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ZORA URL: https://doi.org/10.5167/uzh-78221
Journal Article

Originally published at:
Messelken, Daniel (2013). Physicians at War: Betraying a Pacifist Medical Ethos? Filozofski Godišnjak, 26:379-400.

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Originalni naučni rad
UDK 174:61
172.4:614.253

DANIEL MESSELKEN

PHYSICIANS AT WAR: BETRAYING A PACIFIST MEDICAL ETHOS?

Introduction

This paper examines the question whether physicians are obligated by their professional ethos to defend a pacifist position. The question is a more concrete and applied formulation of the general thesis that there are what I will call "pacifist professions": professions whose ethos requires their members to act in a pacifist way. Since the present paper is rather one in applied philosophy than a theoretical one about the foundation of pacifism, it will concentrate on the practical issue of whether and how physicians can execute their profession in or during war. Theoretical questions on the nature and extent of pacifism will be considered only to the extent necessary to treat the main issue.

The introductory section will give a short overview of some historical aspects of physicians' participation in war and show the relevance of the issue with recent examples. The remainder of this section will thus serve to set the stage and to outline the connections between the medical profession and questions of war and peace. The paper will then be divided into three other main parts: the first part will be devoted to defining in a general manner so-called "professional pacifism". The second part will investigate whether and to what extent the medical profession can be classified as a pacifist profession, and the third part will look at the consequences of such a classification.

Historical aspects of physicians' acting during war

Physicians have been involved in wars or in the aftereffects of wars since medicine came into existence (cf. Sidel (2004)). Hippocrates recommended to his scholars that "he who would become a surgeon should join an army and follow it" (Vastyan 1978, 1695) in order to learn on the battleground about surgery and medical treatment. This shows that Hippocrates seemingly did not see a reason why a surgeon should not work within the military. On the other side, "Hippocrates […] apparently rejected the principle that physicians have an obligation in war to succor 'enemies' as well as 'friends'" (2004a). The idea of the physician as an impartial healer seems to be relatively recent and was famously promoted by the Swiss banker Henri Dunant after his witnessing the battle of Solferino in 1859. In his book *Un souvenir de Solferino*, he described the battle and its terrible aftermath, calling for the development of societies with the task of helping the wounded on the battlefield. He asked:

"Would it not be possible, in time of peace and quiet, to form relief societies for the purpose of having care given to the wounded in wartime by zealous, devoted and thoroughly qualified volunteers?" (Dunant 1862)

The idea of the Red Cross was born and was translated into International Humanitarian Law (IHL) by the Geneva Conventions in the following years. From that time, physicians were (morally and legally) expected not to actively engage in the fighting but to dispense their medical aid impartially to all those on the battlefield in need of it and according to medical reasons only. Thereupon, serving within the medical services of the armed forces became an alternative for those who did not want to bear arms for conscientious or other reasons. Pacifists found "a ready refuge in medicine" (Gross 2006, 287), as the medical services were deemed to be impartial and not to be taking part in combat operations.

Until about the eighteenth century, however, the medical knowledge did not allow for much help or relief for the wounded. Only later advances in medical technologies and better methods changed this and led, eventually, to the high standard of current military medicine (at least of the armed forces of wealthy countries). Today, as a medical officer stated, the chance of surviving a battlefield wound during an engagement in Afghanistan is higher than the chance of surviving a car accident in rural European areas.

Recent examples illustrating the relevance of the issue

Looking back into recent history, the Second World War saw numerous examples of immoral research and inhumane treatment, of which

physicians had a part. Shortly after the war, the trials against the Nazi doctors revealed the degree of what had happened, and the trials eventually led to the establishment of the "Nuremberg Code". The latter essentially addresses research ethics and is concerned with principles for human experimentation. In recent years, however, the mistreatment of "patients" by military doctors has not been a problem related to experimentation and research. The problems and misconduct of medical personnel rather occurred, for example, when doctors participated in so-called "harsh interrogation methods" (torture) on the one hand, or when medical personnel participated as part of fighting units on the other hand. Both these and other recent examples show that the behaviour of physicians during war and conflict still and rightly gives rise to public debate and moral indignation.

Physicians and war: Prevention or adequate reaction

With regard to war in general and against the background of a possibly pacifist obligation of the medical professions, physicians may have different moral duties at different times. The following three quotations illustrate three duties that have been ascribed to physicians, recommending to them different courses of action and giving weight to different aspects.

(a) Preserve peace: "The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all" (World Health Assembly 1981). Given the primary task of medicine (namely to achieve health), the World Health Assembly stated in 1981 that this goal could best be reached by preserving and promoting peace. Peaceful conditions are seen as necessary for a healthy life and as a prerequisite for a decent standard of medical care. War, on the other hand, by its very nature brings destruction and harm.

