Dual Loyalty among Military Health Professionals: Human Rights and Ethics in Times of Armed Conflict

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Point:

> Wars must be won if our country . . . is to be protected from unthinkable outcomes, as the events on September 11th most recently illustrated. . . . This best protection unequivocally requires armed forces having military physicians committed to doing what is required to secure victory. . . . As opposed to needing neutral physicians, we need military physicians who can and do identify as closely as possible with the military so that they, too, can carry out the vital part they play in meeting the needs of the mission.[1]

Counterpoint:

> We believe the role of the "physician–soldier" to be an inherent moral impossibility because the military physician, in an environment of military control, is faced with the difficult problems of mixed agency that include obligations to the "fighting strength" and . . . "national security."[2]

These two quotes typify the competing worldviews brought to bear on the ethical and human rights obligations of health professionals in the armed forces. Attention has focused increasingly on the role of health professionals in abuses of detainees in military custody[3] following revelations of gross human rights violations at the Abu Ghraib detention center in Iraq.[4] It is important to note, however, that detainee abuse illustrates but one example, albeit particularly egregious, of a deeper problem of dual loyalty (alternatively called mixed agency)[5] in the military.[6] As health personnel are torn between duties to heal on the one hand and to support military objectives on the other, these tensions result in inevitable ethical and human rights consequences for both soldiers and civilians.

Historically, ethical obligations of health professionals have privileged the need for loyalty to patients. In the modern world, however, health professionals are frequently placed in settings where they are asked to weigh their devotion to patients against service to the objectives of government or other

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third parties. Dual loyalty poses particular challenges for health professionals when the subordination of the patient's interests risks violating that patient's human rights. Thus it is critical that the problem of dual loyalty be addressed through recasting the dilemma not as health professional neutrality versus identification with military objectives, but rather as imposing a mandate to engage with the human rights laws and principles at stake. In other words, the inescapable "mixed agency" of health professionals serving in the military demands heightened attention to potential human rights pitfalls.

This paper attempts to reframe the current debates around health professional complicity in human rights violations during wartime in terms of dual loyalty. We analyze the spectrum of dual loyalty conflicts and explore ethical models developed to explain the role of health professionals in the military. Given their limited success in resolving dual loyalty conflicts, we turn to a human rights analysis of the problem through the example of medical involvement in interrogation during armed conflict. Drawing on the three-year project of an international working group on the question of dual loyalty,[7] we propose guidelines for health professionals in the military context and identify key institutional mechanisms needed to ensure that human rights are not violated by military medical personnel.

Definition of Dual Loyalty Conflict

Current international codes of ethics generally mandate complete loyalty to patients.[8] In practice, however, health professionals often have obligations to other parties besides their patients, such as family members, employers, insurance companies, and governments, which may conflict with undivided devotion to the patient. Dual loyalty may then emerge as role conflict between the clinical 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, the state,[9] or in this context, military command. The problem of dual loyalty is therefore evident in many settings, including, for example, occupational health, forensic services, managed care, and the military environment.

Where dual loyalty exists, elevating state over individual interests may nevertheless serve justifiable social purposes,[10] such as medical evaluation of an individual's condition for the resolution of a lawsuit or a claim for disability benefits. Such departure from complete loyalty to the individual during an evaluation is accepted as warranted, provided that the patient can freely give informed consent, because of the need for objective medical evidence to resolve the claim in a fair and just manner. In other circumstances, a health professional may be required to breach the confidentiality of a patient relationship to protect third parties from harm or to notify a health authority of communicable diseases for health surveillance purposes. In such circumstances where departure from undivided loyalty takes place, the fairness and transparency of balancing conflicting interests and the consistency of such balancing with human rights are critical to the moral acceptability of such departures.

Dual loyalty conflicts can potentially give rise to human rights violations in all societies, even those thought to be the most open and free. However, they are likely to be greatest in societies that lack freedom of expression and association, for example, where state officials demand that health professionals contribute to the suppression of dissent. Dual loyalty conflicts also occur

frequently in closed settings or total institutions characterized by secrecy and ambiguity about the health professional's role.

