

# BIOETHICS and ARMED CONFLICT

## MAPPING THE MORAL DIMENSIONS OF MEDICINE AND WAR

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Medical ethics in times of war are fundamentally different from those in times of peace. War brings military and medical values into conflict, often overwhelming other moral obligations, such as a doctor's charge to relieve suffering, in the face of military necessity.

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**M**edical ethics in time of armed conflict are identical to medical ethics in time of peace,” declares the World Medical Association.<sup>1</sup> Were this the case, wartime and peacetime medicine would turn on the same principles and present similar dilemmas. But war fundamentally transforms the major principles and central issues that engage bioethics. A patient's rights to life and self-determination contract; human dignity strains under the barrage of military necessity; and the interests of the state and political community may outweigh considerations of patients' welfare. Also, actors and interests multiply. Combatants and noncombatants, enemies and allies, states and individuals, citizens and soldiers, prisoners of war, the wounded and the

dying, those who can return to combat duty and those who cannot—all of these litter the battlefield.

Armed conflict augments the general principles of bioethics with those peculiar to the conduct of war. For instance, states are obliged to recognize noncombatant immunity, minimize collateral damage, and adhere to a principle of proportionality when fighting threatens to take the lives of civilians and destroy their property. If difficult bioethical dilemmas arise when fundamental moral principles conflict, war adds novel dimensions of its own, as competing bioethical principles must contend not only with one another, but also with the overriding “reason of state” and military necessity that animate any issue of military ethics and may overwhelm other fundamental moral obligations.

Medical ethics in war are not identical to medical ethics in times of peace. Moreover, the nature of war is itself changing as conflicts between nation-states and sub-state actors—guerillas, insurgent ethnic

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groups, and international terrorist organizations—replace conventional war between sovereign nations. The changing modes of warfare create difficulties for the established conventions of war. They also create new dilemmas for medical personnel, who may be called upon to lend their expertise to the prosecution of war rather than simply to relieve the suffering it causes.

### Medical and Military Ethics

In contrast to medical ethics, a wide range of agents, interests, and principles characterize military ethics. Whereas bioethics turns its attention to the patient, either as an individual or class of individuals, military ethics focuses on the rights and interests of three distinct actors: combatants, noncombatants, and the state. The 1949 Geneva Conventions define noncombatants as “persons taking no active part in the hostilities.” These include civilians—“people who do not bear arms”—as well as prisoners of war and wounded soldiers. Combatants, on the other hand, bear arms and belong to military organizations that oversee compliance with international law; they include uniformed soldiers, irregulars, members of militia, and guerillas. This definition excludes terrorists who defy international law by intentionally targeting civilian populations.

Alongside individual actors stands the nation-state or political community with interests of its own. Nation-states are internationally recognized sovereign bodies, while political communities reflect the underlying linguistic, historical, ethnic, or religious groups that state or sub-state actors may represent. Representing a “collective way of life” or national ethos, states and political communities are “super-personalities” with a range of interests not necessarily identical to, and possibly in conflict with, the interests of their members.

In spite of divergent actors and interests, the ethics of medicine and armed conflict share norms anchored

in the right to life, autonomy, dignity, and utility. The right to life, a central feature of contemporary political theory, grounds a state’s obligation to safeguard the lives of its citizens, while liberty interests secure political self-determination and its close cousin, medical autonomy. Dignity is of more recent political interest than either the right to life or self-determination, although it is certainly an integral part of Kant’s discussion of autonomy and an enduring aspect of medical ethics. Enshrined in post-war humanitarian law, dignity turns on the inherent worth of any person by virtue of being human. First among Rawls’s primary goods, dignity is a

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correlate of self-esteem, a function of the value and confidence one places in one’s own life plans, and the respect others accord their fellow men and women as they pursue their vision of the good.<sup>2</sup> Degradation, humiliation, ill-treatment, and debasement invariably cripple self-esteem and make it impossible for individuals to formulate, much less realize, the goals that will make them better people.

Despite the supreme value we attach to life, liberty, and dignity, they sometimes conflict. One way of avoiding these conflicts is to invoke a “utility maximizing” principle, according to which one should act so as to bring about the outcome that best promotes human welfare. Bioethics, which has largely resigned itself to the difficulties of using multiple first principles, places utility maximization alongside other principles. Military ethics, on the other hand, elevates utility in a way that may run

roughshod over other fundamental principles, as utility allows military necessity to trump other moral constraints on military action.