(b) Prevent war: "Preventing health crises, war being an example, is a professional moral duty for physicians" (List 2008, 244). With the destruction and harm that war and violent conflict bring about, they inevitably entail a public health crisis. The scale may vary from case to case, but it always worsens the situation compared with the pre-conflict situation. This is probably true also for so-called "humanitarian interventions" that, in the long run, aim at ameliorating the situation, but initially may worsen it by the use of military force and the unavoidable consequences thereof. Thus, one could argue above that physicians should strive to prevent war in the same manner as they strive to prevent other kinds of health crises.

(c) Restrict war: "[I]f war is unavoidable, then it should be waged with as little barbarity as possible" (Lewer 1992, 11). With this recommendation, Lewer summarises the spirit of the Geneva Conventions and the

ideas of Henri Dunant that led Dunant to establish the Red Cross. Nothing is said here about an obligation to prevent war, even if the word "unavoidable" suggests that war should not be waged if unnecessary.

Preserving peace, preventing war, or restricting war—physicians seem at least to be obligated not to further war in any way. The remainder of this paper will explore to what extent a positive obligation to pacifist action may be inferred from the ethos of the medical profession.

1. Pacifist Professions

This first part of the paper investigates if and how a link can be established on a theoretical level between professional obligations and a pacifist commitment. Without concentrating on a single profession, the question shall be put very broadly: Are there professions whose ethe require their members to defend a pacifist position? This question can be further split into questions (i) of the moral ground, i.e., how can the connection between professional ethos and pacifism be established; and (ii) of the extent of the resulting duties, i.e., what kind of professional obligations imply what kind of pacifist obligations. To tackle these questions we must first have a short look at various forms of pacifism in order to know on what the argument may be based (1.1). Second, the notions of professional ethos and professional moral obligation have to be clarified (1.2) before they can be related to pacifism (1.3). The aim is to define what is meant by "professional pacifism" in general. Thus, this section lays the theoretical basis for the applied question of "medical pacifism" that will be considered in part 2.

1.1 Pacifism

In a very general manner, "Pacifism is a commitment to peace and opposition to war" and as such "is thought to be a principled rejection of war and killing" (Fiala 2010). However, different forms of pacifism can be differentiated (a) with regard to what forms of violence and war are morally condemned and (b) according to the extent of their resulting moral obligations. Even if these differentiations are not always clear-cut and do overlap at certain points, it is important and helpful to keep their various aspects in mind.

(a) Forms of pacifism with regard to their position against war

Different forms of pacifism can first be distinguished with regard to what forms of war and violence they object to. Following the classification

presented by Bleisch and Strub (2006) we can distinguish categorical pacifism from less strict anti-warism and so-called pacificism. Hence, we have three broad categories of pacifism with regard to the rejection of war as a means.

Categorical pacifism rejects all forms of violence and calls for strictly non-violent behaviour. Even if faced with aggression one should not use violent means, according to this extreme position. War is an evil that has always to be avoided. Often, categorical pacifism is based on religious ideas and it "is often tied to the idea that there is merit in suffering violence without retaliating" (Fiala 2010). Most prominently, this position has been criticised to be self-refuting by Jan Narveson (1965).

Anti-warism is less extreme insofar as it postulates only a commitment against all forms of war. Using violence in self-defence can, according to this position, be morally justified. Going to war, on the other hand, is deemed to be wrong under all circumstances. This position often differentiates between violence used *within* a state to defend the internal order and violence used *between or among* states to settle international conflicts. The rejection of war remains a categorical one; the rejection of violence, however, is less fundamental.

Pacificism, finally, denotes a teleological commitment to abolishing war. As such, it does not preclude that the recourse to war or the use of violent means may be necessary and justifiable on the way to achieving a peaceful world. War and the use of violence are deplorable, but "military force to defend […] political achievements against aggression" (Ceadel 1989, 5) might sometimes be unavoidable. It can thus be described as a "doctrine about political—in fact international—institutions, dedicated to doing away with war as a means to resolve disputes between states" (Alexandra 2006, 111). It is not primarily about how people should react to a concrete situation, but its adherents "are committed to working to bring about a future state of affairs" (Alexandra 2006, 111).

The shared assumption of these three pacifist doctrines is that war is generally bad and must be avoided, and that aggressive war is wrong under all circumstances. Thus, anti-warism can be seen as the common denominator of all pacifist doctrines.

