Project MUSE®
http://muse.jhu.edu

Dilemmas in Military Medical Ethics Since 9/11

EDMUND G. HOWE

The attack on the United States by terrorists on 9/11 and the war with Iraq have raised new ethical questions for the military and for military physicians (Herman 2002; Elshtain 2003). How and when attacks may occur now is less predictable. Planes have been hijacked, and persons dressed as civilians may carry bombs to blow themselves and others up. These dangers pose an increased threat, and, thus, there is a need for new defensive measures. How far these measures should go is, however, greatly open to debate.

One of the most difficult ethical question raised for the military and military doctors by these developments is what interrogation methods are permissible when questioning captured terrorists. The licitness of different interrogation practices is, however, only one of the ethical problems potentially encountered by military physicians now having to treat terrorists and POWs. The following discussion presents the major concerns regarding this and other issues.

TREATMENT OF TERRORISTS WHO HAVE BEEN CAPTURED

Interrogation and Inhumane Treatment

Some reporters claim that the U.S. already has sent terrorists to Jordan, Egypt, and Morocco so that they can be tortured and then be more likely to give information (Priest and Gellman 2002). They claim also that when the CIA has interrogated al Qaeda and Taliban prisoners at the U.S. occupied Bagram air base in Afghanistan, it has deprived them of sleep; forced them to assume "awkward, painful positions;" and "softened them up" with beatings (Priest and Gellman 2002; Editorial 2002).

It is open to controversy whether such techniques are ethical or legal. Some say that to call such practices inhumane "trivializes the torture that does take place in so many areas of the world" (Rivkin and Casey 2003). Other individuals argue that since terrorists lack the protection of the 1949 Geneva Convention it should be permissible to treat them differently from prisoners of war (POWs). Lawyer Alan Dershowitz believes, for instance, that after acquiring a "torture warrant" from the court, the government should be able to torture these prison-

Kennedy Institute of Ethics Journal Vol. 13, No. 2, 175–188 © 2003 by The Johns Hopkins University Press

ers to try to gain information from them if doing so could save soldiers' and civilians' lives (Cohen 2003). As of the fall of 2001, 45 percent of one group of Americans polled agreed (Morse et al. 2002).

On the other hand, still other commentators assert that practices such as those described are "inhuman and degrading," and, thus, unlawful (Cooperman 2002). Individuals in this camp maintain that, notwithstanding the Convention, all approaches involving any kind of torture should be absolutely proscribed. They contend that once captured, these prisoners no longer pose a threat, and, thus, "universal values" require that they then be regarded only as fellow humans. They further contend that if torture is used, American society will have regressed to pre-civilized standards. This, in turn, would negate the very principles for which we are fighting (Amery 1980; Drinan 2001).

If certain interrogation practices are deemed unethical or illegal, military physicians have professional obligations as doctors and military obligations, like all soldiers, to oppose them. If they remain silent, they, like the rest of society, will be guilty of moral complicity (Feitlowitz 1998; Westermann 1996).

One criterion by which the ethical and legal permissibility of interrogation techniques might be judged is their long term effects on prisoners. Keeping prisoners in cramped positions can, for example, cause long-lasting and profound psychological harm. Sylvia Karcher, a therapist who works with patients who have been subjected to such treatment, relates, for instance, that after prisoners have stayed in cramped positions for extensive lengths of time, their physical postures become "ossified." Only by slowly inviting these patients to try to move and to talk about what they feel as they do can these prisoners finally reacquire the capacity to move normally. What they have lost, she says, is more than their capacity for physical movement. They have lost the feeling that they can *choose*. She states, "The capacity to choose and to decide can be restored, [and is] *a prerequisite for autonomous action*" (Graessner, Gurris, and Pross 2001).

The obligation to treat prisoners humanely has existed for some time, of course, in regard to POWs, but even in regard to them, some claim that techniques permitted in interrogations never have met the internationally required standards. They argue that since countries that signed the Geneva Convention must treat POWs equally, those countries should not subject such prisoners to *any* physical or mental abuse (Drinan 2001). This would mean that interrogators should not deprive POWs of food or water, for instance, or ever use "aggressive" interrogation techniques.