### The Right to Life in Medicine and War

Most countries hold that the right to life obligates the state to protect its citizens’ life and well-being, and that this entails, among other things, the provision of medical care, particularly acute care. Liberty interests and the right to self-determination also secure the right to medical care, since access to adequate and basic medical care is necessary if a

person is to exercise liberty. The sick, after all, make poor citizens. The state’s duty to protect life is not absolute, however, and contemporary medical practice generally allows individuals to withdraw or withhold life-sustaining care when the quality of life deteriorates badly.

War fundamentally abridges an individual’s right to life together with the state’s concomitant duty to protect life. Combatants lose their right to life as they gain the right to kill. Whether they pose an immediate threat or man a desk, fight for a just cause or engage in open aggression, soldiers are perpetually at risk. Noncombatants, too, find their lives subject to the constraints of permissible harm, as the principle of noncombatant immunity provides only limited protection from the destruction and devastation of armed conflict.

Just as war impinges on one’s right to life, it undermines each actor’s right to medical care. Enemy soldiers’

right to medical care is a function of the threat they pose. Deprived of their right to life, enemy combatants have no intrinsic right to medical care. Once wounded and no longer a threat, however, they regain their right to life and to medical care. This is the moral significance of *hors de combat* (literally “out of combat”), the special status accorded combatants who are no longer a threat. Yet once wounded enemy soldiers recover sufficiently to pose a threat, their status reverts again to that of enemy combatant.

If the enemy’s right to medical treatment is contingent upon the threat they pose, the right of one’s own wounded soldiers to receive medical care is contingent upon their “salvage value”—that is, the likelihood that they will return to duty. “Salvage,” a criterion of medical care unique to war, largely replaces “quality of life.”<sup>3</sup> During war, medical personnel do not treat individual soldiers as discrete patients, but as components of a fighting force, a living collective entity. To maintain this force, medical personnel bear an obligation to salvage soldiers and return as many to duty as quickly as possible. Salvage speaks to a specific and *objective* measure of quality of life distinct from the patient’s own, subjective evaluation. Salvageable soldiers may not invoke quality of life to refuse treatment, however painful or onerous, if it will return them to military duty. Those beyond salvage, on the other hand, may not appeal to any right to life to secure medical care when resources are scarce. Combatants who are critically wounded and unlikely to return to duty revert to a noncombatant status and lose their privileged claim to scarce medical resources.

War significantly restricts non-combatants’ rights as well. Although civilians are generally immune from the ravages of combat, they remain vulnerable to “collateral harm,” that is, to unintended but proportionate harm that noncombatants suffer as the unavoidable outcome of a legitimate military operation. This is the

original context of the much-vaunted doctrine of double effect, which prohibits adversaries from intentionally harming noncombatants.<sup>4</sup> Though it is subject to considerable controversy and conflicting interpretation, the doctrine subordinates a noncombatant’s right to life, and access to medical care, to the imperatives peculiar to war, most notably those concerning military necessity and scarcity of resources.

In the final analysis, each set of actors—enemy wounded, unsalvageable friendly soldiers, and civilians—has a fundamentally different claim to medical treatment contingent on the threat they pose, their salvage value, and military necessity, respectively. Further, the status of each actor is not stable, and constant shifting from one status to another plays havoc with medical ethics.

During war, neither combatants nor noncombatants enjoy the same right to life as ordinary patients. Moreover, the state has a life of its own and will wage war to preserve its right to life and common good. Sometimes the common good reflects the welfare of many citizens, but during war the state rarely sacrifices a few lives to save many. Instead, it sacrifices the lives of many to save some intangible national asset that embodies its common vision of the good life and the collective goods that it believes are worth saving.

### Autonomy and Self-Determination in Medicine and War

As ordinary citizens, patients command the right of political and medical self-determination. The former embraces such commonly accepted political rights as representation, movement, and free speech, while the latter encompasses the well-known principles of autonomy and patient self-determination: informed consent, privacy, and confidentiality. War complicates and attenuates these principles. Regardless of a nation’s state of war, military service limits, if

not alters, the nature of autonomy. Autonomy no longer denotes “self-rule”—that is, rule of one’s self for the good of oneself—for the good of the self is not a concern of anyone in the military. Rather, autonomy gives way to benign paternalism as others (officers, for example) rule one’s self for the good of the state and its armed forces.

As a consequence, civil liberties—be they freedom of speech, movement, or assembly—face distinct limits, and autonomy in medical decisionmaking largely disappears. Informed consent, confidentiality, and privacy are all curtailed, and as a result, bioethical questions largely settled during peacetime emerge with renewed vigor during war.