(b) Varieties of pacifism with regard to the extent of the commitment to non-violence

Several varieties of pacifist doctrine may be further distinguished according to their commitment to non-violence and anti-warism. Pacifism can be differentiated following several dichotomies that help to better

understand the different varieties of pacifist commitments, even if they overlap with some of the distinctions described above.

A first dichotomy consists in distinguishing *absolute* from *contingent* pacifism. Absolute pacifists as categorical pacifists reject all forms of war and violence. Thus, contingent pacifism may be more interesting to look at. Contingent pacifism is a more pragmatic and gradual approach, and its rejection of war is a conditional one that depends upon other factors. Different forms of contingent pacifism are distinguished by Fiala. His first form, which restricts pacifism to specific moral agents, is of particular interest here. Following this argument, "pacifism may not be required by all moral agents. Thus pacifism may only be required for members of particular professions" (Fiala 2010). Usually (and also in Fiala's reasoning) this is an argument about religious vocations that exempts, e.g., clerics from military service, and it can be traced back to Thomas Aquinas. It may be a good starting point for our reflection on pacifist obligations of certain professions as there is no reason to restrict the argument to religious professions only.

A similar distinction is drawn by the second dichotomy, which distinguishes *universal* from *particular* pacifism. This dichotomy describes the "issue of whether everyone is required to be a pacifist or whether pacifism can be a moral choice of some particular individuals" (Fiala 2010). Universalists claim that if war and violence are wrong, then they are wrong for everyone; therefore, everybody should refrain from participating in it. Particularists, on the other side, hold that pacifism is rather a question of personal choice, and they do not condemn war or the soldiers who fight in it altogether. This argument can be related to the topic of this paper by not taking particular pacifism as a personal choice but rather as an obligation derived from a professional ethos. Without condemning war once and for all, it could nevertheless argue against the participation of some groups of persons in war and violence. In this sense, pacifism would be a kind of supererogatory obligation of particular professions, without claiming universal validity.

(c) Justifications of pacifism

Pacifist positions have been defended on the basis of different moral theories. Besides philosophical arguments, *religious* convictions have played a major role (and still do) in the defence of pacifism. Important historical representatives of pacifism, like Gandhi or Martin Luther King, Jr., were inspired by religious motives. In this paper, we will nevertheless concentrate on ethical arguments, which may be divided roughly into consequentialist and deontological ones.

Deontological arguments in favour of pacifism usually point out the fact the war always involves the killing of (innocent) people and, thus, does not respect their moral status and basic (human) rights. As Fiala puts it, “the pacifist may claim that all human beings have a right to life and that killing in war violates this right” (Fiala 2010). Arguments like these lead to a condemnation of each and every war and are, thus, close to or even congruent with absolutist forms of pacifism. For this reason they have confronted similar criticism, namely, that defending the rights of others can, under certain circumstances, require the use of force.

Consequentialist accounts claim that war always brings about more negative consequences than positive ones and, thus, leads to a negative overall situation. However, these accounts are most often not categorical in their condemnation of killing and war, but represent rather contingent forms of pacifism. In other words, they do not deny the (at least theoretical) possibility of a morally justified war. Nevertheless, some forms of contemporary consequentialist pacifism come close to condemning war in general; they argue that as a result of the development of modern weaponry, wars inevitably lead to catastrophic consequences. This is, for example, the argument of IPPNW (International Physicians for the Prevention of Nuclear War).

1.2 Professional Ethos and Professional Moral Obligations

As this paper wants to look at a possible connection between professional ethics and a pacifist obligation, we must deal briefly with what we mean by professional ethics. Even if the concept of professional ethics at first seems to be a rather new one, it can be traced far back in history. In fact “the idea that there should be special codes of ethics peculiar to particular professions has been current since ancient times, when the Hippocratic oath was required of those engaging in medical practice” (Almond 2011). Chadwick has given the following description of what modern professional ethics is about:

> ”Professional ethics is concerned with the values appropriate to certain kinds of occupational activity, such as medicine and law, which have been defined traditionally in terms of a body of knowledge and an ideal of service to the community; and in which individual professionals have a high degree of autonomy in their practice.” (Chadwick 1998)

Usually, the rules of professional ethics or the ethos of a profession are binding for the members of the profession either by law, by an association’s regulation, or by an oath. If none is the case, a professional ethos may

also consist of customary habitude or tradition with a purely moral commitment.