The Scope of Dual Loyalty Conflicts in Military Medical Services

Dual loyalty conflicts are therefore common in the military, occurring in a variety of situations. Involvement of military medical personnel in torture whereby medical skills have been used to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment has been documented all too frequently. Uruguay,[11] Chile,[12] Kuwait,[13] and South Africa[14] are cases in point. As well, expertise of South African military medical personnel was used to develop chemical and biological weapons against opponents of the apartheid regime[15] and military doctors stationed in Namibia during the apartheid era were shown to have limited care to local civilian populations in the occupied territory, in violation of their human rights.[16] In Russia, physicians working under the supervision of military officials to help secure the required quota of draftees subordinated their medical judgment by neglecting to register severe illnesses in conscripts they examined, resulting in numerous fatalities among the soldiers.[17] Dutch military doctors in the former Yugoslavia did not provide critical medical care for civilians under siege in Srebrenica in 1995.[18] American military physicians were alleged to have failed to maintain adequate medical records to protect detainees' health or ensure their access to medical care at the Abu Ghraib prison in Iraq.[19] The latter contributes to the secrecy that allows violations to go unchecked, while the former prevents victims from seeking redress.[20]

Another common type of dual loyalty conflict arises from the disclosure of confidential detainee medical information, as took place in military detention at Guantanamo Bay.[21] Pressures to breach confidentiality apply also to the military's own personnel. For example, U.S. military rules dictate the exclusion of persons with eating disorders and of homosexuals, posing ethical dilemmas for military doctors who become aware of such information.[22]

Although strenuously denied by the Offices of the Armed Forces Medical Examiner[23] and the U.S. Military,[24] there is evidence that medical certificates of detainees who died under U.S. military authority in Afghanistan and Iraq were falsified and/or delayed.[25] More generally, under pressures of military command structures, medical personnel face significant dual loyalty conflicts when performing evaluations for legal or administrative purposes that have serious implications for victims' human rights.

Finally, the silence of medical personnel in the face of human rights abuses remains one of the most striking features of the recent revelations of torture at Abu Ghraib and mistreatment of detainees at Guantanamo.[26]

Ethical Analyses Related to Dual Loyalty in the Military

Ethical analyses related to dual loyalty in the military context struggle to resolve these conflicts satisfactorily. First, because "there has been no formal ethical theory specific to military physicians," the notion that responsibility "to reflect on how . . . personal values relate to being a physician in the military" falls to the individual physician soldier[27] is problematic because of the wide range of variability inherent in such a stance. Equally, the argument that

military medical practice is inevitably unethical because it breaches fidelity to the patient is flawed because deviations from absolute fidelity occur in many practice settings. What rests at the heart of the debate is the claim that military physicians "limit themselves . . . to serving a role determined by their superiors, because their superiors have a wider view regarding what is necessary to win the battle or war."[28] This view holds that far from being allowed to exercise independent ethical judgement,[29] the exigencies of armed conflict often require the doctor to subjugate his or her ethical concerns to the decisions of nonmedical military command. This is the *military necessity argument*, namely, the trumping of doctors' independent ethical judgment by military necessity.

Military necessity has been justified by the argument that in wartime the physician–soldier "is not violating his (*sic*) professional responsibility to relieve pain and suffering; rather it is being met in a special way."[30] By supporting the same goal as the military—the preservation of the public good through protection of national security—the physician–soldier is seen to serve a higher purpose. This view ignores substantive differences between the two professions, not least because healing cannot easily be reconciled with the purposive infliction of harm on an enemy for the survival of society. By definition, military professionals are restricted to obeying (legal) commands, whereas the hallmark of medical practice is the extent to which, within prevailing best practice clinical guidelines, the health professional interacts with his or her patient, or evaluee, in arriving at a diagnosis and treatment decision. Not withstanding some problematic aspects to the concept of self-regulation, it is difficult to imagine other professionals (such as lawyers, architects, and teachers) being accorded professional status if they were not to be trusted to exercise independent judgment and autonomy in delivering services to society. Yet, even were one to accept the need to forgo autonomous practice in the name of national security, the biggest questions in the military necessity argument remain: What social goals are justified, what methods are to be employed to achieve them, and, most importantly, who makes such decisions?