Mental torture includes, of course, not only harming prisoners, but also threatening to harm persons they love. For some, the pain they experience from others being threatened is worse than that inflicted directly on themselves. An example is provided by Major Rhonda Cornum, who was shot down during the first war in Iraq. After she had been molested, she heard cries from a fellow POW in a nearby room. She reports, ". . . it was far worse for me to feel helpless for someone else, for someone I cared about" (Ursano et al. 1996).

What might prove legally permissible in the U.S. is currently unclear. According to Kenneth W. Starr, the independent counsel during the Clinton administration, five Supreme Court justices recently indicated that the increased danger represented by terrorists requires "heightened deference to the judgements of the political branches with respect to matters of heightened security" (Pincus 2001). Legally, therefore, at least these five justices draw a distinction between terrorists and POWs with regard to what methods of interrogation should be allowed.

A final concern, which would support *not* making this distinction, is the potential negative effect that the act of inflicting greater harm could have on interrogators. In order to inflict greater harm, interrogators may have to accomplish what Lifton (1986) has called "doubling." "Doubling" involves individuals having to dissociate their spontaneous feelings of compassion in order to feel less or no pain themselves when they inflict harm. The effects of such dissociation may extend beyond their interrogations. It may, for example, affect how they experience themselves with their families. Moreover, it may alter who they are as "persons." They may, for example, lose some capacity to experience love. Robert M. Blitzer, the former chief of the FBI counterterrorism section, may have been referring to this risk, at least implicitly, when he said, "Torture 'goes against every grain in my body'" and, thus, "there has to be another way" (Pincus 2001).

Suicide and Psychological Care

Military physicians also face numerous new ethical questions regarding how they should treat terrorists in prison. For example, this group is at higher risk of committing suicide for several reasons: First, they can be detained indefinitely and thus never know if or when they will be released; second, they cannot contact their families; and, third, they are subject to aggressive interrogations. To minimize the risk of suicide, military physicians could place these prisoners in some kind of restraints, but such treatment most likely would harm them psychologically in the long run and also would involve treating them differently from POWs and U.S. troops. Presently, in Guantanamo, military doctors treat suicidal terrorists as they do our own troops. They observe them around the clock. There have been 19 suicide attempts since January 2002. This 24-hour watch may be one of the main reasons that no suicide attempt to date has succeeded (Roig-Franzia 2003).

Other questions remain, even regarding suicide prevention. For care providers to maximally prevent persons from committing suicide, for instance, their patients must feel sufficient trust in them to disclose when they feel suicidal. Some captives, of course, may feign suicidal feelings in an attempt to demoralize the U.S. soldiers guarding and caring for them. For those prisoners who are not feigning, however, military doctors—and the military as a whole—must decide how far they should go to maximize the degree to which terrorists under these circumstances are enabled to feel trust. Should, for example, the military provide translators during psychiatric examinations who are different from those provided during interrogations?

TREATING PRISONERS OF WAR

As already stated, whereas legally the minimal standards for treating terrorists are open to controversy, the minimal standards for treating POWs are not. POWs by law should be treated equally to our own U.S. soldiers. Pragmatically, this policy should enhance the likelihood that enemies will reciprocate by treating our own soldiers better. As suggested, however, many feel that even if this is not the case, military doctors should treat POWs equally because doing so is necessary to respect POWs as persons. This requirement of equality raises the inherent question of whether POWs must be treated absolutely equally—e.g., triaged randomly, assuming equal injuries—or whether all U.S. soldiers can be treated first, again assuming equal injuries. I shall discuss this question in more detail later.

Some soldiers and military physicians, however, believe that it is ethical to violate the Geneva Convention because, like terrorists, POWs can give valuable information. Others believe that, even if POWs cannot or will not provide information, they still should not be treated equally because they do not deserve to be: First, they may have killed U.S. soldiers; second, even if they have not, since they are enemy soldiers, they are not innocent bystanders; and, third, treating them equally would demoralize U.S. forces, especially if U.S. soldiers were not treated or their treatment was postponed, as a result.

The extent to which POWs or captured terrorists will give information that will save others' lives is, of course, always open to question. Blitzer, quoted earlier, states, for instance, "Chances are you are going to get the wrong person and risk damage or killing them" (Pincus 2001). Information recently obtained from terrorists shows, on the other hand, that sometimes, the information acquired can be substantial.