Noncombatants find that war tears their liberties apart in a similar manner. During war, nations will often abridge civil liberties, including the rights of free speech, assembly, and representation, to safeguard national security and protect the state’s sovereignty and territorial integrity. The patient rights of noncombatants, on the other hand, should remain secure and intact. An occupying power, for example, must provide medical care to civilian populations under its control. Exigencies may occasionally prevent this, but there is nothing to indicate that military medical personnel are relieved of their duty to guarantee informed consent, privacy, and confidentiality. On the contrary, developments since World War Two render it imperative to take particular care with the medical rights of occupied peoples to prevent the kind of abuses that characterized Nazi medical experimentation. This, of course, was the intent of the Geneva Conventions and the post-war Nuremberg Code.<sup>5</sup> These prohibit medical experiments contrary to a person’s medical interests. Interestingly enough, wartime medicine brings the principles of autonomy and self-determination to the fore far more urgently than peacetime medicine. The same is true for human dignity and self-esteem.

## Dignity and Self-Esteem during War

While war curtails the right to life and autonomy of all but the state itself, human dignity should remain unaffected by the vagaries of armed conflict. Dignity entails respect for personhood and a commitment to non-humiliation. For most medical practitioners, neither principle is particularly controversial. However, dignity and self-esteem are among the first casualties of armed conflict. Humanitarian law embraces absolute rights untouched by war, the threat of war, or any other public emergency, and prohibits humiliation, torture, slavery, cruel and inhuman treatment, crushing poverty, ignorance, and political impotence.<sup>6</sup> During armed conflict there is a great temptation to inflict all this and more upon one's enemy, and humanitarian law exists to insure that human rights do not go the way of civil liberties in time of war.

Human rights are inviolable, however, only insofar as they do not conflict, and during war it is not difficult to imagine conflicts between holders of competing rights. Freedom from ill-treatment may conflict with the right to life, leading a state to consider sacrificing the dignity of some to protect the lives of others. This is the hard problem of interrogational torture, and it often draws medical personnel into its web.<sup>7</sup> While torture is an extreme example, tension between life and dignity and the costs of maintaining each are at the heart of many bioethical dilemmas in war.

War exacerbates these tensions because individual and collective interests are often incommensurable and difficult to reconcile. There is, then, during times of war a tendency to turn to the principle of utility and maximize the interests of state above all else.

## Assessments of Utility during War

In an ordinary clinical setting health care professionals weigh many aspects of a patient's welfare, including quality of life, dignity, and autonomy. Sometimes medicine can promote all of these simultaneously. At other times, one must choose among them. One way of doing so is by employing some version of a utility calculation—by calculating how the various goods promote human welfare and trying to maximize what is most valuable. Utility calculations are complex, turning on the value one attaches to specific goods and the probability that one course of action or another will achieve the best results. Apart from this, however, one must also consider the scope of one's action: whose utili-

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ty must one maximize? In medicine it is always the patient's. Beneficence and nonmaleficence speak to the welfare of the individual patient. Policymakers also consider the welfare of entire classes of patients. During war, however, the scope of utility shifts dramatically to focus almost exclusively on aggregate welfare.

Aggregate utility reflects the welfare of many individuals composing a particular group. These may be soldiers whose aggregate welfare characterizes the fighting force described earlier. War also weighs the aggregate interests of noncombatants, as the laws of armed conflict seek to protect civilians from intentional and disproportionate harm. More often than not, however, nations wage war to protect the welfare of the nation-state and political community, a super-personality whose interests do not necessarily coincide with those of its citizens. As nations fight one another they will adopt the means necessary

to achieve their strategic and tactical goals. In doing this they appeal to military necessity to guide their actions.

Military necessity addresses both the ends and the means of war necessary to preserve the welfare of the state, its army, and its citizens. In neither case does necessity "know no law." States go to war for political and strategic reasons: to protect their security, safeguard their autonomy, or to uphold their dignity. They fight to disable rather than annihilate their enemies—an oft-noted, self-limiting feature of modern warfare that distinguishes it from wars of antiquity.<sup>8</sup> These self-imposed limits spill over into the tactical means to wage war. States that arm their citizens must regulate their activities with careful instructions that stipulate whom sol-

diers may and may not kill. Humanitarian law protects states from anarchy as much as it protects noncombatants from indiscriminate death. States must also protect the conventions of surrender, without which battles would continue until one side simply exterminated the other. Surrender demands reciprocal provisions so that soldiers can lay down their arms without fear of execution, and victors can treat enemy wounded without fear the injured will turn on their benefactors. This fragile trust between adversaries informs the 1949 Geneva Conventions and 1977 Protocols<sup>9</sup> protecting the rights of prisoners and the wounded and asserting the inherent limits of modern warfare.