The rules and regulations of professional codes of conduct or professional ethics can serve several purposes. On the one hand, they are ethical guidelines for the practitioners of a profession, which tell them how to deal with certain situations. As such, they define what good professional practice looks like. First, a professional ethos consists of ethical norms, values, and principles that guide a profession and form a set of beliefs, practices, and good professional conduct. We could call this the internal aspect of professional ethics, as it addresses primarily those within the profession. On the other hand, a (publicised) professional ethos also allows those who consult a professional as client to know what they can reasonably and morally expect from them. Thus, professional ethics also set out role obligations that go along with adherence to the profession in question. This second aspect of professional ethics can be labelled the public aspect, as it deals with the mutual expectations between a profession and society as a whole. It is evident, that the two aspects are intertwined and cannot always be consistently separated. Still, with regard to the topic of this paper, it is important to keep the second aspect in mind, because it deals with professional role obligations and possible pacifist professional obligations would fall under this aspect.

To summarise and to further illustrate these points, let us have a look at how the two aspects may be distinguished for the medical profession. As mentioned, professional ethics governs one's conduct and practice during the professional work. Physicians, then, have two sorts of obligations. First, they have obligations to the individuals whom they meet during their practice, such as patients or relatives. Second, physicians also have obligations to society as a whole or to the public good, such as public health. In both cases, both internal and public aspects of professional ethics are needed to address ethically difficult situations. Yet, where the public good is concerned, the aspect of role obligations can gain higher importance, whereas treating individual patients might rather concern questions of good professional practice.

We must underline one last and important limitation of professional ethics. As the term itself suggests, it is about the professional life and professional activities and does not (extensively) reach into the private life. Obligations resulting from a professional ethos do not address the person as an individual, but as someone who is fulfilling a professional role. As a result, the associated duties fade when the person stops exercising her job, even if a certain degree of coherency of acting professionally in private life might be called for. One would, for example, not accept it if a policeman or attorney were a regular criminal after work. Still, as long as we distinguish a

profession from a vocation, there can be a separation between professional and private life, with their respective and independent moral obligations.

1.3 "Professional Pacifism"

How can we now conceptualise a connection between the duties of professional ethics with a possible obligation to oppose war? We have seen that two important justifications of pacifism lie in the assumptions that war first leads to the violation of basic rights and that it leads to overall bad consequences for the society affected by it. Thus, if a professional ethos included either the protection of the basic rights in question or the increase of the overall good of society as an aim of professional practice, it could imply a commitment to pacifism. This would be the case, because war then ran contrary to the achievement of the aims of the professional code.

It is important to see that such a commitment to pacifism would not be based on a personal belief, and neither would it leave room for personal choice. Rather, it would then impose a duty to pacifist or at least anti-warist action on the members of the concerned profession as long as they were exercising their profession. We cannot talk, at this stage, about concrete implications or name the resulting obligations; yet, it would be clear that participation in any activity that could favour war would then not be allowed.

One could—and with good reason I think—ask whether the decision to live and defend according to pacifist standards should not be an individual one; that is, a choice that has nothing to do with professional obligations. We will keep this reservation in mind when analysing, in the next chapter, the question of whether the medical ethos or medical ethics oblige physicians to be pacifists.

2. Medical Pacifism

Medical ethics, the professional ethics of the medical profession, has a very long tradition. The Hippocratic Oath and other similar documents are evidence of a long history reflecting what good medical practice should look like. This is not surprising, as medical knowledge and the skills of physicians often contribute to decisions about life and death. Medical practice touches existential questions and, therefore, calls for sound ethical justification. Looking at the Hippocratic Oath and later codes of conduct, we can assume that the main issues in medical ethics have always converged around the questions of who should be treated, what kind of treatment is allowed, and what underlying values physicians should defend. But how do these

questions and medical ethical principles relate to pacifism? In order to investigate this question, we will first look at medical ethics in general, and then present codes of medical ethics for wartime to finally address the question of medical pacifism.

2.1 Physicians' general professional codes and general medical ethics

The Hippocratic Oath is usually seen as the origin of medical ethics, and it will serve us here as a point of departure for a short assessment of medical ethics. It will be complemented by its modern counterpart, the World Medical Association's (WMA) Geneva Declaration, before we will summarise the so called "Principlism"—the currently most influential approach to medical ethics.

The spirit of the Hippocratic Oath is commonly summarised by the dictum *Primum non nocere—first, do no harm*. This simple prescription can still be seen as the most relevant principle in medical ethics. However, the oath does not name this principle explicitly, and it goes beyond this simple statement. Its most important passages for our context read, in a modern translation, as follows:

> "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.
> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. […]
> What I may see or hear in the course of the treatment […] I will keep to myself." (Post 2004, 2650)

Thus, the oath imposes on the physician to (i) act (only) for the benefit of the patient, (ii) to prevent harm and injustice from his patients, (iii) not to make wrongful use of medical knowledge, and (iv) to keep medical secrets in order to protect the patients' privacy. Overall, the oath can be interpreted as an obligation to act in the best interests of the patient and only to use medicine in a way consistent with the general aim not to do harm. These obligations and principles have remained unchanged since the Hippocratic era even though medicine has undergone many developments since. Medical ethics have been amended to keep up with the times.