Judging what POWs deserve ethically is, of course, problematic. Iraqi civilians, for instance, have been told to fight or they and their families will die. Iraqi soldiers have been told that if they do not continue to fight, "execution squads," created for this purpose, will kill them (Ware 2003).On the other hand, U.S. soldiers, including military physicians, may, indeed, feel enraged if some of their own forces die or are permanently harmed because POWs must be treated equally. Conceivably, this devastation of morale could be so great that the lives of military physicians who follow the Convention strictly could be put at risk. For principally these reasons, some military physicians believe, or at least have in the past, that notwithstanding the Convention, all U.S. soldiers should be treated prior to POWs, even when they have less severe injuries. Six hundred Army and Navy physicians were surveyed within six months after they served in the Gulf War in 1991. Documents describing the legally required "Priority of Care" had been circulated prior to combat, and most respondents indicated that they had read it. Twenty-two percent believed that regardless of injury, U.S. soldiers should be treated first (Carter 1994).

What happens in actual practice? A military surgeon who served in the Gulf War says this:

> It must be remembered that the Geneva Convention mandates that enemy casualties be treated in a similar fashion [to U.S. troops]; however, traditionally U.S. casualty care has been directed toward U.S. casualties first, allies second, civilians third, and enemy fourth. This is a time for re-evaluation of ethical and moral principles and a reaffirmation that if the most seriously injured casualty is, in fact, an enemy soldier, he goes first. (Swan and Swan 1996)

In addition to the reasons given above, the doctors who opposed equal treatment for POWs did so because they believed that the enemy would not honor the Convention. One soldier described this response, saying that it was exceptionally difficult to remain objective toward enemy prisoners "once we saw the massive numbers of women and children slaughtered by the [Iraqi] Republican Guard. Toddlers were stabbed repeatedly . . . ." (Carter 1994).Similar practices were carried out in the most recent war with Iraq. Weapons were stored in schools that children were still attending. Weapons also were placed in hospitals, such as the hospital in Nasiriyah from which Army Pfc. Jessica Lynch was rescued (McMillan 2003).

One question raised by this documented opposition to equal treatment is whether the military should undertake efforts to try to influence soldiers and/or military physicians who currently oppose equal treatment to accept it. The military has, for example, required military-wide training to combat racism. Some believe that any anti-gay bias also is "probably modifiable by different official military rules and expectations" (Jones and Koshes 1995; Editorial 2003). The Uniformed Services University of the Health Sciences (USUHS), at which medical students receive special military training, has, since the school's inception, taught students through lecture and example the importance of treating POWs equally.

Some opponents might fear that such required training for all soldiers will impair their capacity to fight and add to their psychological trauma once they face combat. This concern is open to question. Regardless, military *physicians* should be willing to treat POWs equally. Indeed, even if some active military physicians have underlying beliefs opposing equal treatment, most, if not all, presently seem to have transcended them. In the recent war, as in the previous Gulf War, U.S. doctors treated more enemy casualties than U.S. soldiers, and they clearly gave Iraqi prisoners superb medical care.

The high level of care was indicated in the earlier war, for instance, by large numbers of Iraqi prisoners actually seeking out and receiving medical care voluntarily. Apparently, they believed that the U.S. medical care was not only good but better than the care they could receive "at home." Iraqi civilians, seemingly, were conscripted for military duty with less regard than U.S. troops for their health. For example, U.S. military physicians treated many Iraqi soldiers for conditions such as insulin-dependent diabetes and schizophrenia (Longmire 1991).

Military physicians' capacity to transcend whatever negative attitudes they may have had toward Iraqi POWs is illustrated also by the profound grief many

felt during the 1991 war when they learned that they had to let Iraqi soldiers return to their own country. They feared that these soldiers would receive worse or no care and felt that they were abandoning them. They also feared that when these POWs returned to Iraq, they might be killed.

An anecdote from the current war that further suggests military physicians' capacity to transcend negative attitudes is this: An Iraqi POW, while being treated by U.S. soldiers, allegedly laughed and said, "I killed two of yours." Still, he was treated. A Navy corpsman, commenting, spoke, perhaps, not only for herself but for others: ". . . [O]nce they're here, . . . you just take care of them. They're *human*" (Perry 2003, emphasis added).

SHOULD PRISONERS BE GIVEN PROTECTIVE AGENTS?