Howe offers a different approach to resolving the mixed agency argument.[31] He proposes that doctors, in fact, are subject to role-specific ethics, and that these roles change in different circumstances. In certain scenarios, it is justifiable to sacrifice the interests of individual soldiers to serve the greater good of allowing society to survive (*military role-specific ethic*) whereas in other circumstances, reversion to a *medical role-specific ethic* would be more appropriate. He deduces three types of dual loyalty conflicts in the military: those subject to the military role-specific ethic, those where patients' interests warrant exclusive priority (medical role-specific ethic), and those where the physician should exercise some discretion because "the needs of the military are not absolute."[32] In the first category are the classic conflicts in battle such as treatment priorities or triage for casualties, management of combat fatigue, administration of unproven pharmaceuticals without consent, truth telling, and decisions about returning soldiers to combat.

However, Howe's analysis is of limited helpfulness. By what mechanisms should the individual health professional decide when to apply a *military-specific ethic* and when can the situation be dealt with from a *medical-specific* ethical perspective? Is the military health professional bound by a commander's assertion of military necessity? If not, how is the health professional supposed to evaluate such a claim, the veracity of which is presumably beyond

his or her competence to determine?[33] Is the health professional free to act without intimidation by the weight of the military authority contained in the chain of command urging a particular course of action? Proposed algorithms to resolve this problem may help to clarify the conflict but do little to identify how the physician makes such a complex decision, and, indeed, reinforce the authority vested in the commander or his/her designee.[34]

Moreover, there is little evidence elsewhere in medicine that exceptions to the general principles of ethical rules actually justify creating new role-specific ethics, for example, in occupational medicine[35] and forensic assessments.[36]

Are there arguments to be made that the military is special and therefore merits such ethical exceptionalism? In wartime, the exigencies of battle pose unique challenges incomparable to the civilian context because of the scale of the threats to life, unpredictability, and the levels of violence.[37] As we have seen, these "high stakes" circumstances are said to excuse the doctor from a medical-specific ethical role. Moreover, it is argued that both the physician and soldier willingly and knowingly give up much autonomy when entering military service, making the military context unique.[38]

However, it seems to us that even such a tacit agreement does not waive all of a military patient's human rights nor relieve healthcare providers of their ethical obligations. Further, if these "high stakes" justify unique approaches to ethical frameworks, the consequences of these approaches must be addressed. In particular, medical personnel must also be able to anticipate and prevent the threat of violation of human rights, which, as we have illustrated, occur more in the military than in other contexts.

What about checks and balances in the "exceptional" model? At the moment, the only permissible reason for a military health professional to exercise independent judgment by refusing to follow a command is in the "clear case of an unethical or illegal order."[39] This is a circular argument, because in a military-specific role, the health professional has already ceded any decision-making about the ethics of a policy or clinical decision to a nonmedical commander. Moreover, suggestions that military lawyers may arbitrate requests for confidential information[40] ignore the fact that all military personnel are subject to similar dual loyalty conflicts in this setting.

Another approach, asserted by the U.S. military, is that ethical obligations only apply to those providing clinical treatment, not to medical personnel who occupy other roles such as advising commanders or interrogators. But this fails to recognize that ethical obligations adhere because of authority, training, and social expectation related to health professionals who do not have narrowly defined roles.[41]

Thus, despite the existence of ethical codes and attempts to develop heuristics for ethical analysis specific to the military context, such approaches have not appeared to resolve adequately the dilemmas inherent in the dual loyalty conflict. Indeed, the prevailing view within the military is that uncertainty in moral choices is inherent to the work of military doctors.

The Contribution of a Rights-Based Approach to Resolving Dual Loyalty Conflicts in the Military

Arguing from the perspective of human rights offers a powerful and complementary approach to addressing the kinds of moral dilemmas outlined in the

preceding discussion. Whereas ethical discourse provides tools for applying philosophical reasoning to moral dilemmas, an understanding of human rights protections and the obligations of health professionals to uphold human rights offers a different strategy for resolving these dilemmas, one we believe is more explicit both about processes to resolve dilemmas and about the fundamental justice of the outcomes achieved.