A modern form of the medical oath can be found in the codes of conduct of many national associations and as an international paradigm example in the WMA's Geneva Declaration. The Hippocratic tradition clearly remains visible, but the content of the oath and its language have been adapted to remain understandable and to respond to modern challenges to medical ethics. The more relevant clauses state the following:

> ”I SOLEMNLY PLEDGE to consecrate my life to the service of humanity; […]
> I WILL PRACTISE my profession with conscience and dignity;
> THE HEALTH OF MY PATIENT will be my first consideration;
> I WILL RESPECT the secrets that are confided in me, even after the patient has died; […]
> I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient; […]
> I WILL MAINTAIN the utmost respect for human life; […]
> I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat” (World Medical Association 2006)

The guidelines established in the ancient oath reappear in the Geneva Oath, and they are nourished with other more general principles illustrating the “noble tradition of the medical profession” (ibid.). Among the obligations that are more interesting in our context, we find the principle of equal care for all patients, the highest respect for human life, and again and very clearly, the obligation not to use medical knowledge inappropriately, i.e., for purposes other than healing and caring for patients. The fact that physicians shall act accordingly “even under threat” makes it clear that the oath requires a high degree of commitment. Its authors were aware of situations in which physicians might be under pressure to further non-medical causes by using their medical knowledge. Acting in such a way should be prevented by the Declaration. Interestingly, physicians pledge even to consecrate their *life* “to the service of humanity”, which seems to imply an obligation beyond the strict sphere of their professional activities.

In addition to these written codes of professional conduct, general medical ethics are an important resource of guidance for physicians. Ever since it was first published in 1979, the book *Principles of Biomedical Ethics* by T. Beauchamp and J. Childress was one of the most influential positions in medical ethics. Today, it can be seen as the paradigm approach as it finds a widespread application. Even though it received a lot of critique, it still provides a convincing framework for debates and case discussions in medical ethics. Beauchamp and Childress name four principles rooted in common morality, which form the core of medical ethics: patient autonomy, non-maleficence, beneficence, and justice (Beauchamp and Childress 2009). All four principles have equal importance and produce *prima facie* obligations that, in case of conflict, have to be resolved on a case-by-case basis.

The principle of (patient) autonomy obligates physicians to actively involve their patients in any decisions about possible therapies. This requires

providing patients with relevant information on alternative therapies and their respective (dis)advantages in order to reach the patient's informed consent. However, respecting the autonomy also means respecting a patient's decision not to receive any treatment (see Beauchamp and Childress (2009), 104). If a patient is currently unable to give her informed consent, it can be replaced by the best-interests approach, which puts the physician in a more paternalistic role. Nevertheless, any treatment contrary to the (assumed) will of the patient is deemed to be immoral, as it overrules the patient autonomy principle.

The second principle, non-maleficence, is one of the oldest rules in medical ethics: *primum non nocere*, that means do not harm your patient. Even if the notion of harm is not always clear, it at least evidently forbids certain courses of action. The obligation not to harm is generally more stringent than the third principle, beneficence. The latter implies some positive action of helping the patient or averting harm from happening. The question of the objectively best course of action can sometimes compete with the autonomous will of the patient. Such situations can lead to the danger of paternalistic decisions if the values of the physician do not coincide with those of the patient. Accordingly, the ethical deliberation process must be carried out with appropriate caution.

The principle of justice, which is the fourth and last principle listed by Beauchamp and Childress, requires the equal and fair treatment of all patients. Mostly, it comes into play in situations where (scarce) resources have to be distributed. Thus, it goes beyond the strict domain of the physician-patient relationship, as it takes into account societal issues or a larger context.

The four principles can collide in many situations and thus do not prevent ambiguities in ethical judgment. In such cases, a refinement is needed during the ethical decision-making. Beauchamp and Childress propose, if necessary, to specify and balance the principles. During that process, the abstract and indeterminate character of the principles has to be reduced in order to generate more specific, action-guiding content. On the other hand, conflicting principles have to be balanced against each other, as their weight and strength can vary from case to case and according to a case's characteristics. The openness of the principles and the nature of the deliberation process make it possible that different people may come to different conclusions in the same case. However, this is not per se problematic, but may be interpreted as an advantage with regard to the universal applicability of the principlism approach.

Following the approach of Beauchamp and Childress, reasoning in questions of medical ethics is thus centred on the well-being of the patient and stresses the patient-physician relationship. Medical ethics can thus be

understood to follow an individual logic: it is centred on the needs and the will of one person, namely the patient. Only if questions of distributive justice come into play does the picture open up and larger groups or the whole society become relevant factors.

