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FROM THE EDITORS

One of the advantages of our arcane academic discipline is the opportunity it allows for a range of approaches, on a variety of topics. Perplexing issues confronting contemporary society are wrestled with by our colleagues, as well as enduring metaphorical conundrums. In this issue two philosophers deal with the conflict of scientific progress and political process: Pearson and Dreisbach address a recent bill proposed to mediate the social turmoil surrounding stem cell research. Five philosophers explore the ambiguities of professional obligation in times of war. Some perennial problems of personal identity are contextualized by the Philosophy and Medicine committee panel at the Pacific Division meeting on “Persons, Human Organisms and Bioethics.” And our poets have not abandoned us: two contributions adorn our pages.

Readers, this is your newsletter. Tell us what you would like to see more of—or less of—in our pages. Poetry, from epic to koan, is always welcome; review those books you are reading; and if you are presenting work that would be relevant to our interests in other meetings, consider submitting it here as well.

Good reading!

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FROM THE CHAIR

Common morality theory has come to be accepted as the basis of bioethics by a number of eminent philosophically trained bioethicists, including Tom Beauchamp, James Childress, Bernard Gert, Ruth Macklin, and Robert Veatch. The theory has evolved since its formulation in the 1970s and has been reformulated significantly in the sixth edition of Beauchamp and Childress’s *Principles of Biomedical Ethics* (2008) and in Gert, Culver, and Clouser’s *Bioethics: A Systematic Approach* (2006). Continuing our collaboration with the American Society of Bioethics and Humanities (ASBH), the Committee on Philosophy and Medicine will sponsor a panel on “Common Morality Revisited” at the 10th Annual Meeting of ASBH on October 23-26, 2008, in Cleveland, Ohio. Tom Beauchamp (Georgetown) and Bernard Gert (Dartmouth) will present their latest versions of common morality theory. John Arras (University of Virginia), who takes an eclectic approach to method in bioethics and is co-editor of *Ethical Issues in Modern Medicine*, will critically probe their positions. Robert Baker (Union College and Mt. Sinai) will act as moderator.

The Committee on Philosophy and Medicine has arranged to sponsor a panel on “Ethical and Conceptual Issues in the Classification and Treatment of Mental Illness” at the next Eastern Division Meeting of the APA on December 27-30, 2008, in Philadelphia. The speakers will be Dominic Murphy (California Institute of Technology), Claire Pouncy (Temple University), and Jennifer Radden (University of Massachusetts, Boston). Kenneth Richman (Massachusetts College of Pharmacy and Health Sciences, Boston) will chair and moderate the discussion. This topic is of particular and immediate concern, given the increased use of psychoactive drugs in young children and the increasing suspicion with which the public views pharmaceutical companies. We hope that the session will go beyond familiar criticisms of the *Diagnostic and Statistical Manual of Mental Disorders* to explore foundational issues and their connection to bioethics.

Our special sessions at the last Central and Pacific Division meetings of the APA went well. At the Central Division meeting, Kevin McDonald (St. Mary’s College, Notre Dame) chaired an important and timely panel on “Physicians at War: The Dual Loyalties Challenge.” Papers were presented by Fritz Allhoff (Western Michigan), Michael Davis (Illinois Institute of Technology), Matthew Wynia (American Medical Association Institute for Ethics), Marcus Adams (Western Michigan University), and Justin List (Loyola University, Chicago – Stritch School of Medicine). Their articles appear in this edition of the Newsletter.

The topic for our session at the Pacific Division meeting was “Persons, Human Organisms, and Bioethics.” It featured papers by Marya Sichechman (University of Illinois at Chicago), David Shoemaker (Bowling Green), David Hershenov (University at Buffalo, SUNY), and Mary Anne Warren (Professor Emeritus, San Francisco State University). I chaired this session and can attest that the panelists were well prepared. In advance of the session, they dutifully provided each other with copies of their talks. They also provided each other with written comments, and there was also a round of comments on the comments. The fruit of their intellectual labor also appears in this edition of the Newsletter.

By convening this session on the metaphysics and bioethics of persons, we hope to have brought together philosophers working on more theoretical issues in the ontology of persons and those occupied primarily with the practical cases in bioethics. The panel was interested in exploring how alternative views of the nature of the relationship between persons and human organisms affects the evaluation of bioethical cases at the beginning and end of life, and, conversely, how ethical and practical considerations may be relevant to deciding among alternative theories of personhood and the relation between the person and human organism, There is some degree of disconnection between philosophers engaged in more
theoretical work on morality and the metaphysics of persons and those engaged primarily in bioethics. This may be reflected in how the mainstream analytical discussion of persons and personal identity has been dominated by its consideration of hypothetical thought experiments, whereas bioethicists have focused their discussion more on actual clinical cases set in particular historical and cultural contexts. It is interesting to consider how the more theoretical discussion of persons and personal identity might be affected by a change from an emphasis on consideration of hypothetical thought experiments to a consideration of real clinical cases.

C coincidentally, after our session at the APA meeting, I attended a session on environmental philosophy that was considering the relevance of theoretical work in moral philosophy to the more practical ethical and political issues faced by those working on the front lines of the environmental movement. Again, there was a certain disconnection between the more theoretical considerations and the evaluation of the practical cases. After all, what do all those wayward trolleys have to do with one’s stance on a pressing environmental issue in which the details of the particular social, political, economic, and cultural context seem especially relevant? It’s not that the hypothetical cases and theoretical considerations do not or should not have bearing on the practical decisions, but clearly more collaborative work needs to be done to show the connection.

In closing, on behalf of the Committee on Philosophy and Medicine, I would like to thank Robert Baker for his three years of very active service on the Committee. He was instrumental in organizing and contributing to many of the APA and ASBH sessions that the Committee sponsored over the last three years. We benefited from his experience, energy, and enthusiasm.

**ARTICLES AND POEMS**

**Persons and the Practical**

Marya Schechtman

*University of Illinois, Chicago*

Many bioethical problems are naturally couched in terms of personal identity. This suggests that an established theory of personal identity should be of assistance in resolving bioethical questions, and that established principles of bioethics should illuminate outstanding questions of personal identity. In my remarks today I will investigate this relation at a rather abstract level by looking at a debate within the metaphysics of personal identity—that between those who take a psychological approach to defining personal identity and those who take a biological approach. This debate is especially relevant because the disagreement between the psychological and biological approaches is at the same time a debate about the connection between personal identity and practical judgments, and this has implications for the way in which facts about identity can be brought to bear on ethical issues.

I will begin with a brief overview of the arguments for the psychological approach and the challenge raised against this view by supporters of the biological approach; next I will look at David DeGrazia’s sophisticated attempt to capture the intuitions behind both psychological and biological approaches with a two-part account of identity (a view he applies to a wide range of bioethical problems). Finally, I will suggest a more integrated approach that I believe could potentially go even farther than DeGrazia’s in illuminating the issues and capturing the relation, such as it is, between personal identity and bioethics.

**Psychological Theories and Animalism**

In the second edition of Locke’s *Essay Concerning Human Understanding* he tells us that “Person” is a “Foresnack term” (sect. 26, line 26). Locke thus seeks to determine the limits of the person by describing various hypothetical situations and asking us to make practical judgments about him. He imagines, for instance, the soul of a prince entering the body of a cobbler, and asks whether the person with the body of the cobbler and memories of the prince shouldn’t be held accountable for the actions of the prince rather than those of the cobbler. In another case he imagines a person with the soul of Nestor or Thersites but no consciousness of any of their actions, and says that that person cannot be “concerned in” those actions any more than in anyone else’s. Locke offers many such cases, and believes that in all of them we will find that our practical judgments track continuity of consciousness rather than of soul or body. He therefore defines personal identity in terms of continuity of consciousness rather than sameness of either material or immaterial substance.

Modern day psychological continuity theories start from the same basic assumption of a connection between personal identity and practical judgments, and use much the same methods as Locke. Although these theorists do not usually worry about sameness of soul views, they seek to adjudicate between psychological and biological approaches to identity by offering cases like teleportation, fission, and brain transplants, which separate these two types of continuity in thought. They, too, ask us to make judgments about moral responsibility, self-interested concern, and other practical matters in these cases and assume that when we do we will see that our judgments of responsibility and concern track psychological continuity (a relation they define somewhat more broadly than Locke’s sameness of consciousness) rather than bodily continuity.

Crudely put, the psychological approach to personal identity starts from the assumption that persons are units of moral responsibility, self-interested concern, and similar practical relations. To determine the limits of the person they thus separate in thought the various continuities that coexist in cases where we make unproblematic judgments of identity and consider where these practical relations apply. They presume that most people will judge that these relations are appropriately applied where and only where there is psychological continuity, and therefore conclude that personal identity should be defined in terms of that relation.

The intuitions behind the psychological approach are very compelling, and this view enjoyed a long period of dominance. Biological approaches have always had their supporters as well, however, and one recent statement of this position that has garnered a great deal of attention is found in Eric Olson’s *The Human Animal: Personal Identity without Psychology*. According to Olson’s account, persons as we know them—human persons—are fundamentally human animals with biological persistence conditions. A person continues to exist, on this view, as long as a single human organism continues.

