disaster clinicians lies in establishing a requisite *bushi damashi* or warrior spirit” (Trotter,²³ p 411). The call for a warrior spirit in clinicians undermines the idea of non-combatants, causing instability to well established tenets of professional medical ethics.

“[M]edical ethics in war are not identical to medical ethics in times of peace.”²⁴ As a high official in the US military hierarchy puts it, a medical degree is not a sacramental vow, it is a certification of skill. “When a doctor participates in interrogation, ‘he is not functioning as a physician’, and the Hippocratic ethics of commitment to patient welfare does not apply”.²⁵ A disruptive blow is being dealt to medicine if the physician is told when his medical knowledge and skills become subservient to the vagaries of power, and medical ethics is also damaged if it agrees to dismantle its long held moral convictions.

“Enemy combatants have no right to life, they therefore lose their intrinsic right to medical care” (Gross,²⁴ p 24), unless their wounded condition places them beyond being a threat. As for one’s own wounded soldiers, their right “to receive medical care is contingent upon their ‘salvage value’: their claim to medical treatment is only sustained if they are ‘salvageable’—that is, recoverable for

combat duty. As for non-care giving situations, the deterrent capacity and non-lethal feature of chemical and biological weapons “may demand that anyone with appropriate technical expertise, including physicians, contribute to the development of unconventional weapons when necessary” (Gross,²⁴ p 29). Such enormities are not arguable, for they fall outside the language of (medical) ethics.

To classify the wounded, whether enemy or friend, as salvageable or not, and to lay down conditions for legitimate claims to medical care, are typical examples of biopolitical stances that are immune to ethical considerations. They flagrantly violate both the World Medical Association’s Declaration of Geneva, which disallows discriminatory considerations from “interfering between my duty and my patients”, and the American Medical Association’s statement that physicians may choose whom to treat “except in emergencies”. Now, however, we are told that it is precisely in emergencies where it is mandatory to discriminate by treating enemies only if they are unable to regain combatant status, and the friendly wounded only if they be salvageable for future combat.

These are not unimpeachable military orders, they are recommendations argued in a reputed journal on bioethics, illustrating how ethics indulges in subservience and alienation. Discussing medical ethics, or any other kind of ethics, in a biopolitical environment is otiose because dialogue in moral terms has been thereby rendered impossible. Forcefully silencing medical ethics in emergencies is unfortunate but perhaps unavoidable; a much more serious matter is to implode ethical tenets and deny the internal morality of medical practice.

When military codes are imposed on the rules of medical ethics, moral tension may become unbearable if ethical experts agree that healthcare professionals should act like non-deliberating soldiers. For even soldiers are expected to be “good soldiers”, avoiding cruelty and being judicious in not “blindly following orders irrespective of their ethical merits”.²⁶ It seems strange that soldiers should be encouraged to behave ethically while medical personnel are required to adamantly obey strategies that are harmful and contrary to their professional code of ethics.

CONCLUSIONS

An ethical crossroad lies between accepting that warlike conditions may temporarily obliterate medical rights, duties, and the moral convictions of medicine on the one hand, and

witnessing how bioethics distorts and adjust its normative language to the needs and whims of strategists on the other. Moral justification of medical participation in bellicose acts is an unfortunate distortion of professional ethics. Rather, ethicists should engage in supporting sustained resistance against the internal erosion of healthcare ethics.

A new and ugly trend in bioethics is gaining ground, by rehashing and questioning certain conclusions that had seemed definitive and unassailable. This has happened in connection with tenets as firmly established as informed consent; a person’s absolute right to emergency medical care, with no discrimination of any sort applied; the non-participation of physicians in torture, and the abstention of biomedical professions from collaborating in the development of chemical and biological weapons. Reactivating dormant and purportedly settled issues will erode international agreements, as occurs when justifying medical participation in violence, even though this was explicitly addressed and condemned in the Declaration of Tokyo (1975) and other documents. The weakness of declarations becomes clear and makes it all the more important to continue debating in their favour.

Philosophers may find reasons to accept qualified violence and they may show understanding for the unwilling involvement of healthcare professionals, but this unfortunate participation should not be ethically whitewashed. Both the medical professions and society at large need the reassurance that while taking part in bioterrorism, violence, torture, war strategy, and the like may be unavoidable for those engaged in caring and curing, such participation should decidedly not receive ethical approval. It will be an unfortunate consequence of power tactics if healthcare professionals feel compelled to participate in such areas, but if they do feel so compelled in exceptional circumstances their participation should receive no ethical endorsement whatsoever.

An unwelcome distortion occurs when scholars pretend to revalue and modify biomedical practices for the purpose of acquiescing to extraneous strategic needs as occurs—for example, when moral approval is given to forcing dialysis on a prisoner of war against his explicit will.²⁷ Bioethics should not be encouraged to wander from its obligation to buttress the ethics of medical practice, biomedical research, and public health programmes, and should staunchly resist extraneous forces that seek to compromise its moral premises.²⁸

Up to the present, physicians and the medical ethics by which they abide, have at times of emergency been overridden by strategic considerations. However, what is happening now is that medicine and its ethics are being undermined by a self inflicted process whereby ethical precepts themselves are temporarily distorted and risk never regaining their previous form. Allowing any military, political or power group to urge medical ethics into justifying ultimate goals that are contrary to medical practices proper, is a first step towards instrumentalising medicine for non-medical purpose. History has presented us with horrifying examples of such a process.

J Med Ethics 2006;**32**:464–467.

doi: 10.1136/jme.2005.012831

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Received 24 May 2005

In revised form 4 October 2005

Accepted for publication 5 October 2005

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