The preceding ethical questions involve military physicians' moral obligations when prisoners are subjected to possibly unethical or illegal interrogation techniques and their moral obligations to treat prisoners equally. The requirement to provide equal treatment involves additional, new questions since the U.S. now sometimes gives its soldiers "treatments" that have not been fully tested. These interventions include the administration of agents to protect military personnel from biological and chemical weaponry (Howe and Martin 1991; Fitzpatrick and Zwanziger 2003), as well as new agents to minimize the risk of bleeding to death in the event of traumatic injury on the battlefield (Kolata 2003; Libby 2003). In the future, there may be additional agents that would slow the rate of cell death following injury enough to allow critically injured soldiers to acquire the care that they need (Bellamy et al. 1996; Safar and Kochanek 2002).

During the Gulf War, some U.S. soldiers received vaccines to help protect them from botulism. They also were given pyridostigmine to carry with them and take in case of a chemical attack. These protective agents were given out to U.S. soldiers in the Gulf War solely as treatments, although they had not been fully tested for the specific uses stated. It would, of course, have been unethical, and presumably always will be, to require military personnel to participate in research testing of these protective agents for uses on the battlefield (Howe and Martin 1991). That is, humans could not be subjected to the effects of biological or chemical weaponry to ascertain the extent to which these protective agents are effective, because the potential harm would be too great.

The present discussion focuses on the fact that these prophylactic agents could have been offered not only to military personnel, allies, and civilians in Kuwait, but also to captured POWs, presuming there were adequate supplies. Assuming, in addition, that it would have been possible to obtain POWs' consent, the question is: Ethically and legally should "equality"—as required by the Geneva Convention—be carried this far?

If it is assumed that these prophylactic agents could be lifesaving and that they involve minimal risk, an additional ethical question is whether such agents ever

should be administered to POWs who could *not* give consent, for example, to someone who is temporarily unconscious but expected to recover fully, yet who is vulnerable to biological or chemical attack.

I suggest that the answer is "Yes" for both groups of POWs. In regard to blood clotting agents, it theoretically is possible to obtain advanced "consent" to use these agents on POWs either from authorities in the enemy country(ies) or from individuals themselves, just as is possible for our own soldiers. The former would, of course, not be consent, but would be based on beneficence. Enemy authorities would approve the use of blood clotting agents because the alternative for their soldiers would be almost certain death. This type of advance "consent," at least from authorities, is less plausible in the case of biological or chemical prophylaxis because the enemy countries are unlikely to disclose their willingness to use such weaponry.

A final question raised in regard to biological and chemical prophylactics is what should be done for POWs if supplies of these agents are insufficient to treat everyone. Should the agents first be given to U.S. soldiers and/or their allies and/or civilians or first be divided equally between POWs and U.S. soldiers, before being given to allies and civilians? And even if they are to be divided between the former two groups, should they be given to all U.S. soldiers first and then to POWs or should they be given to both groups on a strictly equal basis *even though some U.S. soldiers, as a result, could die*? This question will be addressed by analogy later.

As mentioned, another type of intervention that also is not "fully tested" is being given to some soldiers on the battlefield in the hope of reducing the risk of them dying from blood loss before receiving treatment. These interventions could, and normally would, be tested more fully in civilian settings prior to being made available for use, but their present use in a military setting is justified because, without the agents, more injured soldiers likely would die.

One intervention involves a special substance that can be sprinkled on a wound; others involve specially treated bandages that also help blood to clot (Kolata 2003; Libby 2003). The surgeon who developed "Quik Clot," the substance that can be sprinkled on wounds, did so after he had been "haunted" by soldiers in Somalia who had bled to death before they could reach surgeons (Kolata 2003).

Allied soldiers encountering severely wounded enemy soldiers on the battlefield could administer these clotting agents to them, too. The use of such agents for POWs in the combat setting without consent can be meaningfully compared with interventions now permitted in some civilian settings in an emergency situation. Unconscious patients who are brought to emergency rooms in dire straits can be given, without their express consent, potentially life-saving treatments, even if they have not been fully tested in the context of a research protocol.

In contrast to unconscious patients in the emergency room, U.S. soldiers who might receive the new clotting aids on the battlefield can give prior consent to their use. POWs, as stated, could be asked this too by their leaders or medical care

providers prior to entering battle. This advance in making war more humane would, of course, be a major step for countries going to war and go far beyond what most countries would agree to today. This would have involved, for example, the U.S. informing Iraq prior to going to war that it planned to use these blood clotting techniques in selected contexts during combat. Iraqi leaders, in turn, knowing that wounded Iraqi soldiers who are bleeding to death might live if U.S. medics or soldiers with these clotting agents reached them in time, could give blanket consent on Iraqi soldiers' behalf, or obtain consent individually, like U.S. soldiers. In such a case, the Iraqi soldiers could wear some pre-arranged signal, such as a green badge, indicating prior consent to the use of these agents.