Olson’s defense of this view takes place against the background of an assumed essentialism (a commitment he shares with most philosophers currently involved in discussions of personal identity, but probably not with Locke). In this framework, each concrete particular belongs most fundamentally to one and only one kind. This kind determines its persistence conditions in that it cannot cease to belong to that kind without ceasing to be. A puppy, for instance, may cease to be a puppy simply by maturing into an adult dog; it
In Human Identity and Bioethics, David DeGrazia enters into this debate by developing an account of personal identity and applying it to core problems in bioethics. DeGrazia is largely convinced by the animalist position with respect to questions about our numerical identity, which he says should be defined in biological terms. But he also allows that we have another, distinct, notion of personal identity—narrative identity. Our narrative identity is the kind at issue in an “identity crisis.” It is, roughly, our sense of our own biographies—what we have done, what we are like, and where our lives are headed—and is closely associated with questions of autonomy and self-creation. Narrative identity is defined in largely psychological terms. Of the two types of identity, numerical identity is the more ontologically fundamental, because narrative identity presupposes numerical identity, but not vice versa.

After developing this theoretical framework, DeGrazia applies it to a vast array of bioethical problems. He offers sophisticated and meticulous arguments which I cannot begin to reproduce here. What I want to emphasize, however, is his general claim that both numerical and narrative identity can be important in considering these problems, although they apply to different problems in different ways. So, with the psychological approach, Olson’s animalism, and DeGrazia’s two-pronged approach, we now have three different positions on the relation between personal identity and practical concerns. Psychological theorists see these concerns as intimately connected to identity, so much so that we can essentially read a theory of personal identity off of judgments of moral responsibility and egoistic concern. Animalists (represented by Olson) see questions of numerical identity as truly distinct from almost all practical issues, and DeGrazia gives us two kinds of identity—numerical and narrative—both of which can have practical implications of different sorts.

An Alternative View

It is perhaps not surprising that I prefer DeGrazia’s account of the relation between the metaphysical and the practical to the other two. In the time remaining, however, I will sketch an alternative view that I think goes even farther than DeGrazia’s in capturing the complexity of the relations between personal identity and practical concerns. My view starts from a reinterpretation of the implications of Olson’s arguments for the biological approach. The moral we should actually draw from his analysis is not that the numerical identity of persons should be defined in biological terms, but rather that the notion of the practical in the psychological approach fails to capture the full range of practical implications associated with personhood and personal identity. Once we see this, it is possible to expand the notion of the practical, leading to a broader conception of identity that includes both biological and psychological features in an integrated account. This notion of identity has the advantages of DeGrazia’s, in that it captures the importance of both biological and (a wide range of) psychological features to bioethical questions, and has the further advantage of being an integrated account that more accurately reflects the practical importance of biological facts.

Let me briefly outline the argument for this alternative view, and in so doing provide some of its most general contours. First, it is important to point out (I cannot here give the full argument) that the biological account of numerical identity favored by Olson and DeGrazia runs into problems very like those they raise against psychological theorists. Where psychological theorists have difficulty explaining the relation of persons to fetuses and vegetables, animalists have difficulty explaining the relation of human animals to zygotes and corpses. And where psychological theorists have a problem explaining the connection between the person and the human animal
with which it is completely coincident, the animalist has a problem explaining the connection between the animal and the collection of matter with which it is completely coincident. The animalist has answers to these challenges—but so does the psychological theorist. The bottom line is that neither biological nor psychological continuity makes a particularly graceful account of numerical identity.

The considerable commonsense appeal of animalism flows, I argue, not from its suitability to serve as a criterion of numerical identity, but rather from the fact that the kinds of practical considerations at work in psychological theories seem obviously too high-order and complex to define what is required for our literal continuation. Psychological and narrative theories imply that a person literally ceases to exist when she falls into a vegetative state or suffers from severe dementia. But this seems hyperbolic. Quite independent of metaphysical considerations about substance terms and persistence conditions, it seems obvious that someone in a vegetative state, or severely demented, is still there; just ask her loved ones and caretakers. Many bioethical problems arise precisely because these people are still there, but profoundly altered.

All of this sounds very sensible, but I do not think it has much to do with judgments of numerical identity. Instead, it has to do with what I will call fundamental practical relations. The reason it seems like common sense to say that a person survives dementia or a vegetative state is not because a substance persists but because there is still someone there with whom one interacts in all kinds of ways. Obviously, someone in a vegetative state cannot actively participate in these interactions, but she is there to be cared for—fed and bathed and clothed and visited. Decisions need to be made about where she should live and what should be done for her, and those decisions are most naturally made by those with whom she had close personal relationships. The considerations we respond to here are practical, not metaphysical; this person cannot maintain the same place in the fabric of social relationships that she once did, but she still maintains a place and this is what stands behind our judgment that she is still present.

My claim, then, is that the psychological approach is vulnerable to attacks like Olson’s and DeGrazia’s because it uses only a very small subset of the relevant practical judgments to determine the limits of a person. The limits of responsibility, practical reasoning, and autonomy may indeed define one notion of personhood and personal identity—what might be called “moral identity.” But this is only part of a broader practical notion of personhood and personal identity that is not numerical identity but is nevertheless more fundamental and literal than moral identity; its limits are set by looking at the full range of practical relations that make up a human life and not just the higher-order ones (e.g., moral responsibility and self-interested concern, but also those rooted in our biological, embodied nature). It is to be presumed that an account of this sort of identity, unlike an account of numerical identity, will admit of degrees, include both biological and psychological elements, and depend upon features not strictly internal to the individual.

I cannot, of course, develop the view here, but let me say a few things about what it might look like. DeGrazia’s conception of narrative identity refers to a narrative account I gave earlier in The Constitution of Selves. While I think DeGrazia’s reading of my earlier account is accurate, I also think that within that account there are the seeds of a more inclusive practical approach of the sort I am after now. Olson defines the continuity of an organism in terms of the continuity of a biological life (a notion he borrows from Locke). I am proposing that we think about the continuity of a person in terms of the continuity of a life more broadly construed—a “person-life.” A person-life typically involves embodiment, relationships, work, play, thinking, and sensing; it might involve parenthood, vacations, hobbies, athletics, and/or artistic self-expression. A life is something we live, and something we build for ourselves. The idea of a person-life is a cluster concept; none of the elements I have listed is by definition essential to it. It might seem that embodiment is, and perhaps it will turn out to be, but to the extent that we can coherently imagine, e.g., Socrates continuing to discuss philosophy freed from the fetters of his body in an afterlife, we can coherently imagine a single life continuing after biological death.

My suggestion is that we think of the continuation of a person in terms of the continuation of her life. This is certainly not an all-or-nothing thing. Since a life has so many different components, and they interact in such complicated ways, we will probably be faced less often with the question of whether a person-life is continuing than with questions about the ways in which it does and does not continue. Some changes run deeper than others, and those that involve deficits with respect to the fundamental capacities we make use of in living our lives will cut quite deep indeed. In different ways paralysis, loss of central cognitive functions, or loss of the capacity to form and maintain relationships with others will interfere with the capacity to continue living one’s life, and so, on this view, with one’s capacity to continue as oneself.

Developing an account of personal identity in terms of the continuity of a person-life will allow us to capture the most compelling aspects of both the psychological and biological approaches and, unlike DeGrazia’s view, to also capture the ways in which the various aspects of our identity interact. This account is also not committed at all to talking about numerical identity, hence avoiding the problems all complex, relational views have in this regard. Finally, it should be clear that this is an especially congenial picture to use in considering bioethical problems. Unlike the other views I discussed, it does not set the threshold for personhood so high as to rule out many of the individuals who are the subject of concern in bioethics, but it does retain the link between personal identity and practical concerns that makes this notion useful in bioethical contexts.

One might ask at this point (Olson certainly would) why what I have described needs to be called “identity.” I have already said that it is not numerical identity, so why not simply acknowledge that there are a group of practical concerns here that are not about identity at all? I do not insist these issues must be described in terms of identity, but I think it is useful to do so. The term underscores the way that the fundamental capacities at issue here are implicated in our very survival. It emphasizes the way in which some of these deficits are not just practical inconveniences, but go to the core of what we take ourselves to be. There is a quite common and legitimate sense of “identity” that reflects this, and I do not see why we should not help ourselves to it.

What’s Identity Got To Do with It?

David W. Shoemaker
Bowling Green State University

This panel addresses the nature of the relation between personal identity and bioethics. There has long been consensus that the two are importantly intertwined, in particular that certain key bioethical positions depend heavily on the truth of certain metaphysical views of identity. In 2003, David DeGrazia forcefully concluded an essay on the topic in Philosophy & Public
Affairs by saying, “[W]e cannot ignore personal identity theory in examining the marginal cases [in bioethics]....” I think, on the contrary, that we can, that identity is far less significant to bioethics than is usually thought. To show this, I’m going to examine arguments on three main bioethical issues where personal identity theory has been thought to be nonderivatively important—abortion, the definition of death, and advance directives—and show that in each case there is a relation other than identity that does the relevant work. I leave open whether or not there might be other successful examples of a bioethical argument depending nonderivatively on identity, but one might think of this talk as both a challenge to present such a case and an expression of skepticism about its prospects. Due to time constraints, I’ll focus solely on numerical identity, setting aside for now the more recently exploited narrative identity.