The necessities of war, therefore, reflect multiple interests. While a state's and its army's welfare are of first and foremost concern, neither is always an overriding force when calculating the expected utility of going to

war or adopting various tactics to wage war. Military necessity functions within particular moral parameters that limit the ends and means of war. Nevertheless, military necessity retains a distinct if not superior status, if only because most individuals gladly weigh the interests of state above their own. Military necessity, therefore, joins the pantheon of other principles that guide medicine and war and contributes to the peculiar dilemmas that characterize bioethics during armed conflict.

### Dilemmas of Bioethics during Armed Conflict

During armed conflict, bioethical dilemmas arise in several overlapping settings. First, they may arise in either caregiving or non-caregiving—that is, non-healing—situations. Caregiving dilemmas are the familiar ones; they arise as medical personnel provide individual patients with medical care and confront conflicting bioethical imperatives that may impinge on patient rights. Non-caregiving dilemmas are peculiar to war and arise as physicians are asked to contribute their expertise to the practice of war and the development of weapons systems rather than healing the sick or injured.

Second, dilemmas may arise in both conventional and unconventional armed conflicts. Conventional war denotes relatively symmetrical conflicts between sovereign nation states wielding modern armies and fighting according to the war conventions and laws of armed conflict embodied in the Hague and Geneva conventions.<sup>10</sup> Conventional war, however, has largely disappeared from the international scene, replaced in recent years by fierce ethnic or religious rivalries and asymmetrical conflicts between states and sub-state actors, or between solely sub-state actors. Taking note of the changing nature of warfare, the international community revised the 1949 Geneva Conventions in 1977 to regulate so-called “CAR conflicts,” or wars

fought by guerillas and insurgents against “colonial, alien, and racist” regimes that dominated the post-war period. The 1977 Protocols extended combatant status to guerillas and irregular forces who, while part of a loosely organized military force, are required neither to wear uniforms nor to carry their arms openly at all times. Civilians also gained additional protections from occupying powers.

These changes created some unforeseen consequences. On the one hand, adversaries are obligated to protect civilian interests to an extent not previously required. On the other, lack of identifying insignia, coupled with the ease with which combatants can shed their status and attain civilian protection simply by leaving the battlefield, has made it difficult to observe the distinction between combatants and noncombatants so necessary for the latter’s protection. At the same time, many belligerents are no longer content to disable their enemies, but employ whatever means seem necessary to displace entirely both military and civilian populations from disputed territory. This sometimes encourages adversaries, usually the weaker, to embrace terror, consider unconventional weapons, and abuse civilian protections by masquerading as civilians, placing their armed forces in close proximity to civilian populations, or using medical facilities for hostile purposes. Wars in the former Yugoslavia, Central Africa, and the Middle East typify these conflicts. In these conflicts, the difficulty of identifying combatants and handling the perfidious tactics they sometimes employ seriously hinders the implementation of humanitarian law in general, and medical ethics in particular.<sup>11</sup>

Conventional and unconventional war engender both caregiving and non-caregiving dilemmas for medicine. Patient rights in time of war, medical neutrality, and unconventional weapons development exemplify some of the complex issues that bioethics faces during armed conflict.

### Caregiving Dilemmas in Conventional War: Patient Rights

Informed consent, confidentiality, and the right to die are patient rights anchored in personal autonomy and the right of self-determination. If war abridges autonomy, these subsidiary rights should narrow significantly. Consider three examples:

- In 1990 and 1998, the U.S. Department of Defense weighed the use of investigational chemical compounds to protect combatants against the threat of chemical and biological warfare. Inasmuch as these drugs were not standard care, many observers demanded that the army obtain informed consent. Arguing that this was not feasible, the Defense department prevailed with an appeal to military necessity.<sup>12</sup>
- The term “medical ethics” appears in a curious context in the 1977 Protocols as lawmakers grapple with violations of confidentiality and a physician’s duty to “denounce,” that is, turn in, enemy patients to the authorities.<sup>13</sup> The framers seem to have in mind the dilemma facing a physician who unknowingly treats an injured guerilla only to discover his identity during treatment. In a fictionalized account, Pearl Buck applauds a Japanese doctor who treats and then releases an injured American serviceman rather than condemn him to the horrors of a Japanese POW camp.<sup>14</sup> Some people would be less pleased, I imagine, should an American doctor treat and release a suspected Iraqi insurgent.
- Combatants have no right to refuse medical treatment and, by extension, no right to die. But what of critically wounded soldiers who cannot return to duty? If salvage guides medical care and unsalvageable soldiers revert to ordinary civilians, then should not a

soldier facing paraplegia or simple amputation, who is therefore unsalvageable, maintain his right to refuse treatment and die?