Thus, both medical codes of conduct like the Hippocratic Oath or the Geneva Declaration and most of medical ethics are concerned with how a physician should act when treating her patient. The broader context or circumstances do not seem to play a relevant role here, as they are only mentioned very rarely: be it when the Geneva Declaration upholds that even under external pressure medical ethics have to be followed or when the principle of justice calls for a fair distribution of scarce goods.

2.2 Specific regulations and codes for physicians' activities during wartime

Two other documents (or bodies of documents) explicitly deal with physicians' obligations in the face of and during armed conflict. Thus, they are relevant for our broader question of medical pacifism: the WMA's Havana Declaration and the Geneva Conventions. From a legal point of view their character is rather different, as the Geneva Conventions are an integral part of International Humanitarian Law (IHL), whereas the Havana Declaration has rather to be seen as a recommendation or as a corporate code. We will thus first present the relevant rules in IHL established by the Geneva Conventions and then look into the more detailed account proposed by the World Medical Association.

The overall aim of the Geneva Conventions is to reduce the atrocities of war to a minimum and to establish at least some rules for that purpose. Mainly, their purpose is to protect all those who are not or who are no longer taking part in hostilities and to spare them from further harm. Basically, "[t]he wounded, sick, and shipwrecked, to whichever Party they belong, shall be respected and protected in all circumstances" (Kleffner, 2008, 329). In order to achieve this aim, several rules are established by the Geneva Conventions, and some of these rules directly concern physicians' activities during conflict. Those delivering medical services first shall not be attacked and second shall not be hindered in doing their work. In their recent study on customary IHL, the ICRC summarises these points in the following rules:

> ”Rule 25. Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy. […]

> Rule 26. Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited." (Henckaerts and Doswald-Beck 2005, 79–86)

Thus, medical personnel are by the rules of the Geneva Conventions accorded a special status during war: they shall be protected in order to care for the wounded. It is important to recognise, however, that this status is not a personal privilege, but "*a natural consequence of the requirements designed to assure respect and protection for the victims of armed conflicts*" (Baccino-Astrada 1982, 31). Physicians shall exercise their professional duties and shall not actively take part in the hostilities; their obligation is to uphold the principle of humanity in the midst of war. Inter alia, the provision of medical care has to be distributed according to medical needs only, according to the principle called "medical neutrality". This also implies that physicians "*must respect the principles of medical ethics in the same manner as in peacetime*" (Baccino-Astrada 1982, 36). Medical ethics are explicitly referred to in article 16 of the Protocol Additional from 1977; it is, however, never specified in the Conventions what exactly is meant by it. For this reason, one has to assume that general medical ethics as presented in section 2.1 above remain valid during armed conflict and that ordinary professional regulations apply.

Interestingly, the World Medical Association has, in addition to the general code of ethics known as the Geneva Oath presented in section (a) above, adopted special regulations concerning the work of physicians in times of armed conflict. The most important passages from this document called "Havana Declaration" (adopted in 1956 and revised 2006 the last time) read as follows:

> "1. Medical ethics in times of armed conflict is identical to medical ethics in times of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics.
>
> 2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:
>
> a. Give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable for the patient's health care;
>
> b. Weaken the physical or mental strength of a human being without therapeutic justification;
>
> c. Employ scientific knowledge to imperil health or destroy life;

> d. Employ personal health information to facilitate interrogation;
> e. Condone, facilitate or participate in the practice of torture or any form of cruel, inhuman or degrading treatment. […]
> 4. The medical duty to treat people with humanity and respect applies to all patients. The physician must always give the necessary care impartially and without discrimination on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing or any other similar criterion. […]
> 10. Where conflict appears to be imminent and inevitable, physicians should, as far as they are able, ensure that authorities are planning for the protection of the public health infrastructure and for any necessary repair in the immediate post-conflict period." (World Medical Association 2006)

The regulations mostly repeat the same topics that are treated in the Geneva Conventions. Physicians shall only be bound to one set of medical ethics; their task is about saving lives and preserving health; and they shall care for all human beings equally, without distinctions other than medical need. The last quoted provision makes mention of a new and interesting aspect. Physicians shall, in the face of imminent conflict, make sure that the medical infrastructure is working and is well-prepared for what is to be expected. Nothing is said here with regard to a special duty of physicians to prevent the conflict from breaking out. In other words, no special pacifist commitment is attributed to physicians; rather, they shall concentrate on what may be called their primary professional task: to guarantee and provide adequate medical care.