Abortion

Generally, there are two ways a theory of personal identity has been thought to be important to the abortion debate. One is that it can support a theory of moral status. The other is that it can be used to distinguish abortion from contraception. Those engaged in the first move tend to favor a moderate to liberal pro-choice conclusion. Jeff McMahan, for example, rests his view of moral status entirely on his Embodied Mind account of personal identity, according to which we, who are essentially embodied minds, don’t begin to exist until the organisms we inherit develop the capacity for consciousness. This, McMahan suggests, implies that an early fetus (pre-consciousness) lacks the “special moral status” you and I have “sufficient to make it seriously wrong to kill it.” It is, in his terminology, a something rather than a someone. As a result:

An early abortion does not kill anyone; it merely prevents someone from coming into existence. In this respect, it is relevantly like contraception and wholly unlike the killing of a person. For there is, again, no one there to be killed.3

Nevertheless, the fact that some entity isn’t identical with one of us doesn’t mean that its different moral status is a function of that non-identity. We can see this point more clearly in McMahan’s treatment of late abortions, the killing of fetuses that are one of us, having passed the point at which their capacity for consciousness has been activated. One might think that once one of us has been brought into existence it will have the same moral status as the rest of us, but this isn’t the case for McMahan. Rather, you and I have the high moral status we enjoy because we are persons, and so deserve respect. But there are entities that, while one of us in virtue of a common essence, are not yet persons, and so lack our high moral status. Rather, any moral status they have—determining the seriousness of the wrongness of killing them—depends entirely on their time-relative interest in continuing to live, itself a function of the value of their future and their expected psychological unity with the embodied mind that will undergo that future good. But because they lack the ability to anticipate, contemplate, and form intentions about their future good, their psychological unity with that future self is extremely weak, and so their time-relative interest in continuing to live is itself weak, rendering the wrongness of killing them far less serious than the wrongness of killing persons like you and me.4

So what role do the conditions of our essence and personal identity play here? As it turns out, having an embodied mind—being a someone—isn’t what does any of the work to generate moral status. For one thing, being an embodied mind isn’t what generates full moral status; for that, one needs to be a person, an entity deserving of respect. For another, being an embodied mind isn’t even what generates partial moral status; for that, one merely needs to be an entity with interests, something other animals possess. Furthermore, the degree to which one’s interests determine one’s moral status depends on one’s psychological unity with some future beneficiary of value, but psychological unity just isn’t a numerical identity relation.

Now McMahan explicitly assumes that identity should “coincide as closely as possible with our sense of what matters.”5 but he also claims that the degree of warranted egoistic concern for one’s future (part of what matters) may rationally vary in accordance with the degree to which one will be psychologically unified with that future self. So, insofar as the degree of one’s prudential concern (partially) determines one’s time-relative interests, and insofar as the degree of said concern may diverge widely from one’s numerical identity (which admits of no degrees), what determines one’s moral status with respect to abortion—namely, one’s time-relative interests—does so independently of one’s numerical identity.

David DeGrazia explicitly rejects the idea that what matters—presumably, what grounds egoistic concern—is numerical identity.6 This is because his essentialist-grounded criterion of numerical identity is biological: X (a person) at one time is one and the same as any Y at another time just in case X’s biological life is Y’s biological life.7 But one can easily see that a criterion like this will have a poor fit with our practical concerns, which more or less track psychological relations (as he essentially admits).8 As a result, DeGrazia appeals to the notion of narrative identity to ground some bioethical matters, an account of a different sense of “identity” drawn primarily from the work of Marya Schechtman,9 and on which I have forewarned commentary.

Nevertheless, he does make use of the biological criterion of numerical identity in the abortion case. On his view, unlike on McMahan’s, the early fetus is, in fact, an individual-like-us, for its essence—its biological organism—is in existence and individuated roughly two weeks after conception (once the possibility of twinning is gone). In this respect, he agrees with one of the constituent parts of Don Marquis’s famous “future like ours” account of the wrongness of killing, or FLOA.10 Nevertheless, DeGrazia denies Marquis’s conclusion—that if a fetus has a valuable future like ours then it has an equal interest to ours in not being deprived of it—by adopting a version of McMahan’s time-relative interests account. He argues that what matters for determining the moral permissibility of depriving someone of his or her future is that entity’s time-relative interest in staying alive, itself determined by that entity’s psychological unity with its future, beneficiary self. But “the complete lack of psychological unity between the early fetus and later minded being requires a very heavy discounting of the value of its future in considering the fetus’s stake in continuing life.”11 and so the fetus’s interest in staying alive could be outweighed by virtually any conflicting interest of the mother (or anyone else, I suppose).

Our question is what identity has to do with the argument or verdict here, and the answer is obviously none. The only real disagreement between DeGrazia and McMahan is over whether or not the early fetus is an individual like us: DeGrazia says it is; McMahan says it isn’t. But in neither case does this turn out to be relevant for their arguments justifying abortion. Instead, what is relevant is the relation that matters for prudential concern, namely, psychological unity, which is neither a numerical identity relation itself nor a tracker of the numerical identity relation for either party.

Nevertheless, DeGrazia insists that “personal identity theory can illuminate the marginal cases and the connections between them,”12 but it turns out that what he means by this is that “[a] plausible theory of what matters in survival—a part
of personal identity theory, broadly construed—proves very important.” So, while numerical identity itself may not turn out to be important for bioethical concerns, what matters in identity may, and if that’s the case, then we can still say that personal identity theory is important for bioethics. This is far too broad a construal of personal identity theory, though. One could easily come to place ethical weight on the relation of psychological unity utterly independently of any investigation at all into the nature of personal identity, in which case one would openly be doing what McMahan and DeGrazia are more obliquely doing, namely, straightforward ethical theory.1

By contrast, in Marquis’s reply to Earl Conee’s argument that “there is no metaphysical support for a moral conclusion about abortion,” he tries to show precisely where metaphysics, and in particular personal identity theory, supports his own famous view by distinguishing between contraception and abortion. In abortion, what’s deprived is the fetus’s valuable future-like-ours, and that’s what makes it prima facie wrong. One might then worry that the valuable future of the sperm and/or unfertilized ovum would be lost in contraception, too, making it also prima facie wrong, and that result would, Marquis insists, constitute a reductio of his view. But he claims instead that the two cases are quite different, insofar as what makes killing someone (an adult human or a fetus) wrong is the loss to the victim of her future life. But a “necessary condition of this being so is that the future life that is lost would have been the actual life of the same individual who dies prematurely…” Killing the sperm or unfertilized ovum that were my precursors, then, could have constituted a loss to them only if they would have been numerically identical with me. But neither could have been me insofar as that would make them (by transitivity) numerically identical with each other, which they obviously were not. As a result, neither could have been deprived of the valuable future that is my life had my parents engaged in contraception at the time I was conceived.

Nevertheless, despite appearances, Marquis’s ethical view just isn’t nonderivatively dependent on conclusions about numerical identity. To see why, note that what makes killing the fetus wrong is that doing so deprives it of its own valuable future. Marquis then takes a fetus’s ownership of a valuable future to entail the numerical identity of the fetus with the individual who would otherwise have lived through that future. But there is no such entailment between ownership and numerical identity. Ownership—proper attributability—isn’t necessarily a uniqueness relation. Just as one may jointly own property with another, so too one may jointly own a valuable future with another. This may be so in cases of marriage, business partnerships, sporting ventures on teams, and so on, where one enters into a relationship with other individuals, together creating and constituting an entity to which various valuable things accrue, e.g., tax deductions, profits, victories, and so on. What Marquis wants is an account of what makes some valuable future mine, but that simply consists in a relation between me-now and some set of future experiences, say, not a relation between me-now and some future experiencer. As a result, if ownership is what matters, and ownership doesn’t entail numerical identity, then there’s no reason in principle why a sperm and unfertilized ovum couldn’t jointly own a valuable future, regardless of their individual lack of numerical identity with that future experiencer, in which case the alleged disanalogy between contraception and abortion is lost. Marquis’s ethical conclusion directly rests not on a view of numerical identity but on a theory of ownership-of-future-experiences, a theory which remains to be worked out. And even if it turns out that ownership of this sort does (contingently) depend on numerical identity, identity would still have only derivative importance to Marquis’s argument—garnering attention only in virtue of its support for the ownership relation—not the nonderivative importance he claims it to have.

Death

Turn briefly now to the other end of life. What might seem to be a purely conceptual matter—determining the definition of death—is actually motivated by some major bioethical concerns. Probably the most pressing is the question of when it is morally permissible to remove organs from someone for transplantation. The answer often given to this question is “only when the patient is dead.” What does it mean, though, for a patient to be dead? I am going to focus on three different definitions of “death,” each one alleged to depend squarely on a different theory of personal identity. As we will see, none of them clearly do.

The first is Green and Wilder’s famous ontological defense of brain death—irreversible cessation of brain function—as constituting the proper understanding of death.2 They base this view on a psychological criterion of the identity of persons. Consequently, in order for Jones, a patient, to be alive, then the patient must be alive and the patient must be Jones, and given that Jones is essentially a being with psychological properties whose identity over time is preserved by psychological continuity and connectedness, the irreversible loss of this psychological capacity via irreversible loss of brain function signifies the cessation of that person’s existence, which “of course” means that Jones is dead.