These three scenarios highlight complex dilemmas. Without attempting to resolve them here, I want to draw on each to underscore several distinct characteristics of bioethics during war.

First, each scenario highlights the different claims people on the battlefield make on medical care. In the first case, the individual interests of one's own soldiers are subordinate to collective welfare. One treats soldiers with either standard or investigational drugs to maintain the integrity of a collective fighting force, not to care for particular patients. The second case emphasizes the close connection between medical care for enemy soldiers and the threat they pose. A physician may provide care only insofar as his patient no longer constitutes a material threat. Care is predicated on the assurance that an enemy patient cannot return to his threatening status once he recovers. A physician must, therefore, consider denouncing his patient precisely so he can treat him. Finally, the last case shows how a combatant's right to medical care depends on his salvage value. Salvageable soldiers command the right to medical care, but lose the right to die. Unsalvageable soldiers lose their right to medical care, but gain the right to die when they can no longer fight.

These scenarios also highlight a noticeable shift in the burden of proof during war. In peacetime, those *violating* patient rights must justify their action; during war, those *upholding* patient rights generally bear the burden of proof. In the first case, this may not be immediately obvious, since FDA regulations stipulate that informed consent is a rule that only the President can waive, and only when obtaining consent is not feasible, not in a service member's interest, or not in the interests of national security. The reality, however, is quite the opposite. The military prevailed

by arguing that informed consent for administering investigational drugs, ordinarily a good thing, is in general not feasible during war. Since the option to refuse will usually debilitate a fighting force as key troops choose to opt out, the burden shifts to those who must prove that it will not. Only then is informed consent necessary.

In the second case, the rule leans heavily in favor of violating confidentiality unless there are mitigating circumstances. What can these circumstances be if enemy soldiers, by definition, are always threats? One answer comes from Pearl Buck. Faced with the prospect that a patient will be ill treated, or face certain death or abuse, a physician may find sufficient cause to maintain confidentiality. Even then, one might expect physicians to denounce suspected terrorists or guerillas whether or not they face the

diers face high risk all the time, and casualty rates in excess of 50 percent are not unusual in many situations.<sup>15</sup> To require consent, however, risk must be distributed unfairly and fall on the heads of relatively few individuals. So it is, perhaps, with medical informed consent. Risk alone, even the high risk of an investigational drug, is insufficient to require informed consent from soldiers if medical risk is no higher than military risk, distributed fairly among all troops, and necessary to accomplish military objectives.

Confidentiality, too, plays an important part in the war convention, given that captured soldiers are not required to divulge certain information. Confidentiality is respected because captured soldiers are innocent (that is, they are not criminals) and non-threatening. The same principles

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prospect of aggressive interrogation and incarceration. The third case, by its very nature, shifts the burden of proof. Military medical personnel will always deny a patient the right to die unless they can show that he is longer fit for duty.

Finally, as we think about how to resolve these dilemmas, we see that each of the principles at stake—consent, confidentiality, and the right to die—appear during war in a non-medical setting and in ways that are not always controversial. In rare cases, soldiers are sometimes asked to volunteer for or give informed consent to certain missions. Why? The answer turns on both risk and fairness. High risk alone is insufficient to make seeking consent necessary. Combat sol-

may apply as we consider violating the confidentiality of enemy soldiers who require medical care, respecting confidentiality when they are non-threatening, and violating it when they are. Finally, the right to die surfaces, albeit rarely, when wounded soldiers demand to be left behind enemy lines to die rather than risk jeopardizing a mission by being carried along. The request turns on military necessity and the duty to maintain the fighting capability of one's unit, if in their wounded state the wounded can no longer contribute to, and may even jeopardize, a mission's success. The same reasoning may govern the disposition of soldiers who wish to refuse medical treatment and die. They regain their right to die

when they are no longer militarily useful.

### Caregiving Dilemmas during Unconventional War: The Problem of Neutrality

Since the founding of the Red Cross, international law has consistently protected medical personnel and facilities. A number of norms govern these practices and, depending on battlefield conditions, guarantee timely evacuation for the wounded and blanket protection for the facilities that treat them, such as mobile surgical units, fixed medical facilities, and hospital ships. Ordinarily, these rules are not problematic. Compliance is widespread; violations are quickly condemned. Changes in warfare, however, threaten these protections and create new dilemmas for military commanders.