A rights-based approach identifies the potential for violation of clear standards that are not subject to reinterpretation based on one's personal values or military objectives. This approach also locates accountability in one or more duty-bearers. Unlike ethical principles that have to be balanced, human rights cannot be traded off, except under very limited circumstances permitted under international human rights law.[42] Even then, such a restriction of rights may not involve discrimination on the grounds of race, color, sex, language, religion, or social origin. Moreover, certain rights, including the right to be free from torture, can never be abrogated (termed nonderogable human rights).

We now apply this approach to the question of interrogation and military necessity.

Torture, Interrogation and Military Necessity

In 1985, a global compact reaffirmed every person's right to be free from torture as a nonderogable right in international human rights law regardless of the purpose for which torture is intended. The recent upsurge of global terrorist activities has prompted some to rethink this absolute prohibition.[43] Gross, considering the unique ethical challenges posed by armed conflict, argues that states, faced with trade-offs between protection of life and freedom from ill treatment, may reach the conclusion that torture may be justified in exceptional circumstances, a conclusion seemingly justified in ethical terms by resort to utilitarian reasoning.[44]

Human rights, however, are not like philosophical theories or bioethical constructs that require mediating in an ethical analysis. Nonderogable human rights are precisely nonderogable because they signal universally adopted commitments to core beliefs such as freedom, dignity, and equality of individuals that not only reflect shared moral consensus but self-imposed binding legal treaty commitments. They are fundamental to every human being—no matter how heinous—and abandoning such rights on the basis of utilitarian assumptions obscures the fact that the decisionmaking that determines utilitarian outcomes is entirely value based and fails to protect the most vulnerable in any society. Moreover, even where utilitarian arguments to justify torture on the basis of protection of innocent victims have been previously advanced, they have been rebutted by careful utilitarian analysis that arrives at the same conclusion as a rights-based analysis.[45]

Asking health professionals to balance the nonderogable human right to be free from torture against "reasons of the state" on a case-by-case basis[46] also places them in an invidious position in relation to line commanders and reinforces conditions leading to medical complicity in torture: over-identification with state interests, fear, career dependence, and lack of knowledge.[47] Moreover, health professionals cannot be expected to make judgments on matters for which their training and expertise have not equipped them.

Second, even when rights are in conflict or can be restricted, determining whose rights should be privileged over others requires consideration of principles of freedom, equality, and dignity, the needs of socially vulnerable and marginalized individuals and groups, and transparency and fairness in the process by which such a decision is reached.

The perils of abridging human rights are also apparent in "lesser forms" of coercive interrogation. For example, a 1987 Commission permitted Israeli authorities to use "a moderate measure of physical pressure" during interrogation of Palestinian prisoners.[48] Detainees were forced to hold stressful positions and were subjected to noise, hooding, or threats of death.[49] Yet, even here, it should be clear that medical participation in such violations of a prisoner's humanity cannot be justified in and of themselves by the existence of a greater social purpose. Indeed, following concerted international condemnation, "moderate pressure" and other techniques such as sleep deprivation were declared unlawful by the Israeli High Court in 1999 on the basis that these measures constituted forms of actual torture and were therefore in breach of international human rights law.[50]

In sum, the human rights framework represents a priori moral reasoning that privileges the protection of vulnerable people from state-sponsored harm, no matter the alleged justification. Health professionals are thus implicated as duty-bearers in ensuring that the interests of justice, equality, and dignity are upheld. Invoking human rights is not meant to block critical dialogue; instead it provides a call to responsibility that cannot be easily overstepped.

Guidelines and Institutional Mechanisms to Prevent Human Rights Violations in Dual Loyalty Conflicts in the Military

Because of the pervasiveness of dual loyalty conflicts and their potential for giving rise to human rights violations in military settings, an International Working Group developed guidelines for physicians working in this context (Table 1). These guidelines draw on existing national and international ethical codes but locate their perspective firmly within international human rights law. Unlike the oft-quoted maxim "You are first and foremost soldiers, and only after that, doctors,"[51] the guidelines state explicitly that the military health professional's first identity and priority is that of a health professional, asserting that civilian medical ethics apply equally to military health professionals. Guideline 7 specifically proscribes any direct, indirect, or administrative cooperation in torture and cruel, inhuman, and degrading treatment at all times, including during interrogations (Table 1).