The second and third accounts of death come from, respectively, DeGrazia and McMahan. Both are alleged to be grounded in their essentialist views about identity. DeGrazia insists that you and I are essentially living human animals, biological organisms, such that our ceasing to exist just consists in the death of our organisms, and he thinks the most plausible account of organismic death is the circulatory-respiratory standard, according to which “human death is the permanent cessation of circulatory-respiratory function.” Now McMahan actually agrees that a human organism dies “when it irreversibly loses the capacity for integrated functioning among its various major organs and subsystems.” But this won’t be what my death consists in, because I’m not an organism; rather, I’m essentially an embodied mind, so I cease to exist—that is, I die—when I irreversibly lose the capacity for consciousness, and this happens as a result of loss of function in the higher brain, or cerebral death. This leaves us with two concepts of death, one for the death of organisms, the other for the death of persons. But given the practical concerns related to our interest in the nature of death—regarding the morality of organ transplants, life-prolonging treatments, and so forth—the concept that matters is cerebral death.

My worry about each of these three definitions has to do with the relation each theorist assumes holds between numerical identity, ceasing to exist, and death. The general reasoning advanced by each view goes as follows (with each specific variation in brackets):

1. X exists only insofar as X’s numerical identity is preserved across time, i.e., X at t1 ceases to exist at t2 just in case there is no Y at t2 with whom X is numerically identical.
2. What preserves the identity of some individual across time is preservation of that individual’s essence (psychological continuity, mind, biological organism).
3. If X ceases to exist, X dies.

4. Thus, if X’s essence (psychological continuity, mind, biological organism) is not preserved, X dies.
This is the sort of argument many have thought ensures the relevance of personal identity to the concept of death, but this conclusion is unwarranted because premise 3 is far from obvious (and actually strikes me as false). A powerful reason to doubt it comes from consideration of fission cases, of both the non-fiction and science fiction varieties. When one amoeba splits into two, it seems the original ceases to exist without dying.\(^{23}\) This is also true of the embryo that twins and the sci-fi person who enters the fission machine. In such cases, there is no Y at the time of the split, twinning, or fission with whom the original X is identical, precisely because uniqueness, an essential constituent of numerical identity, has been lost. Nevertheless, it seems bizarre to say that X died at that point, that fission killed him, given that everything else involved in ordinary survival remains completely intact.\(^{24}\)

This is an important point, for it makes clear that preservation of one’s essence can at most be one necessary condition for the preservation of one’s numerical identity. The inclusion of uniqueness as another necessary condition, however, reveals the conceptual gap between ceasing to exist and dying: one may cease to exist where either uniqueness or one’s essence is lost, whereas dying has nothing to do with the loss of uniqueness at all. If there’s such a gap, then, it’s difficult to see what relevance appeals to either our essence or our numerical identity could have in this arena.\(^{25}\)

One might be reluctant to admit this point, however, given the obviousness of the fact that, if a living X ceases to exist, then X is no longer alive. One might then further think that if X is no longer alive, X must be dead.\(^{26}\) But this doesn’t follow. Suppose you magically popped out of existence. It would no longer be true of you that you are alive, certainly enough, but it would also not necessarily be true of you that you are dead: you would more likely be, it seems, not. In any event, it’s an open question whether or not one would be dead, and to admit as much where it would also not be an open question that one had ceased to exist reveals the conceptual gap at issue. Ceasing to exist doesn’t entail dying, and until that’s established, what’s relevant for the definition of death remains independent of considerations of numerical identity.

**Advance Directives**

My treatment of advance directives preceding severe dementia will be even briefer. The relevant question is usually thought to be, “Is the pre-demented signer of the directive numerically the same individual as the later demented patient (someone who is by definition a non-person, let’s say)?” This is particularly a problem in the case in which the younger signer (YS) directs treatment (or non-treatment) that the consented demented patient (DP) claims not to want. Our strong intuition is that YS’s directive is authoritative over the wishes of DP. Call this the *Intuition*. Identity-based arguments on the topic typically go as follows:

1. YS’s preferences are authoritative over DP’s if and only if YS is numerically identical to DP.
2. YS [is/is not] numerically identical to DP.

3. Thus, YS’s preferences [are/are not] authoritative over DP’s.

Start with the negative version of premise 2, something a person-essentialist or psychological continuity theorist would likely maintain.\(^{27}\) This view yields what DeGrazia calls the “someone else problem.”\(^{34}\) Here, notice that one can still deny the conclusion that YS’s preferences aren’t authoritative, and thus rescue the *Intuition*, by denying premise 1’s assertion that numerical identity is necessary for authority. One way to do this is by appeal to “surviving interests,” interests people have regarding certain states of affairs whose (dis)satisfaction depends on what happens after they cease to exist.\(^{28}\) Another way is by appeal to “substituted judgment,” which depends on close family members or loved ones to determine what treatment the formerly competent patient would have wanted (where the advance directive counts as authoritative evidence for that). But in either case, the loss of identity is irrelevant to the preservation of the Intuition.

On the other hand, one might claim to preserve the Intuition by embracing the positive version of premise 2, something a mind-essentialist or biological continuity theorist would likely do. This would allegedly render YS’s preferences authoritative over DP’s. But for those who adopt this option (e.g., McMahan and DeGrazia), the problem now is to figure out why this individual’s earlier preferences are to be respected over her current preferences, when this is the opposite of ordinary practice in other arenas. There are various replies here, having to do with how to place precedent autonomy into the hands of YS. McMahan appeals to the time-relative interest account again.\(^{29}\) DeGrazia appeals to considerations of narrative identity as a way to show how DP’s experiences may be unified into YS’s life in terms of what matters.\(^{30}\) But neither view depends on numerical identity to preserve the Intuition, precisely because doing so depends entirely on a particular account of what makes certain preferences authoritative, and identity is neither here nor there with respect to that.\(^{31,32}\) Whether it’s relevant to some other issues in bioethics, then, or whether there’s some other sense of “identity” relevant to these issues, that’s a discussion for another day.\(^{33}\)

**Endnotes**

3. Ibid., p. 267.
4. See, e.g., ibid., pp. 275-76.
5. Ibid., p. 54.
7. Ibid., p. 421.
12. Ibid., p. 416.
13. Ibid.; emphasis mine.
14. Another way to think about this point: what matters in survival, in identity across time, may be very different from what matters in egoistic concern. So what matters in preserving what we ordinarily think of as survival might be some biological relation, whereas what matters for purposes of anticipation and self-concern might well be some psychological relation. One might, then, easily adopt the latter view independently of any investigation whatsoever into the nature of identity, and if so it would be clear that one was engaged squarely in ethical theorizing. My point here is that this is essentially what DeGrazia and McMahan are doing.
17. Ibid., pp. 77-78.
18. Ibid., p. 78; emphasis in original.
19. Ibid.
20. I’ve argued for this in “Responsibility without Identity,” unpublished manuscript.
21. My own thought is that there’s no difference between the early fetus and the sperm/ovum case with respect to ownership of a valuable future, but instead of both having such a future, neither do. This is because, for one thing, I suspect a proper account of ownership would require owners to possess some basic sort of psychological capacities, which these entities altogether lack. But I’m not prepared to defend such a view here.
23. Ibid. See p. 118 for the “of course” comment.
26. Ibid. McMahan explicitly uses the phrases “die” and “cease to exist” interchangeably.
29. Strangely, McMahan admits as much (see *The Ethics of Killing*, pp. 27 and 425), but he doesn’t appreciate the force of the admission against his view.
31. One might resist this argument by saying that, in the real world, fission (of full-fledged human beings, anyway) doesn’t occur, so we can safely set such considerations aside and so assume that cessation of existence in all ordinary cases equals death. But this reply misses the point, for the bioethical debate about death is a conceptual debate, an exchange about the proper definition of death, and there’s no reason at all to think the relevance of our conceptual intuitions is restricted to the everyday or the likely (“water” and “XYZ,” anyone?).
38. This point is made quite clear once we realize that some authors actually counsel abandoning the *Intuition*, arguing instead that YS’s preferences aren’t authoritative over DP’s, given that DP may still have an important sort of autonomy. On this view, identity is explicitly irrelevant to a determination of the bindingness of the advance directive. See, e.g., Agnieszka Jaworska, “Respecting the Margins of Agency: Alzheimer’s Patients and the Capacity to Value,” *Philosophy & Public Affairs* 28 (1999): 105-38.
39. Steven Wall has suggested a possible account of advance directives in which YS binds herself via the directive, such that no matter what she might think or feel when demented, her earlier wishes are to be authoritative. On such an account, it seems as if numerical identity might do some real work: what renders the later self subject to the directive is precisely her numerical identity with the earlier, binding self. I don’t want to rule out the possibility of such an account, but I haven’t seen one like it developed before, so I’ll remain agnostic until I can assess the details. (One initial worry is that we let ourselves off the hook sometimes in such self-binding arrangements, so it would be unclear whether or not (a) there would be legitimate instances of “letting off the hook” in cases of advanced directives, or (b) a hypothetical later competent self might have done so where the actual later self was pleasantly demented.)
40. I’m extremely grateful to both Steven Wall and Douglas Portmore for insightful comments and discussion on earlier drafts of this essay.

References


**Organisms, Persons, and Bioethics**

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**Introduction**

My contention is that considering a person to be co-located with an organism, or identified with one of its spatial or temporal parts, gives rise to a host of problems as a result of there then
being too many thinkers. These problems, which Olson has emphasized, can be mitigated (somewhat) by a Noonan-style pronoun revisionism. But doing so will have very unwelcome consequences for bioethics, as autonomy, informed consent, advance directives, and substituted judgment will be impossible for the human animal.

I count it as a point in favor of Olson’s answer to the metaphysical question “What are we?” that it avoids such ethical quandaries. But his animalism—with its Parfit-inspired claim that it is not identity that matters in survival, but, rather, the continuation of our psychology, even if someone else is its subject—appears to be at odds with our self-conception and practical concerns. If the only argument for this thesis is the fission scenario, then the thesis is further undermined, as Parfit’s account of fission runs afoul of Wiggins’s “only a and b” rule.