Consider the conflict between Israel and the Palestinian militants. Obligated by the Geneva conventions to provide medical care to an occupied people, expeditiously evacuate the wounded from the battlefield, and protect medical personnel and ambulances, Israel has found that the threat of terror and the inability to clearly distinguish combatants from noncombatants has made these obligations sometimes difficult to fulfill. Blockading Palestinian cities in order to prevent terrorism disrupts access to medical care as the sick are detained at check posts and ambulances are stopped and searched. During combat, Israelis have attacked ambulances, killed medical personnel, and obstructed the evacuation of wounded militiamen and civilians—as Palestinian guerillas have booby trapped the wounded, used ambulances to transport men and matériel, and taken refuge in hospitals.<sup>16</sup>

The dilemmas these situations pose turn on the army's duty to prevent terror attacks and shield civilians from harm. There are also two countervailing duties: the obligation to protect neutral medical facilities, and the duty to avoid harming the sick

and injured. In one sense, the very nature of neutrality eases the tension of fulfilling these two protocols. Medical neutrality grew from convention, that is, from mutual self-interest and reciprocity, rather than any deontological principle, so that any violation by one side may scuttle the convention and leave the other side to violate neutrality.<sup>17</sup> This turns the decision to remain neutral into an assessment of the relative costs and benefits each side can expect from violating neutrality. Hampered by uncertainty, however, this assessment is difficult to make. If one ambulance is used to transport arms or terrorists, what are the chances another will be used in the same way? Human rights activists call on Israel to show restraint because the probability is not high. In fact, most ambulances are utilized for their intended purpose. Israeli responses echo rational choice: under uncertainty, the odds of abuse are even. And if the odds are even and the potential harm posed by terrorism pales next to the harm a single patient in an ambulance may suffer, then simple utility demands stopping each and every one. Palestinians complain that harm accumulates to their detriment; Israelis fear that the next ambulance may carry a bomb. In this environment, civilians and wounded suffer as medical care is disrupted in precisely the way the Red Cross hopes to prevent. Here we see how clear and traditionally honored guidelines are upended by insurgency warfare, creating ethical challenges for which international law and custom offer no ready solution.

### Non-Caregiving Dilemmas during Unconventional War: Chemical and Biological Warfare

Non-caregiving dilemmas present special problems as medical personnel are called upon to use their expertise in a way that causes death and injury. In some nations, physicians continue to find themselves asked to develop weapons for chemical and bi-

ological warfare (CBW) despite the international ban on these weapons and the WMA's declaration that it is "unethical for the physician, whose mission is to provide health care, to participate in the research and development of chemical and biological weapons."<sup>18</sup> Most nations honor the international conventions and WMA declaration prohibiting CBW. However, some states do not. Moreover, the WMA overlooks the very difficult issue of nonlethal chemical weapons. Consider the following two cases:

- None of the parties to the current conflict in the Middle East have ratified the international conventions against chemical and biological weapons, and although there is no similar ban on nuclear weapons, only Israel commands the resources to maintain a nuclear arsenal. This has left Egypt, for example, to pursue the "poor man's" option of deploying chemical and biological weapons to deter Israel's nuclear threat.<sup>19</sup> What is an Egyptian physician to do when asked to participate in his nation's CBW program?
- "There is a fundamental ethical dilemma for doctors," writes an official of the International Red Cross. "The development of this new generation of [nonlethal] weapons incorporates knowledge from the remarkable advances made in medical science; two examples are calmatives [compounds that depress or inhibit the function of the central nervous system] and eye attack lasers. . . . *The medical community must guard against use of its knowledge for the purposes of weapon development.*"<sup>20</sup>

Non-caregiving dilemmas such as these are unique because they upend the conventional paradigm that guides medical practice, and within which some aspect of a patient's welfare is always a primary consideration. In these cases, there are no patients, only ordinary human beings who are harmed by one's deliberate actions

during wartime. As such, CBW programs compel an individual to weigh reason of state against one's humanitarian duties.