2.3 Medical Pacifism?

What can be said, then, about medical pacifism? Is there any *professional* obligation for physicians to prevent war or the outbreak of conflicts? As we have seen in section 1.3 above, an obligation to professional pacifism could result from either the professional duty to protect basic human rights or the professional duty to work toward the overall good of society, which would be thwarted by war. The question then is whether the obligations of medical ethics as spelled out above qualify as such duties.

As quoted in the introduction, one could argue like List that "[p]reventing health crises, war being an example, is a professional moral duty for physicians" (List 2008, 244). In his argument, he distinguishes the public health role of physicians from the clinical role of physicians and associates the former role with the obligation to prevent war. If we understand the public health role in a way that implies an obligation to society as a whole, it could entail a pacifist obligation. War and its consequences would

have to be prevented by physicians in the same manner as epidemics, because they have equally negative consequences on the general public health. However, pacifism, or the prevention of war in this understanding, would only be a means of achieving the greater public good of health. Thus, the obligation is rather indirect and somewhat questionable: it is basically valid only on the assumption that avoiding war always has better consequences than going to war. Eventually, the pacifist obligation would rely on a consequentialist calculus and, therefore, be reduced to a form of contingent pacifism.

The public health role can also be understood in a more individual way. As such, it implies the duty to deliver medical care to those in need in order to foster the general public health. Interpreted this way, the public health role comes closer to the clinical role, to which it would only add the collective aspect. Looking at the clinical role and thus taking the individual perspective, there is on the one hand no special *medical* obligation to prevent war. Everyone, physician or not, should act in favour of the protection of basic rights. Medical personnel during war, on the other hand, certainly have a special obligation with respect to the protection of basic human rights on two levels. First, they have to protect them when providing medical care. This implies, for example, the duty to treat every person equally and to distribute scarce resources based on medical needs only, and also to maintain general medical ethical principles like patient confidentiality and informed consent. Second, physicians very often, and especially during conflict, are in a privileged position to identify human rights abuses against, for example, prisoners of war. The (legal and moral) obligation to report those kinds of human rights abuses is part of the medical duties that are usually summarised under the heading of *medical neutrality*.

All of the arguments discussed so far do not to imply, strictly speaking, what we called medical pacifism, but rather call for what I would term a "concerned exercise" of the professional medical duties. Basically, this means that physicians do not have a professional obligation to prevent war, but they nevertheless have the duty not to become an integral part of the war effort, as this would run contrary to medical ethics. A similar conclusion has also been defended by Geiger, albeit for different reasons. He argues against what we called medical pacifism, because it might damage medical ethics itself:

> ”The danger is that the attempt to shelter what I believe are political decisions — absolutely defensible in their own right, and available to any citizen — under the umbrella of conventional medical ethics may threaten the special protection society has afforded those ethics." (Geiger 1991, 115)

Being citizens (and humans), all physicians have a right to militate for whatever political position they support. However, in fulfilling their professional role, they should refrain from using its power in order to bring about political aims. Certainly, one could argue that pacifism is more than a political aim and that medical ethics share some of its principles. Still, the duty to uphold medical ethics in the face of conflict and under the harsh circumstances of war might be seen as an ambitious task. Rather than supplementing medical ethics with the extra-medical obligation to pacifism, one should perhaps concentrate on the fundamentals and, in return, call for the strict compliance of physicians with their basic professional duties. The remainder of this paper illustrates with examples what this could mean and what a "concerned professional practice" should look like.

3. Practical Considerations: Physicians at War

Physicians and medical personnel face numerous difficult situations and ethical challenges during war. In the following, we will present three problematic issues and try to explain what a concerned exercise of medical duties should look like. Owing to the limited space available, our account will be rather short and the arguments may remain sketchy.

3.1 Mixed roles and blurred responsibilities

Traditionally, and as fixed in the Geneva Conventions, a strict separation of medical and military roles has prevailed within the armed forces. This reflects the special status accorded to the medical services, and, at the same time, guarantees impartial and optimal medical care. In recent years and during current deployments, this separation has been blurred, and it seems questionable whether there is commitment enough to uphold it. With rising standards of medical care and the aim of reducing the timeframe for medical intervention and evacuation, there are strong *tactical* arguments in favour of embedding medical personnel within fighting forces. Vastyan noticed such a development thirty years ago and stated:

> "[A]s armies have become more and more dependent on upon medical technology, so too have physicians become more integral to any war effort. The traditional distinction between the wounding (or combat) role and the healing (or medical) role have become increasingly more ambiguous." (Vastyan 1974, 327)

Yet, embedding physicians into combat forces not only leads to losing the clear-cut role distinction, but also has other problematic conse-

quences. One of the most discussed issues in recent years is the question of the armament of medical units and medical personnel and their bearing of the distinctive emblems. When a protective emblem (red cross, crescent, or diamond) is displayed, medical personnel are only allowed to carry "light individual weapons for their own defence or for that of the wounded and sick in their charge" (AP I, Art. 13,2). As long as they were not too close to combat operations, this restriction did not pose a problem. If medical units are, however, embedded into combat patrols and become a (albeit illegal) target, they often choose to camouflage or to remove the emblem and to mount heavier weaponry on their vehicles (cf. von Uslar and van Schewick (2010)).