What I will very tentatively suggest is that we explore two (incompatible) accounts of animalism which deny that being identical to a future being is only of derivative importance to us.

I: Pronoun Revisionism’s Bioethical Problems

Assume that we are essentially thinking beings that are related to, but distinct from, organisms. The problem which arises is that if the person can think, why can’t the organism think, since it shares the same brain? I doubt there is a convincing account of why the overlapping beings don’t all have similar mental lives. Olson draws our attention to four specific problems. There is first the duplication problem: The thinking organism would seem to meet the same cognitive criterion for being a person—it too is self-conscious, rational, free and responsible, etc. Secondly, there is the trivialization problem: If the organism is denied personhood because it has the wrong persistence conditions, personhood then becomes insignificant, for there would be non-persons that were also self-conscious and moral, etc. Third, there would also be an epistemic problem: An individual wouldn’t have any reason to believe that he was the person rather than the organism. Any reason the person had to think he was the person, the overlapping thinking organism sharing his thoughts would also have. Finally, there would be the related false self-ascription problem: A truth expressed by one about its essential nature would be a falsehood simultaneously espoused by the other.

To mitigate the problems of too many thinkers, some sort of Noonan-style pronoun revisionism is required. Noonan suggests that to have thoughts about thoughts is not enough to make an entity a person. Rather, an individual must have the appropriate psychological persistence conditions. So the referent of the personal pronoun “I” is not the thinking organism, a thinking brain, a thinking stage, or a less than maximal psychologically-related sum of stages. As a result, while there might be many entities thinking one’s thoughts, they all refer to the same person. This avoids the duplication problem of two persons, one essentially a person and the other only contingently so, because the non-persons are only conscious of the thoughts belonging to the person, not of their own thoughts qua organism, brain, or stage. Unable to use the first-person pronoun to think about themselves as themselves, they don’t meet Locke’s criterion for personhood. And since the non-persons can’t self-consciously refer to themselves by the first-person pronoun, the trivialization problem doesn’t arise. There also isn’t an epistemic problem of a thinking organism, brain, or stage wondering whether or not it is the person, since they all recognize that the referent of the first person pronoun is the person. For the same reason they avoid the false self-ascription problem whereby they claim “I am essentially a person.”

While I am unconvincing that overlapping thinkers would have the limitations Noonan puts on them, I’ll table my doubts for the moment and consider some bioethical dilemmas that arise from a metaphysics adopting pronoun revisionism.

If organisms can’t refer to themselves with the first-person pronoun, then how can they be said to autonomously agree to any treatment, or make provisions for their future in an advance directive? While I don’t have a favored theory of autonomy to expound, it would seem safe to say that one couldn’t be autonomous if one could not reflect upon one’s interests, desires, and reasons as one’s own. And if there isn’t autonomy, there won’t be the possibility of the informed consent which is so important to the doctor/patient relationship. The person could agree to a treatment, but the organism qua organism wouldn’t be agreeing to it. So, pace DeGrazia, there is a “someone else” problem even if organisms are spatially coincident with persons.

The problem is not just with advance directives, but arises as well with everyday care. It would also seem that substituted judgment would be impossible. Substituted judgment involves deciding for the patient as he would have when competent and autonomous. But if the organism could never be autonomous, the only way to decide for his care would be to rely upon the “best interests” doctrine, generally considered a less attractive option. (Incidentally, some of the same problems will arise in the absence of pronoun revisionism due to the epistemic problem.)

One might respond that the interests of the person and the overlapping organism’s interests are the same, so the organism’s inability to construe itself as the subject of thought is not a bioethical problem. I think it is more likely that human organisms (and other thinking non-persons) don’t realize they have distinct interests because of pronoun revisionism or the epistemic problem. The fact that they don’t protest that their interests are being neglected provides us with no more reason to deny that their interests are being ignored here than it would in cases of the brainwashed or constitutionally unreflective. For instance, I don’t see why it is not true that embedded perduring objects are having their immediate gratification sacrificed for that of the 4D worm composed of them. Nor do I see why it would be in the 3D or 4D organism’s interest to acquire a new body to avoid a non-fatal but physically incapacitating disease. While the person might embrace the opportunity to survive with a new body, the organism “seconding” that treatment will be endorsing the end of its mental life in the brain transplant scenario, or the end of its actual biological life in the (slightly more medically realistic) case of too many prosthetics replacing its organic body.

Moreover, if the person and the organism both support donating organs at their deaths, the possibility of the organism’s and person’s deaths occurring at different times prevents the value shared by both from being realized by both. Similar problems will arise if their religious beliefs or conception of dignity demand some immediate posthumous treatment such as next day burial. There is no recourse here to the “conscience” clause that some states have implemented to handle different conceptions of death amongst their citizenry.

If advocates of 3D or 4D try to avoid dilemmas like these by arguing that the organism is just concerned with the welfare of the person, then they will be positing an organism in brain transplant and prosthetic replacement cases that doesn’t care about itself, since it appears to be indifferent to the prospects of being either left behind in a mindless state or destroyed. I find it very hard to believe that with creatures so much alike as the human person and the human organism, it would be in the interest of one to be identical to a future being but not in the interest of the other. It seems that they should either both care about themselves, or identity should matter to neither of them. If
the latter case, I don’t see why audience members would then resist the claim there is only one entity where we are, and it is essentially a living being rather than essentially a thinking entity. Doing so would mean that one doesn’t have to countenance spatially coincident or embedded thinkers. Moreover, if identity doesn’t matter, then the brain transplant and inorganic body thought-experiments fail to provide compelling support for psychological approaches to identity.

Leaving aside issues of patient autonomy, interests, and prudential concerns, consider the havoc that too many thinkers provides for families and friends. Do they start to grieve when the person dies (at the onset of PVS, for instance), or not until the organism dies? Or do they grieve for both, but to a different extent? The latter would be quite different from the two stages of grieving for a single individual whose mental life might be extinguished before his biological life. Even with pronoun revisionism, family members and dear friends conversed with and were loved by both the non-identical organism and the person.

It thus seems a good number of metaphysical and bioethical problems can be avoided if there aren’t any thinkers overlapping organisms. Animalist critics can argue that the advocates of psychological accounts of identity don’t do as well by our practical concerns as they claim because of too many thinkers. Their accounts require that they have to accept that other creatures share our thoughts and intend our actions. As a result, they must either tolerate the claim that identity does not matter to organisms and other person-like non-persons, or deal with the ethical problems that result if such creatures do have interests of their own.

II: Animal Identity Matters

A metaphysical theory is more attractive the better it coheres with the rest of our beliefs. Unfortunately for the Olson-style animalist, thought experiments seem to elicit the belief that we are essentially thinkers. To offset these intuitions, Olson must claim we are misled in the hypothetical cases by the existence of psychological continuity. Our error is due to thinking that such responses are tracking identity. Fission cases, Olson alleges, teach us that identity does not matter; and so our concern is not metaphysically informative, even in the case of the transplant of an undivided brain.

However, I, like many others, fail to share Olson’s intuitions about identity not mattering. I want to survive into the future, and find little comfort in a merely qualitatively identical replacement. Identity seems a precondition for much of what we value, rather than something of only derivative value. Moreover, I suspect if the argument about identity not mattering is based on fission, then it is flawed for the reason Hawley gives: It leaves unexplained correlations between distinct existences. Each of the individuals produced by branching exists only because of the other, but they are without causal connections. Hence the appeal of Wiggins’s “only a and b” rule.

It is also worth adding that the animalist’s claim, ironically, is bad or, at least, peculiar, biology. I would claim that survival is in the interest of a mindless animal, just as water and sun is in the interest of a plant. But according to the Olson-style animalist, when organisms develop significant cognitive function, they aren’t nonderviative concerning for themselves. What they come to care about, or ought to come to care about, is their psychology continuing, not the continuation of themselves as the subject of such thoughts. I think this is an odd sort of disconnect: that organisms at one stage in their ontogenic (and phylogenic?) development have survival as a good, which at that point must obviously be nonderviative; but come later to care only derivatively about their own interests and persistence.

A similar charge against Olson-style animalism can be made in terms of proper function, which will reinforce the above argument, or replace it, if it is judged to be an error to ascribe interests to mindless animals. On Boorse’s account of health, organ systems are functioning properly when they make their contribution to the organism’s survival. But if we read the Parfit-Olson claim about identity not mattering in a normative fashion, then when the organism’s cognitive system develops, it is functioning properly when it serves, not the organism’s survival, but the survival of its psychology, whoever may be its subject. The organism would be malfunctioning if it cared about its own survival in the transplant scenario. This is thus evidence of a rather peculiar biological disconnect between the proper functioning of an organism’s cognition and the rest of its organ systems.

III: Two Animalist Alternatives

So, if psychological approaches of identity give us problems stemming from too many thinkers and pronoun revisionism means a lack of organism autonomy, while Olson-style animalism is incompatible with our practical self-understanding—what are the possible alternatives? I will suggest two alternative accounts of animalism. Both suggest that being identical with a future being is of primary, rather than derivative, importance to us.