Giving such promising, although not fully tested, treatments to U.S. soldiers who otherwise likely would die is particularly justifiable, if not morally obligatory, on the basis of compensatory justice. They risk their lives for their country, and, thus, deserve every chance to survive possible. The question is whether, on the basis of either equality or compensatory justice, efforts should be made to provide these interventions to similarly stricken enemy soldiers, assuming there were adequate supplies and a means of gaining individual or "surrogate, emergency-like" consent, since they are sacrificing their own interests for their countries as well!

Other potentially life-saving interventions, as previously mentioned, may be forthcoming as well. One such intervention would place soldiers' bodies in a state of "suspended animation" so that, despite their loss of blood, the cells of their bodies might survive until they can reach help and be fully revived (Bellamy et al. 1996; Safar and Kochanek 2002).

This intervention, like "clotting aids," would have to be administered rapidly on the battlefield to be effective, but its use raises additional ethical questions. Clotting aids can be given with minimal risk of profound negative consequences, although an allergic reaction is possible. Putting a wounded soldier into a state of suspended animation potentially poses greater risks, since alternative treatments, such as fluid replacement, presently exist. U.S. soldiers, theoretically, could decide for themselves in advance how they would wish to be treated, but the use of such an intervention on POWs raises the potential for misuse by the soldiers administering it. To what degree, then, should potentially beneficial interventions for POWs depend on specific, unique, considerations such as this?

WHAT SHOULD BE DONE WHEN THE MILITARY MEDICAL TRIAGE PRINCIPLE IS AT STAKE?

The military medical triage principle holds in part that when resources are limited, military doctors may first treat soldiers who can return to the front, as opposed to those soldiers who cannot return. They may do this so that war effort can succeed, *even though they anticipate that as a result some of the soldiers whose treatment is delayed or preempted may die* (Howe 1987). This priority is rarely applied today, but it has been uncommonly in the past. During World War II,

when penicillin first became available and the supply was limited, it was given first to soldiers who had venereal disease so that they could return to the front as opposed to soldiers who needed the penicillin to recover from wound infections even when the infections were life-threatening.

The situation could arise in which military doctors must choose between treating soldiers who can return to the front, soldiers who cannot, *and equally injured enemy soldiers*. Then, the ethical question confronted by military doctors would be whether they could apply the military medical triage principle in the usual way by treating first U.S. soldiers who could return to the front, then more severely injured U.S. soldiers, and, finally, equally injured POWs. They could not, since this would not treat equally injured POWs equally. That is, less severely injured U.S. soldiers would be treated before more severely injured POWs and U.S. soldiers with more severe injuries might live while POWs with equally severe injuries might die.

These soldiers could be treated first, however, if U.S. soldiers and POWs with more severe injuries both were given an equal chance of dying as a result of being treated after soldiers who could return to the front. The U.S. then would have two alternatives. The U.S. could treat all seriously injured patients, its own soldiers and POWs, first. Including POWs among those initially treated could, however, so impair the return of less severely injured U.S. soldiers to the front that doing so could risk military defeat. Thus, this approach would seem implausible. Alternatively, the U.S. could treat only a small portion of the most severely injured U.S. soldiers and POWs in the hope of saving these patients' lives while retaining the capacity to treat and return sufficient numbers of soldiers to the front so as not to reduce the likelihood of victory. This knowing sacrifice of U.S. soldiers' lives to treat POWs equally would be the highest "price" the U.S. could have to pay for treating POWs equally. For U.S. troops and military physicians, it would also be the most agonizing.

DOES EQUALITY ALLOW TREATING ALL U.S. SOLDIERS FIRST OR DOES IT REQUIRE TREATING THEIR OWN SOLDIERS AND POWS "MORE EQUALLY" BY PROVIDING TREATMENT ON AN ALTERNATING OR RANDOM BASIS?