The ethical conflicts are not difficult to articulate. Regardless of international law, Egypt sees no alternative but to develop chemical and biological weapons to protect vital national interests. Nonlethal weapons, on the other hand, become the weapon of choice in the low-intensity conflicts that increasingly characterize contemporary geopolitics and that are necessary to reduce civilian casualties while battling insurgents. In each case, reason of state may offer a compelling reason to develop CBW and enlist physician support to do so. On the other hand, of course, stand humanitarian arguments: Chemical and biological weapons may endanger large numbers of civilians, imperil the environment, create unpredictable long-term harm, and cause unnecessary suffering. Yet it is not immediately obvious that a policy of chemical or biological *deterrence* contravenes humanitarian law or invites moral condemnation. If the decades-long debate over the merits of nuclear deterrence is any indication, then there are reasonable grounds to argue that a policy of unconventional deterrence can, in fact, be effective and morally acceptable.<sup>21</sup> Nor do *non-lethal* chemical, acoustical, or optical weapons unequivocally violate humanitarian law or cause unnecessary suffering. Either argument, once sustained, may demand that anyone with the appropriate technical expertise, including physicians, contribute to the development of unconventional weaponry when necessary.<sup>22</sup>

### Bioethics or Armed Conflict?

As citizens evaluate the arguments surrounding patient rights, neutrality, and unconventional warfare, and more generally assess the moral implications of going to war, they may quickly confront conflicting duties. Familial duties, small group loyalties, and professional obligations are

all thrown off track when states go to war, impose military service, and partake in armed violence. Individuals often identify with a nation's reasons for going to war and subordinate their other moral obligations to their civic duties. Often, indeed, they seem willing to risk their own lives and take those of others. They will desist, if at all, only when higher moral principles compel them to pursue conscientious objection or civil disobedience when they perceive wars to be unjust.

In times of war every citizen, regardless of profession, has the same obligation to weigh reason of state and evaluate humanitarian principles. Nevertheless, one is sometimes

quires them to use their expertise solely to promote human good. Similarly, health care professionals may be expected to uphold patient rights and medical neutrality regardless of military necessity.

But this conclusion, if correct, seems to push medicine into a moral class of its own. It allows medical personnel to invoke professional duties in order to avoid causing harm while ordinary citizens must subordinate their professional duties to reason of state when conditions merit. Those who believe medicine answers a "higher calling" may find this conclusion attractive. Yet it confuses professional duties with humanitarian

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tempted to ask whether medical personnel have a unique obligation to resolve dilemmas during war in a way that is consistent with their professional obligations. While one might not expect an individual's professional obligations to assume overriding importance as one contemplates the intractable ethical and moral questions of war, a medical practitioner's duties seem, to many, to be different. In each case above, it appears at first glance that physicians have a special duty to avoid some non-caregiving uses of medical expertise, even if these are militarily justified. Although international law permits certain types of nonlethal weapons, and assuming one could provide reasonable grounds to justify the policy of the Egyptian government, medical personnel must nonetheless refuse to develop these weapons systems because their professional obligation to "do no harm" re-

obligations. When the WMA prohibited medical participation in chemical and biological warfare, it declared: "It is the privilege of the medical doctor to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity."<sup>23</sup>

The WMA, however, uses the word "humanity" in two distinct senses, and this, perhaps, sums up the difficulty facing the medical profession during war. "Service of humanity" refers to beneficence and the imperative to preserve and restore human health. This is a professional obligation and, in principle, no different from those duties that obligate

other professions that serve different human needs and that may fall before reason of state during war. The “laws of humanity,” in contrast, invoke humanitarian law and respect for human rights. They are inviolable insofar as they do not conflict with one another, and, in spite of the tendency sometimes to conflate the laws of humanity and medicine’s professional duty of beneficence, the two are not synonymous. Preserving this distinction is important. While one would not expect a physician or anyone else to use his or her knowledge contrary to the laws of humanity, there is sometimes room to ask whether any individual, physicians included, may violate another person’s “bodily and mental health.” This is the question we all face in the shadow of armed conflict.