Animals with psychological persistence conditions

One possibility is identifying the organism and the person, but claiming it has psychological persistence conditions. Such a being could be reduced to cerebrum-size and transplanted, though it would cease to be alive during the process, and hence is only contingently an animal. The claim that the person is the organism, rather than spatially coincident with it or embedded within it, avoids the extra thinkers and preserves the intuitions many have in transplant and irreversible coma cases.

This view has a few modern adherents, but I think that it is actually the best way to construe the Catholic hylomorphic tradition. (Perhaps here moral considerations restrain metaphysical conceptions even more than in secular theories.) Catholic hylomorphism claims that we are made in God’s image in virtue of our mentality, rather than our animality, and are bodiless when morally reformed in Purgatory. Such a view suggests that we are only contingently living beings. Aquinas’s claim that every deceased human being is resurrected for eternal rewards in a body akin to that of a 32-33-year-old which doesn’t eat, drink, sleep, or otherwise metabolize is at odds with the claim that we are essentially living organisms that persist because our parts are caught up in the same life. The substantial change that Aquinas envisions with the acquisition of rationality (delayed hominization) and then its loss (departed hominization) is akin to the substantial change that Olson has suggested would occur in the transplant scenarios were psychological persistence conditions ascribed to animals. Olson suggests the idea is bad biology, for it would lead to organisms popping in and out of existence (though his own alternative account has cerebrum-size persons popping in and out of existence in the transplant scenarios).

The allegedly “bad” biology that infects hylomorphism is the following: When an organism X with psychological persistence conditions has its cerebrum removed, remaining on the table where the operation took place is not the original organism X in a mindless state, but a new cerebrumless organism, Y, that just came into existence. And, given the assumption that there is no spatial coincidence, when X, who has become cerebrum-sized, is later placed in the mindless body of a third individual Z, that organism, Z, pops out of existence, rather than being said to have acquired the capacity for thought.
Many in the audience will agree with Olson that this is odd biology. They might not think this is offset by our distinctiveness as rational animals, nor want an account intertwined with theology, one which avoids the “only a and b” rule by positing a simple soul configuring a composite animal. However, it is worth pointing out that there is a secular version of hylo-morphism, one that Williams calls a “polite form of materialism.”

Prudential concern without psychological continuity

As an alternative, I wish to tentatively propose a different version of animalism that I’m afraid many will find to be bad psychology rather than bad biology. It is incompatible with a hylo-morphism that suggests we are transplanted when our rational faculties are, but shares the hylo-morphic belief that identity is what matters, and that we human persons are organisms, rather than parts of organisms or spatially coincident with them. It avoids running afoul of the “only a and b” rule, as long as organism fission is modeled on cell mitosis, where a life ends regardless of whether there is one or two successors.

What I now want to suggest, then, is this: That in a brain transplant scenario where my cerebrum will be destroyed and that of my identical twin placed in the body where my cerebrum had been, I not only would survive as the organism, but should now care about my future self even though my psychology will then become just like my twin’s.

To soften up the audience, let me remind them, or some of them, that they did (or will) care that their own mindless embryonic child have a certain future for its own sake. It isn’t that such expectant parents only start to care later about a new being (a person) that emerges, or care now for being yet to come into existence. They want their mindless unborn child to become happy and to flourish for its own sake, and believe that a brain will obviously be beneficial to the child. Their attitudes seem to presuppose that identity is a component in what matters to the child, since they care about that child for its own sake even before it is psychologically continuous with anyone. If we can care for the mindless fetus before it has a psychology on the presumption that the later psychology will be good for it, then perhaps adult human animals can be reasonably thought to have prudential concern for their own future, even in the absence of psychological continuity of any sort, as in the above thought-experiment of my acquiring a new upper brain.

I want to try a different strategy to strengthen this claim that we should be prudentially concerned about our adult conscious organism even when it is without any psychological connection to the present, or even when it is not the same brain playing a role subserving our future mental life. Consider that we care prudentially for the stroke victim that we would become, even if under those circumstances our mental capacities are reduced to mere sentience. Many philosophers believe this shows that it is mere consciousness or sentience, not self-consciousness, that is essential to our persistence. I think instead that such thought experiments can actually be construed as showing that organism-identity matters, rather than being of only derivative concern. Is our concern for our post-injury self with just a rudimentary mind really due to our possessing the same organ that underlies consciousness, or is it rather that it is just the same organism that is conscious? Ask yourself if your reaction to the prospect of coming out of a stroke-induced coma with pain and pleasure sectors intact but no higher cognitive capabilities would be different if such sentience were a result of different parts of your cerebrum having been rewired during the coma? If you would have prudential concern for the same organism independent of the physical conditions for its sentience, why should you react differently to your organism getting an entirely new cerebrum, as suggested in the earlier thought experiment?

Someone might respond that it matters that the different anatomical structures involved in the production of sentience be in the same cerebrum. If so, consider a second case where, early in someone’s life, in the absence of injury and before a web of beliefs and desire arises, different parts of a developing brain give rise to the pain and pleasure “sectors.” Imagine one is in the brainstem (as Shewmon has shown to be possible), and the other is in the cerebrum. Would it be correct to say there were two thinking beings in one body? If one is destroyed, is it correct to claim there is then only one thinking being? Would we say that we have a new thinking being produced by fusion if there is the later development of a self-conscious person who provides the respective pain or pleasure reports when either the sector in the brainstem or cerebrum is “stimulated”? I very much doubt it. I don’t see any reason to identify ourselves with parts of the sentience-producing brain, a la McMahan, nor with a larger being only if it continuously possesses the same functioning brain-like structure, a la (the pre-dualist) Unger, rather than holding that these pains and pleasures would be mine because they are subserved by parts caught up in the same biological life and belong to the same organism. But if you agree with me about this, then why maintain that we would have no prudential reason to care about one’s organism if it received a new brain in the thought experiment?

Perhaps you will argue that you would survive with any parts of your brain producing conscious states, but not with a new brain. I would then ask for a compositional principle that makes the cerebrum, midbrain, cerebellum, brainstem, etc. all parts of the same thing. As far as I can see, what they have in common is that they are caught up in the same biological life. But so would be the assimilated brain in the transplant thought-experiment. If you lack my compositional doubts, imagine that now and after a debilitating stroke your pain is realized by the upper spine while pleasure has a cortical basis.

Conclusion

In conclusion, if either of these animalist approaches is plausible, then we can avoid the metaphysical and practical problems of approaches that construe psychology as essential to us, without abandoning the claim that identity matters. However, I must admit that these appear to be rather thin limbs to climb out on, and so I expect few in the audience to follow me. But my question then is: Where are the sturdier branches?

References


What Would Kant Have Said about Abortion and Embryonic Stem Cell Research, and Why Does It Matter?

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We were asked to consider whether questions about the moral status of persons can be separated from questions about the metaphysics of personhood, questions like whether persons have free will, or whether they are identical to the embryos from which they developed. I would argue that such a separation is not only possible but essential if we are to understand what moral status is, and what entities should have it. Immanuel Kant’s theory of personhood provides an instructive example of the problems that are apt to be generated when we rely too much upon metaphysics in developing theories about moral status.

Kant provides a powerful argument for according full moral status to all persons, human or otherwise. However, the metaphysical theory with which he undergirds his moral theory creates a dilemma with respect to individuals that are not persons. This dilemma still plagues us in debates over the moral permissibility of abortion, contraception, and embryonic stem cell research. The way to escape the dilemma is to look to ordinary experience and the empirical sciences for reasons to treat persons as moral equals. Whether to extend the same moral status to other groups of individuals then becomes a matter not of exploring their metaphysical nature but of examining the predictable consequences of that extension.

Kantian Persons

Kant defines a person as a rational moral agent: a being capable of moral reasoning and of guiding its behavior by moral rules and principles. It is moral agency—"the moral law within"—that gives persons their unique status as ends in themselves who may never be treated as mere means. A person need not be a member of the human species; persons of other species may exist elsewhere in the universe, if not on this planet. Because we are persons, our lives and autonomy demand respect. In contrast, Kant says, entities that are not persons have value only as means, and we have no moral obligations towards them.

This concept of personhood has been enormously important to the development of Western moral and political philosophy. It has been especially useful in constructing the philosophical case for the legal equality of women, ethnic minorities, and other oppressed groups because it provides a way to block the move from the alleged mental inferiority of some persons to the conclusion that they should not have the same basic rights as others. To be sure, many philosophers, possibly including Kant, have denied the rationality of women and other socially subordinate adults; but the question is subject to empirical investigation, and the facts refute these philosophers. This theory of personhood has also played an important role in bioethics, for instance, in establishing the right of competent adults not to be subjected to medical treatment or research without their informed and voluntary consent.

However, difficulties arise when we attempt to use this theory to elucidate the moral status of living things that are not rational moral agents, such as nonhuman embryos, human embryos and fetuses, young children, and severely mentally disabled individuals. Kant’s view was that, because animals are not persons, we have no direct moral obligations towards them. He regarded cruelty to animals as morally objectionable, not because of the harm done to them, but because it corrupts the moral character of the agent, making him less kindly towards other persons.

Kant was compelled to defend this counterintuitive view about animals by certain metaphysical elements of his theory of personhood. He argued that rational moral agency would be impossible if the human will were not free from causal determination. While we cannot observe this freedom in the sensible world (the world to which perception gives us access), we know that we are free in the world of things in themselves because we know the moral law and can follow it. It is this metaphysical freedom that gives persons their unique moral status. Animals do not have this freedom, and thus do not have moral status.