The outcome above, of the U.S.'s having to allow some of its own soldiers to die so that enemy soldiers can be treated with equality might not be necessary in other contexts if equality is interpreted to mean that so long as both groups have equal injuries, one's own soldiers can be treated first. That is, equal treatment could mean that if one's own soldiers and captured enemy soldiers have equivalent injuries, all U.S. soldiers within this group can be treated first and only then enemy prisoners. In practice, this is the interpretation most commonly used (Swan and Swan 1996).

Equal treatment could mean, however, that enemy soldiers with equal injuries should be treated on an alternating or random basis with U.S. soldiers. This would mean again that military doctors could not first treat their own soldiers

who could not return to the front, then treat their own soldiers who could return to the front, and only then treat "equally injured" enemy soldiers. This would mean also, however, that when resources are limited, some U.S. soldiers might die.

This same analysis would apply also, of course, to military physicians treating allied soldiers who, like their own soldiers, could return to the front! If equality was implemented strictly, U.S. and allied troops could be treated first so that they could return to the front, but whenever allied soldiers who could not return would be treated, POWs would have to be treated alternatively or randomly along with them, as well. Further, due to a policy requiring "strict" equality, allied soldiers might have to die.

Treating one's own troops first so long as their and POWs' injuries are equal is in one sense not so ethically problematic. This is because even if military doctors treat only their own soldiers first, there will be no greater net loss of persons' lives. POWs would, however, be subject to the injustice of not being able to be treated early on.

An additional potential problem exists due to military physicians' emotions. In reality, it may be all too easy for military physicians, due to their emotions, to regard inordinately large numbers of U.S. soldiers' injuries as equal to those of POWs so that the U.S. soldiers still could be treated first, even though in significant respects their conditions are not equal.

That is, if all U.S. soldiers with equal injuries can be treated before any POWs need be treated, it could be exceedingly tempting if not emotionally compelling for military physicians to use extremely broad or elastic criteria for deciding who needs "immediate" treatment, since this would allow military physicians to include as many U.S. soldiers as possible. Having some means of avoiding this potential slippery slope by which military physicians could get around treating POWs equally is for this reason, theoretically, at least, desirable. It presently seems, however, unnecessary. Military physicians in Iraq, it appears, have treated POWs equally, regardless of feelings opposing this that they may have. This was exemplified, for instance, in the work of the Comfort, a Navy hospital ship which has just returned to the U.S. Most of the troops this hospital ship treated were from Iraq.

SHOULD MILITARY DOCTORS TREAT ENEMY SOLDIERS OR CIVILIANS FIRST?

Yet another question faced by military doctors is whether they must treat POWs before civilians with equal injuries? Having to do so might evoke rage again within military physicians and other soldiers who think that innocent civilians should be treated before similarly injured enemy combatants. Nevertheless, under the Geneva Convention, U.S. doctors legally may be required to do this, when resources are limited, although in practice the issue may not arise (Swan and Swan 1996).

The U.S. did not agree to the part of the Geneva Convention that requires giving equal care to civilians. The U.S. deemed it implausible, if not impossible, always to provide care equally to U.S. troops, POWs, and civilians. Thus, the

U.S. chose not to make an international, legally binding promise that it anticipated it would be unwilling or, indeed, unable to keep.

For this reason, then, legally, military doctors should treat enemy POWs first and then civilians. If terrorists are injured, this priority, legally, would change. Since terrorists are not "legitimate fighters" of countries that signed the Convention, the legal requirement for POW's to be treated equally does not apply to them. Thus, military physicians could treat civilians first (after treating POWs, if there are any) and then terrorists, or they could treat civilians and terrorists equally. The latter choice would involve their regarding terrorists as equal to civilians and, once prisoners, as no less fellow humans than civilians are.

A final ethical problem, even in the recent Iraq war, is what military doctors should do when it is unclear whether an injured person is a soldier or a civilian. In these cases, military physicians may treat these patients either as if they were POWs or as if they were civilians. If resources are limited, their optimal ethical course may be paradoxical! That is, they must then decide who to treat first. Since POWs legally should be given priority, military physicians may wish to err by considering these persons POWs. Ethically, if they view civilians as deserving equal, if not priority, care, this is the only way under international law that military doctors can fulfill their ethical inclinations and at the same time do what is legal!

CONCLUSION

As a result of the terrorist attack on 9/11 and the war with Iraq, new moral questions have arisen for military physicians and old questions may need rethinking. Questions include the degree, if any, to which terrorists should be treated equally and the degree, if any, to which POWs should receive treatments for purposes for which they have not been fully tested.