## References

1. World Medical Association *Regulations in Time of Armed Conflict*, amended by the 35th World Medical Assembly, Venice Italy, October 1983.
2. J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971): 440.
3. *Emergency War Surgery NATO Handbook*, part 3, chapter 12, ([www.vhn.org/Ew-surg/ch12/12Triage.html](http://www.vhn.org/Ew-surg/ch12/12Triage.html), accessed November 11, 2003). Ordinary triage classifies the wounded so all will receive optimum care, while mass casualty triage treats the injured according to salvage value when the injured overwhelm available medical facilities and not all can be treated.
4. A. McIntyre, “Doing Away with Double Effect,” *Ethics* 111 (2001): 219-55; W.S. Quinn, “Actions, Intentions and Consequences: The Doctrine of the Double Effect,” *Philosophy and Public Affairs* 18 (1989): 334-51; J. McMahan, “Revising the Doctrine of Double Effect,” *Journal of Applied Philosophy* 11, 2 (1994): 201-212.
5. First and Second Geneva Convention, common article 12, Third Geneva Convention, article 13, Fourth Geneva Convention, article 32; Geneva, 1949. These prohibit medical experiments contrary to a person’s medical interests. Requirements stipulating informed consent did not enter international law until 1966. United Nations, “International Covenant on Civil and Political Rights,” article 7. Adopted and opened for signature, ratification, and accession by General Assembly resolution 2200A (XXI) of December 16, 1966, entry into force March 23, 1976 ([http://www.unhcr.ch/html/menu3/b/a\\_ccpr.htm](http://www.unhcr.ch/html/menu3/b/a_ccpr.htm), accessed October 13, 2004). Also, L.C. Green, *The Contemporary Law of Armed Conflict*, Second Edition (Manchester, England: University of Manchester Press, 2000): 234-39.
6. United Nations, “International Covenant on Civil and Political Rights.” The only non-derogable rights during war or public emergency are the right to life; freedom from torture, slavery, servitude, and retroactive legislation; freedom of conscience; the right to recognition before the law; and the right not to be imprisoned for breach of contract.
7. M.L. Gross, “Doctors in the Decent Society: Medical Care, Torture and Ill-Treatment,” *Bioethics* 18, 2 (2004): 181-203.
8. *Declaration Renouncing the Use, in Time of War, of Explosive Projectiles Under 400 Grammes Weight*. Saint Petersburg, Russia, November 29/December 11, 1868.
9. Protocol Additional to the Geneva Conventions of August 12, 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), June 8, 1977.
10. Green, *The Contemporary Law of Armed Conflict*: 234-9. A.P.V. Rogers, *Law on the Battlefield* (Manchester, England: Manchester University Press: 1996).
11. See M.V. Creveld, *The Transformation of War* (New York: The Free Press, 1991), and M. Kaldor, *New Wars and Old Wars: Organized Violence in a Global Era* (Cambridge, U.K.: Polity Press, 2001).
12. E.G. Howe and E.D. Martin, “Treating the Troops,” *The Hastings Center Report* 21 (1991): 21-24; R.K. Miller, “Informed Consent in the Military: Fighting a Losing Battle against the Anthrax Vaccine,” *American Journal of Law and Medicine* 28 (2002): 325-45; W.J. FitzPatrick and L.L. Zwangziger, “Defending Against Biological Warfare: Ethical Issues Involving the Coercive Use of Investigational Drugs and Biologics in the Military,” *The Journal of Philosophy, Science and Law* 3 (2003): 1-16.
13. Commentaries, Protocol Additional to the Geneva Conventions of August 12, 1949, and Relating to the Protection of Victims of International Armed Conflicts (Protocol I), June 8, 1977, article 16, paragraph 676.
14. P. Buck, *The Enemy* (Mankato, Minn.: Creative Education, 1986).
15. R.A. Gabriel and K.S. Metz, *A History of Military Medicine*, Volume 1, *From Ancient Times to the Middle Ages* (New York, Greenwood Press, 1992): 23.
16. Physicians for Human Rights, *Medicine under Attack: Critical Damage Inflicted on Medical Services in the Occupied Territories, An Interim Report* (Jerusalem: Physi-
17. L.C. Green, “Cicero and Clausewitz or Quincy Wright: The Interplay of Law and War,” *Journal of Legal Studies* 9 (1998-1999): 59-98.
18. World Medical Association, *Declaration on Chemical and Biological Weapons*, adopted by the 42nd World Medical Assembly (Rancho Mirage, Calif.: World Medical Association, 1990).
19. E. Barak, “Where Do We Go from Here? Implementation of the Chemical Weapons Convention in the Middle East in the Post-Saddam Era,” *Security Studies* 13 (2003): 106-155.
20. R.M. Coupland, “Non-lethal weapons: Precipitating a New Arms Race,” *British Medical Journal* 315 (1997): 72, emphasis added.
21. For a sample of this literature see a symposium on ethics and nuclear deterrence in *Ethics* 95, 3 (1985).
22. J.P. Alexander, “An Overview of the Future of Non-Lethal Weapons,” *Medicine, Conflict and Survival* 17 (2001): 180-93. For the legal status of various weapons see: D. Fidler, “Non-Lethal Weapons and International Law,” *Medicine Conflict and Survival* 17 (2001): 194-206; M.-A. Coppernoll, “The Non-Lethal Weapons Debate,” *Naval War College Review* 52, 2 (1999): 112-31.
23. World Medical Association, *Declaration on Chemical and Biological Weapons*.