Because individual health professionals in any dual loyalty situation are vulnerable to pressure to conform to state expectations, particularly in the military context, guidelines alone will be meaningless unless coupled with strategies to support health professionals and address the systemic forces that affect how medicine is practiced in a particular setting.[52] The most important structural element is the need for military organizations to recognize the obligations medical personnel have, so that they are not forced into disobeying an order on ethical grounds. This approach is, in principle, no different from the resolution of other dual loyalty conflicts implicating human rights in other settings: The first obligation of the state is to respect human rights and to enable medical personnel to act without fear of retribution. Where there are

Table 1. Guidelines for the Military on Dual Loyalties—Summary

1. The military health professional's first and overruling identity and priority is that of a health professional.
2. Civilian medical ethics apply to military health professionals as they do to civilian practitioners.
3. The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society.
4. The military health professional is a member of the national and international health professionals' community.
5. The military health professional should treat the sick and wounded according to the rules of medical needs and triage.
6. Health professionals should not participate in research or development of chemical or biological weapons (CBW) that could be used for purposes of killing, disabling, torturing, or in any way harming human life.
7. The military health professional should refrain from direct, indirect, and administrative forms of cooperation in torture and cruel, inhuman and, degrading treatment and punishment at all times, including in wartime and during interrogation of prisoners.
8. The military health professional should refrain from direct, indirect, preparatory, and administrative participation in capital punishment, both within the military court martial system and elsewhere.
9. Military health professionals should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities and report human rights violations perpetrated by their own troops as well as by others.
10. The health professional should not engage or participate in any form of human experimentation among members of military services unless the research will provide significant health and other benefits for military personnel and facilitate promotion of their human rights.

Source: International Dual Loyalty Working Group, 2003.

human rights concerns arising from a particular demand, placing responsibility for its resolution on the health professional is untenable. Rather, such decision-making should be devolved to a multidisciplinary medical ethical structure with active civilian participation.[53] Such a structure can assess the human rights at stake, if and how these rights should be restricted in accordance with established human rights law, thus assisting resolution of the military's claim to subordinate individual interests against claims of military necessity.

Those who propose a separate ethics for military medicine[54] often dismiss institutional civilian oversight in the determination of what distinguishes military necessity from military interest as the work of "amateurs"[55] whose incompetence should preclude them from any say over military decisionmaking.[56] However, we believe that civilian oversight, such as a commission with membership that includes an adequate number of civilian health professionals skilled in ethical issues and human rights, provides the needed balance in determining what kind of military necessity justifies deviating from the norms of ethical medical practice.

Such institutional mechanisms aim both to prevent the dual loyalty conflict in the first place and to resolve and redress conflicts that do arise. Recommended strategies include education, professional support, restructuring of contractual obligations, monitoring, victim redress, and holding professionals

accountable for violations. It is especially important to enable medical personnel to seek sources of support, both internal and external, where commanders decline to respect either human rights or ethical obligations. The protection of whistle-blowers is exceptionally fraught in the military context[57] and requires carefully structured processes for protection and the active engagement of professional organizations[58] to support colleagues in at-risk situations.

It is precisely the secrecy of total institutions that fosters practices inimical to human rights and antithetical to ethical guidelines. Health professionals therefore have a duty to speak out, not just to meet their own standards of professionalism, but because exposing such violations is most likely to prevent their recurrence.[59]

Conclusion

The dual loyalty guidelines hold that medical ethics during wartime are not fundamentally different from those applicable in peace, and that the processes and mechanisms required to determine permitted deviations from the norm are not particular to the military context. Rather than generating a new paradigm for ethical practice, which is based on the creation of what is essentially a nonpractice model of undivided loyalty to a military commander, resolving the ethical dilemmas of dual loyalty during armed conflict is better served by an approach grounded in human rights, which ensures that the duties to respect and protect human dignity remain at the core of health professional practice.

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