New military policies also may pose additional questions for military physicians that I have not addressed in the preceding discussion. One such policy is the protective strategy of a preventive strike, like the one on Iraq. Another is a first strike that, while not necessary to protect the U.S., is necessary to protect others from a nation committing genocide or similar atrocities. This second strategy, some say, is long overdue.

The need to achieve peace after a first strike conducted for either reason may require different moral priorities. Military doctors may preferably be concerned with providing patients the urgent medical care they need, exclusively, for instance, as opposed to being concerned also or to a greater extent with whether their skills are being used primarily for political purposes, as they may have been in the past. In the Vietnam conflict, for example, "dramatic" cases involving cosmetic surgery were carried out in part to win over the hearts and minds of Vietnamese civilians. This was criticized ethically, based on the belief that physicians using their skills for political purposes would exploit patients' vulnerability and, thus, treat them as means instead of recognizing them as ends in themselves (Howe 1987).

Similarly, in establishing peace after a first strike, it may preferable to avoid unnecessary additional bloodshed by using new weapons—e.g., to control crowd violence—that will do less harm (Coupland 1997). Perhaps military doctors should participate in research to develop this sort of weaponry, even though physician participation in offensive weapons development generally has been seen in the past as precluded. Military doctors participating in such research would violate a prior ethical duty to not do research on offensive weaponry. This prohibition was based primarily on the implicit promise physicians make when becoming doctors—to use the skills they have acquired through patients' and society's help to heal and not to harm (Howe 1987). The development of such weapons brings about a theoretical risk, however, of a country's going to war earlier, since the weapons to be used are "less destructive."

This issue raises another that has been open to controversy in the past, namely, whether in principle the moral priorities of military doctors are ultimately the same as those of their civilian colleagues (Howe 1981; Moskop 1998). It may seem that military doctors' priorities clearly differ because, for instance, they sometimes give priority to the success of the mission over the welfare of their patients. Civilian doctors may, however, on rare occasions, act in a morally equivalent way. One example might be the restriction of patients' and others' freedom during quarantines. Here, the welfare of the greater society is likewise placed over that of individual patients. Even if, in principle, the priorities of civilian and military physicians were the same, this, too, now may change, as suggested by the examples involving the political use of medicine and physicians participating in research on offensive weaponry.

The cardinal question posed by these new issues is what priorities, if any, should stay the same. If there are any ethical priorities that should remain unchanged, it would seem that the values that should be retained are those relating to the treatment of captured terrorists and POWs. *Some* such values must be maintained even though doing so at times may violate optimal military interests and, indeed, the optimal interests of the societies the military serves and protects. If not, we will have regressed. We will have lost and given up what we have come to believe about what it means to be civilized, and we will have readopted the once widespread rubric that all is fair in war.

To respect all persons, once captured, affirms human dignity. Respecting human dignity may be the major underlying, if not the sole justification, for conducting all wars. Thus if, after 9/11, no other time-honored values are continued, those regarding the treatment of these prisoners would seem most to warrant being retained.

REFERENCES

Amery, Jean. 1980. *At the Mind's Limits: Contemplations by a Survivor on Auschwitz and its Realities*, trans. Sydney Rosenfeld and Stella P. Rosenfeld. New York: Schocken Books.

Arai-Takahashi, Yutaka. 2002. Shifting Boundaries of the Right of Self-Defence—Appraising the Impact of the September 11 Attacks. *The International Lawyer* 36: 1081–1102.

Bellamy, Ronald; Safar, Peter; Tisherman, Samuel A.; et al. 1996. Suspended Animation for Delayed Resuscitation. *Critical Care Medicine* 24: S24–S47.

Carter, Brian S. 1994. Ethical Concerns for Physicians Deployed to Operation Desert Storm. *Military Medicine* 159: 55–59.

Cohen, Richard. 2003. Using Torture to Fight Terror. *Washington Post* (6 March): A23.

Cooperman, Alan. 2002. CIA Interrogation Under Fire. *Washington Post* (28 December): A9.

Coupland, Robin M. 1997. "Non-Lethal" Weapons: Precipitating A New Arms Race. *British Medical Journal* 315: 72.

Drinan, Robert F. 2001. *The Mobilization of Shame*. New Haven: Yale University Press.

Editorial. 2002. Torture is Not an Option. *Washington Post* (27 December): A24.