Embedded in this account are two assumptions that need to be questioned. The first is that moral status does not come in types or degrees; it is all or nothing. The second is that there is exactly one criterion of moral status, one property the possession of which is both necessary and sufficient for full moral status, which Kant identifies as rational moral agency. Together, these assumptions severely restrict our options respecting the moral status of non-rational beings. It seems that we must either (1) exclude from moral status all human or nonhuman beings who do not now have the capacity for rational moral agency; or (2) include all human individuals, including those at the very earliest stages of development, on the grounds that species membership is enough to establish their actual or potential rationality.

Tom Regan assumes that Kant must accept the first option. Regan says that, on Kant’s theory,

"I do no moral wrong to a child if I torture her for hours on end. The moral grounds for objecting to what I do must be looked for elsewhere—namely, in the effects doing this will have on my character..."

However, it is unlikely that Kant would have agreed that his theory has this implication. I suspect that he would have responded to Regan’s charge by saying that children are part of humanity, and that humanity is always to be treated as an end in itself. Such a response appears to contradict the claim that only rational moral agents have moral status. However, Kant may have perceived no contradiction here, since he may well have believed that all human individuals possess a nature or essence that includes rational moral agency.

Appealing to an essence possessed by all humans is one way to justify including young children and mentally disabled individuals in the community of moral equals. But the price for this inclusion is high. Part of that price is that we are precluded from considering the moral relevance of the many mental and behavioral capacities that human beings share with animals of many other species. However impressive the mental and behavioral abilities of animals, unless they are rational moral agents they have no moral status; and however unimpressive the mental abilities of zygotes, they are to be regarded as persons with equal basic rights.

Some philosophers have argued that the latter conclusion does not follow from the claim that all human individuals have full moral status because the early human conceptus is not a human individual. Norman Ford, for instance, argues that an embryo does not become a human individual until about fourteen days from conception, when the primitive streak begins to form. Before that stage, the embryo may divide to form two separate embryos, or combine with another embryo to form a chimeric individual; thus, Ford concludes, it is not yet an individuated human organism. But it is odd to say that the human embryo becomes an organism only when it loses the potential to divide, or to coalesce with another embryo. True,
if an embryo divides in two it may be impossible to identify the original embryo with either of the two new embryos; but that does not show that the original embryo was not an organism. Bacteria typically reproduce by division, and that is not usually taken to show that they are not organisms. Were an adult human being to divide into two smaller human beings, we would be very surprised; but we would probably not conclude that she was not an individual human organism prior to the division event.

I doubt that there is a non-question-begging way to show that zygotes and blastocysts are not human organisms. They are alive, genetically human, and many are capable of developing in the way characteristic of our species. Thus, if we base the argument for the full moral status of young children entirely on their possession of a human essence that is present in all human organisms, we will probably be forced also to include human zygotes.

**Abortion and Human Embryonic Stem Cell Research**

This dilemma resurfaces in contemporary debates about the ethics of contraception, abortion, and human embryonic stem cell research. Many of those who oppose abortion also oppose many forms of contraception, as well as embryonic stem cell research, and for much the same reason. They argue that science has established the humanity of the zygote through the discovery that it contains in its cell nucleus a complete (and typically unique) instance of the human genome. 9 That, together with its potential to develop into a fetus, infant, etc., is said to show that it is a person. From this it is said to follow that it is morally wrong to kill it, either to end an pregnancy or to obtain stem cells for research. Even the use of IUD’s and hormone-based contraceptives is often regarded as morally objectionable, since it is possible that these methods of contraception sometimes prevent a fertilized ovum from implanting.

This argument depends upon a metaphysical doctrine similar to the one upon which Kant seems implicitly to have relied. For the personhood of the zygote follows from the microstructure of its nuclear DNA only if that microstructure is thought to be indicative of an essence that includes rationality, or some other trait that is taken as sufficient for personhood. A recent letter in the *New Scientist* states this assumption clearly. The author writes that,

...pro-lifers...do not see an embryo as a “potential” person,... but rather as a person at one stage of their life cycle: from fertilized ovum to blastocyst, embryo, fetus, infant, child, adolescent and, finally, adult. At every stage its essence is the same. 10

This is a metaphysical claim. Nothing that biologists have learned from the study of embryos and fetuses supports the view that they have such an essence. Infants and young children do not exhibit rational moral agency either, since that requires enough understanding of language to grasp the meaning of moral rules. Children learn the prerequisites of rational moral agency along with other elements of culture. The structure of the nuclear DNA establishes at most that, under favorable circumstances, the fertilized ovum may develop into a child who will acquire the mental capacities that adult persons typically have—not that it has those capacities now. Indeed, many (and possibly most) human zygotes have no potential to develop in this way, due to some genetic or other abnormality.

Like Kant, the proponents of full moral status for all human individuals assume that moral status does not come in degrees, and that there is a single property that is both necessary and sufficient for having it. Defenders of abortion and embryonic stem cell research who accept these assumptions are very likely to become embroiled in the same dilemma. Unless they are prepared, like Albert Schweitzer, to extend full moral status to all living things, or, like Peter Singer, to all sentient beings, they must struggle valiantly to find a single criterion of moral status that includes young children and the mentally disabled without also including zygotes and embryos.

**A Better Way**

The way to escape this dilemma is to abandon the search for a single necessary and sufficient condition for full moral status. There is no metaphysical bright line between those entities that have full moral status and those that do not. That being is a rational moral agent is one good and probably sufficient reason for respecting its life and liberty. However, there is no good reason to believe that it is also a necessary condition. There are many compelling reasons for ascribing a strong moral status to many beings who are not moral agents. My view is that we ought to accord the same basic moral rights to all sentient human beings. (One clarification is necessary here. Sentience, like moral agency, is a capacity that can exist without being continuously exercised. We do not cease to be sentient human beings whenever we fall asleep or are rendered unconscious; our capacity for sentience ends only when death or catastrophic brain damage precludes any return to consciousness.)

I will mention just two of the more obvious reasons for including young children and the mentally disabled in the set of beings with full moral status. First, the great majority of us want these individuals to be protected and cared for, and consider this a moral necessity. Second, protecting sentient but non-rational human beings does not normally violate the basic moral rights of human moral agents. On the contrary, it contributes immeasurably to the well-being of human communities and their individual members. Without protection and care, few children would survive to adulthood and most adults would die before their time.

As David Hume and many others have pointed out, we are beings who care not only about ourselves but also about others. Psychologically normal adults experience the full range of what he called the “social sentiments.” 11 These include empathy for the feelings of other human beings, especially those to whom we have social connections; and a strong tendency to disapprove of actions that needlessly harm them. We know now that the capacity for empathy is related to our “mirror” neurons, which respond both when we ourselves perform a meaningful action, or when another individual performs a similar action. The capacity for empathy is not unique to our species, and it often operates across species boundaries, making it possible for our social communities to include animals of many other species.

Social sentiments have survival value for a species like ours, whose members fare best in groups that cooperate, minimize aggression within and between groups, and care for young and disabled members. These emotional predispositions are the bedrock upon which moral rules and principles are built, and without them we almost certainly would not have become moral agents. They are never the final word on the content of moral rules and principles; but it is appropriate to give them substantial weight.

To appeal to social sentiments as a factor that is relevant to moral status is not to ignore the darker side of human nature. The violent, cruel, hateful, and deceitful elements of human psychology are the primary reason that our distant ancestors prepared, like Albert Schweitzer, to extend full moral status to all living things, or, like Peter Singer, to all sentient beings, they must struggle valiantly to find a single criterion of moral status that includes young children and the mentally disabled without also including zygotes and embryos.
pragmatic or utilitarian reasons for adopting non-utilitarian principles.

**Prenatal Human Life**

What can an empirical and nonmetaphysical approach tell us about the moral status of prenatal human individuals? First, it suggests that the moral status of a zygote is substantially different from that of a third-trimester fetus. Microscopic cells or cell clusters are nonsentient, and do not look even remotely human. Were they thinking, feeling beings, their size and appearance would not matter morally. However, there is no reason to believe that sentience can occur in an organism that has neither sensory organs nor a functional nervous system. As the fetus grows, its sensory and nervous systems gradually develop; by the third trimester a degree of sentience is possible, even likely. And, as it becomes more human-like in form and appearance, we find it harder not to respond to it as to an infant—especially now that medical imaging technologies have made fetuses in utero more visible. Thus, both science and ordinary experience provide reasons to believe that the moral status of the embryo/fetus is initially modest, but increases gradually until it becomes equal or nearly equal to that of an infant.

In shaping just laws and policies regarding abortion, the desire of many people to protect embryos and fetuses must be weighed against the known consequences of denying women access to safe abortion. The legal prohibition of abortion does little to reduce its incidence, and greatly increases the death rate for women. The World Health Organization reports that approximately 70,000 women each year die from unsafe abortions, the great majority of these in developing nations that prohibit abortion or severely restrict access. There is no good evidence that early, competently performed surgical or pharmaceutical abortions are likely to harm women physically or mentally. Late abortions are medically more dangerous and more traumatic for all concerned, and it is reasonable to consider them morally more problematic. However, the occurrence of cases in which the woman’s life is endangered, or the fetus has abnormalities incompatible with survival, mitigates against strict prohibition. For these reasons I think that the 1973 decision of the U.S. Supreme Court in *Roe v. Wade* strikes approximately the right balance between competing interests, by permitting states to deny access to abortion only in the third trimester, and only when the woman’s life or health are not endangered.