Such a proceeding clearly leads to the undermining of the purely medical role with its associated special protection. As a result, the medical personnel are perceived and also perceive themselves as soldiers or even fighters, rather than as physicians. Renouncing the impartial distribution of medical care based on medical needs seems the logical next step. This, however, clearly runs counter both to the Geneva Conventions' regulations and to medical ethics. In addition, the medical personnel obviously cannot distribute medical care and engage in combat simultaneously. Giving up the distinguished role of medical personnel thus reduces the level of medical care available in the field and has additional unethical consequences.

3.2 *Ethically problematic tasks of medical officers*

There is another, more fundamental, ethical issue of physicians' participation in war. Basically, it has to be questioned whether it is ethically appropriate to be a physician and a soldier at the same time (for a more detailed discussion see Messelken and Baer (2013)). The problem behind the conflation of the two professions lies in the mission of medical officers, which is, for example, described as the "Conservation of the Fighting Strength" (motto of the US Army Medical Department). In contrast to the WMA's Geneva Oath, where the physician pledges that the patient's health will be his first consideration, one has to assert that "military medical ethics introduces the imperative of military necessity alongside the familiar principles [of medical ethics, DM]" (Gross 2010, 458). But as the wording "necessity" suggests, it is the military role obligations and loyalties that usually (and certainly in a conflict situation) prevail over medical considerations. The priorities that medical officers are very often expected to follow are completely different from those of their civilian colleagues when it comes to, e.g., the order of treatment and the allocation of scarce resources. Adjusting medical decisions to military needs is, however, a clear infringe-

ment of medical ethics, which do not allow the subordination of medical considerations to *any* other argument.

This is not to say that being a physician and a soldier at the same time is always and *per se* unethical. The risk of getting into ethically problematic situations is, however, built into the very definition of the tasks of medical officers. Németh gives a good summary of the issue:

"The military medical personnel faces the conflict originated both from the medical and military professions. Ethical issues arise when the physician is forced to choose between the benefit of an individual patient and the needs of an army." (Németh 2011, 222)

To "conserve the fighting strength", and thus to place the care for a collective body above considerations for individual patients, unavoidably entails the neglect of the duties of general medical ethics. Thus, the tasks and working environment of medical officers are not conducive to the respect of medical ethics, and a concerned exercise of the medical profession requires conviction and courage.

3.3 Medicine turned into a weapon

A third and clear example of wrongful behaviour of physicians during war is when medical knowledge or the distribution of medical care is turned into a weapon. Such a misuse of medicine can happen in several ways, and it is usually disguised to make it less obvious.

A very well-known form of misusing medicine often happens during campaigns aimed at "winning the hearts and minds" of the people. In this genre of campaign, medical aid is used as a means of psychological warfare. To be clear, it is not the fact that medical aid is distributed among the local population, but the motivation for doing so and sometimes also the aims of it. If medical care were given for humanitarian reasons and based on medical criteria, nothing could be said against it. What we find, however, is that, on the one hand, treatment is given and triage administered on political or psychological grounds (Vastyan 1974, 332ff.). On the other hand, medical assistance has been used to gain information or intelligence from the local population that could not have been attained otherwise. Prominently, the whereabouts and identity of Osama bin Laden were reportedly verified by DNA analysis from samples gained during a vaccination campaign that was a hidden intelligence operation.

Even worse from the point of view of medical ethics is the repeatedly reported assistance of physicians in so-called "harsh interrogation" and even torture. Torture is not only clearly forbidden by international law, but the use of medical knowledge or information during torture is the most evident breach of medical ethics. There should not be and there cannot be

any justification for it, and the participation of physicians in torture should not even be envisaged. Kottow makes the argument clear and more general insofar as medicine should never be abused for any other ultimate goals. He states:

> ”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.” (Kottow 2006, 467)

To sum up, turning medicine into a weapon or using it with the intention of advancing military aims cannot be reconciled with a concerned exercise of the medical profession. Even if medicine is not a pacifist profession in the full sense, there are still clear limitations of its use during war.

10.12.2012. Centre for Ethics, University of Zurich

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