———. 2003. No Gays Except . . . . *Washington Post* (26 March): A16.

Elshtain, Jean Bethke. 2003. *Just War Against Terror*. New York: Basic Books.

Feitlowitz, Marguerite. 1998. *A Lexicon of Terror: Argentina and the Legacies of Torture*. New York: Oxford University Press.

Fitzpatrick, William J., and Zwanziger, Lee L. 2003. Defending Against Biochemical Warfare: Ethical Issues Involving the Coercive Use of Investigational Drugs and Biologics in the Military. *Journal of Philosophy, Science and Law* (March): 1–16. Available at *http://www.psljournal.com/archives/papers/drugs2.cfm*.

Graessner, Sepp; Gurris, Norbert; and Pross, Christian; eds. 2001. *At the Side of Torture Survivors*, trans. Jeremiah Michael Reimer. Baltimore: John Hopkins University Press.

Herman, David L. 2002. A Dish Best Not Served at All: How Foreign Military War Crimes Suspects Lack Protections under United States and International Law. *Military Law Review* 172 (June): 40–95.

Howe, Edmund G. 1981. Medical Ethics—Are They Different for the Military? *Military Medicine* 146: 837–41.

———. 1986. Ethical Issues Regarding Mixed Agency of Military Physicians. *Social Science and Medicine* 23: 803–13.

———, and Martin, Edward D. 1991. Treating the Troops/ the Use of Investigational Drugs Without Obtaining Servicepersons' Consent. *Hastings Center Report* 21 (2): 21–24.

Jones, Franklin D., and Koshes, Ronald J. 1995. Homosexuality and the Military. *American Journal of Psychiatry* 152: 16–21.

Kolata, Gina. 2003. Armed with New Tools, Doctors Head to Battle. *New York Times* (30 March): D7.

Libby, Brian. 2003. Pushing to Build a Better Bandage. *New York Times* (4 March). Available at *http://www.nytimes.com/2003/03/04/health/04CLOT.htlm*.

Lifton, Robert J. 1986. *The Nazi Doctors*. New York: Basic Books.

Longmire, Atkinson W. 1991. The Medical Care of Iraqi Enemy Prisoners of War. *Military Medicine* 156: 645–48.

McMillan, Brett. 2003. WRAMC Treats Iraqi Freedom Casualties. *Stripe* 59 (13, 4 April): 1, 4.

Morse, Jodie; Shannon, Elaine; Thompson, Mark; and Zagorin, Adam. 2002. How Do We Make Him Talk? *Time* (15 April): 42.

Moskop, John C. 1998. A Moral Analysis of Military Medicine. *Military Medicine* 163 (2): 76– 79.

Perry, Tony. 2003. Operation Battlefield Survivability: Military Doctors Bring Emergency-Room Style Care Closer to the Front to Save Troops and Others Who Might Die En Route to a Rear Hospital. *Los Angeles Times* (18 April): A14.

Pinkus, Walter. 2001. Silence of 4 Terror Probe Suspects Poses Dilemma for FBI. *Washington Post* (21 October): A6.

Priest, Dana, and Gellman, Barton. 2002. U.S. Decries Abuse but Defends Interrogations. *Washington Post* (26 December): A1,14, 15.

Rivkin, David B., Jr., and Casey, Lee A. 2003. It's Not Torture, and They Aren't Lawful Combatants. *Washington Post* (11 January): A19.

Roig-Franzia, Manuel. 2003. Guantanamo Was Prepared for Suicide Attempts. *Washington Post* (2 March): A7.

Safar, Peter J., and Kochanek, Patrick M. 2002. Therapeutic Hypothermia after Cardiac Arrest. *New England Journal of Medicine* 346: 612–13.

Swan, Kenneth G., and Swan, K. G., Jr. 1996. Triage: The Past Revisited. *Military Medicine* 161: 448–52.

Ursano, Robert J.; Rundell, James R.; Fragala, Richard M.; et al. 1996. The Prisoner of War. In *Emotional Aftermath of the Persian Gulf War*, ed. Robert J. Ursano and Ann E. Norwood, pp. 443–76. Washington, DC: American Psychiatric Press, Inc.

Ware, Michael. 2003. A Family's Last Stand For Saddam. *Time* (21 April): 54–55.

Westermeyer, Joseph. 1996. Compromise, Complicity, and Torture. *JAMA* 276: 416–17.