**Human Embryonic Stem Cell Research**

If there are no sound reasons for according human embryos and fetuses a moral status strong enough to preclude abortion, then what should we say about the use of donated in vitro embryos to obtain stem cells for medical research? Might there still be grounds for objecting to this way of treating embryos? In the stem cell case there is no conflict between the survival of the embryo and a woman’s freedom to end a pregnancy, since no pregnancy is involved. Instead, there is the still-uncertain hope that embryonic stem cell research will some day yield therapies that extend and improve the lives of many people in the future. Thus, it might be argued that, even though IVF embryos are not sentient human beings, they may have enough moral status that they should not be destroyed for the sake of uncertain future benefits, especially if usable stem cells can be obtained in some other way.

An empirically oriented moral theorist will reject this line of argument unless there is evidence that this use of donated IVF embryos seriously harms someone; and such evidence is lacking. The embryos are not harmed in a way that matters to them because they are nonsentient. They will not even lose a future that they will later value, since their progenitors have already decided that they will not be used for reproductive purposes. The progenitors are not harmed either, provided that they have freely agreed to this use of the embryos produced from their gametes. It would be seriously wrong in most cases to damage or destroy an embryo that belongs to a woman or couple who wish to use it to begin a pregnancy. However, the parties most clearly wronged are the prospective parent(s) and/or the future child who may suffer adverse health consequences. The value that the would-be parents place on their embryos calls for respect. But embryos donated for research are not valued in this way, at least not by those who have invested their time, energy, and resources to produce them. Other persons might wish to protect these embryos, but their interests are much less directly involved.

It would, nevertheless, be a welcome development should ways be found to obtain pluripotent stem cells without using human embryos or ova. Researchers in the U.S. and Japan have announced that they have obtained pluripotent stem cells from human adult skin cells, which were genetically altered to revert to the totipotent stage; the altered cells developed to the blastocyst stage, at which point the stem cells were collected. The primary ethical advantage in such an alternative is not that these embryo-like entities are any less human than are embryos produced by the fertilization of an ovum. Their DNA is presumably entirely human; and some might have the potential to develop well past the blastocyst stage, though this has probably not yet occurred.

Rather, the primary ethical benefit of an alternative source of embryonic stem cells would be the avoidance of an escalating demand for human ova and/or embryos, if and when stem-cell-based medical therapies come into widespread use. To donate ova, a woman must be treated with synthetic hormones to cause superovulation, and undergo an invasive procedure to collect the ova. Because the process is onerous and involves some risk to life and health, it is unlikely that enough women would volunteer to donate ova to meet a greatly expanded demand. Moreover, paying women to donate ova is ethically problematic since they are likely not to be fully aware of the risks, which are still not completely understood. For that reason if no other, an alternative source of pluripotent stem cells would be preferable to the use of IVF embryos.

**Conclusion**

Kant’s moral theory provides little guidance with respect to the ethics of abortion and embryonic stem cell research because its metaphysical foundations preclude an empirical approach to the moral status of living things that are not persons. By adopting rational moral agency as the single necessary and sufficient condition for full moral status, Kant embraced a dilemma that haunts us to this day. On a theory such as his, we must either treat all individual human organisms as persons, or treat all sentient human beings who are not rational moral agents as mere things. The dilemma disappears once we pay attention to the many other factors that are relevant to moral status, including sentience and social relationships. Moral status is a human creation which, when it is well crafted, promotes the well-being of persons and the other beings whom they care about, or ought to care about. To serve this purpose, it needs to be informed by all that is known about our species and the other species on this planet.

**Endnotes**


7. See, for instance, *Critique of Practical Reason*, p. 109: "...man must regard humanity in his own person as holy...man alone, and with him every rational creature, is an end in himself."


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**After the Visitor Spoke**

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After the visitor spoke at my high school about climate change, I could not stop crying.

"Do you want to talk about it?" a counselor asked. I shook my head. I did not want her in my life. Besides, she would never believe I was crying because Matt twirled Steffie's hair during the lecture And I heard him ask her to the prom.

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**Physicians at War: The Dual-Loyalties Challenge**

**Fritz Allhoff**

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[Author’s Note: The following essays were presented at a session organized by The American Philosophical Association’s Committee on Medicine and Philosophy at the APA’s Central Division Meeting (Chicago, IL; April 17, 2008). This introduction, as well as the essays by Marcus Adams and Justin List, were originally published in Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Dordrecht: Springer, 2008). The essays by Matthew Wynia and Michael Davis were prepared expressly for the session. The below introduction refers to various contents of the book; I am retaining those references both for context and so that the interested reader might be able to pursue them.]

1. **Introduction**

This project began during the 2004-5 academic year, when I was on a research fellowship at the Institute for Ethics of the American Medical Association (AMA). Just after I began the fellowship, two articles were published in *The Lancet* by Steve Miles in which he discussed alleged violations of military medical ethics that may have transpired through physician involvement in hostile interrogations. Then, right before the holiday break, we received notice that the *New England Journal of Medicine* would be publishing a similar essay by Gregg Bloche and Jonathan Marks, in its first issue of 2005. The American Medical Association in general, and the Institute for Ethics in particular, was extremely concerned about Miles’s papers and the forthcoming one by Bloche and Marks. Not only were these extremely visible publications, but many thought that the allegations they contained were of grave ethical concern. The AMA, which publishes *The Code of Medical Ethics*, takes very seriously the moral status of the medical profession and therefore was very interested in these articles. (Recently, the AMA’s Council on Ethical and Judicial Affairs published an opinion on physician involvement in interrogation, which represents the culmination of its thinking on these topics.)

Having already had a background in some elements of military ethics, and the torture debate in particular, my fellowship year quickly evolved to explore physician involvement in interrogations. One element of this project was to research some of the underlying moral issues, though another was to talk to those responsible for military ethics (including military medical ethics) education. This research led me to speak with those teaching military ethics at the U.S. Military Academy at West Point, the U.S. Naval Academy, and the U.S. Air Force Academy, as well as those teaching military medical ethics at U.S. Army Medical Department Center & School (Fort Sam Houston) and the University Services University of the Health Sciences (Bethesda, Maryland). After I left the AMA, I was also able to spend some time at the Australian Defence Force Academy (Canberra, Australia). In all cases, I was extremely impressed with the professionalism and commitment to ethics that was displayed at each of these training academies.

When starting the research, however, one of the first things that I noticed was how little academic work had been done in military medical ethics. The Borden Institute, an agency of the U.S. Army Medical Department Center & School, had produced two outstanding books which were meant to be used as textbooks for the teaching of military medical ethics. Steve Miles and Michael Gross have each written books about these topics, though these emerged, at least in part, from the previously mentioned journal articles of 2004. Finally, a symposium was held in a prestigious bioethics journal, *Cambridge Quarterly Cambridge Quarterly of Healthcare Ethics* (2006). The point, though, is that few discussions regarding military medical ethics have been held until the past few years. As a final programmatic note, the topic of physician involvement in interrogations was afforded the plenary session at the largest biomedical ethics conference of the year, the American Society of Bioethics and the Humanities (2005). This session was somewhat unbalanced, however, insofar as all three speakers argued for exactly the same conclusion (i.e., there was no conservative or dissenting voice), though a response panel aimed to remediate this shortcoming. It was at this meeting that I met Fritz Schmuhl of Springer, who encouraged the production of this volume, particularly given the interest in the two sessions at that meeting.

In the remainder of this introduction, I would like to provide a discussion of some of the frameworks and issues that appear in this volume (§2) and then to provide a discussion of how
some of these issues might be resolved (§3); the essays in the volume explore these frameworks, issues, and resolutions in greater detail.

2. The Dual-Loyalties Challenge

The motivating premise behind this volume is that, in times of armed conflict, physicians can arguably be subject to dual-loyalties. This concept has been explored in greater detail elsewhere but, for present purposes, we might understand it as the existence of simultaneous obligations which might come into conflict with each other. While dual-loyalties can generalize to all sorts of contexts, our present concern is with the ones that apply to physicians during armed conflict. In these scenarios, physicians have medical obligations to those in medical need. We could ground such obligations in various ways, but the most straightforward way is to acknowledge the medical duties of beneficence and non-malfeasance, both of which have been traditional foundations of medical ethics. According to these duties, physicians are morally bound to render aid insofar as they can and not to (intentionally) make anyone medically worse off.

Such medical duties, however, might come into conflict with non-medical duties, and there are such non-medical duties that we would expect to be expressly manifest during times of war. For example, military physicians are subject to the chain of command and therefore have an obligation to obey their orders. To be sure, it might not always be the case that following orders from the chain of command is morally obligatory, but we can presumably suppose that, at least in the cases of just war, there is a (defeasible) reason—which we could cache out in terms of military efficiency, for example—for obeying commands and that, therefore, such commands have some sort of positive moral status. Second, the physician, in virtue of medical training, might be able to promote national security or, more nebulously, the greater good, and therefore absorb the associative moral obligations.

Of course, these non-medical obligations could precisely oppose the medical obligations previously mentioned. Consider, for example, physician participation in weapons development, which is covered in the third unit of this volume. We can easily imagine cases wherein physicians are operating on the just side in a conflict against an evil regime and that their expertise could be applied to chemical or biological weapons; we could further imagine that such weapons would be effective against the enemy and lead to a quicker dissolution of the conflict. With such weapons, it could be the case that there would be fewer casualties overall—perhaps by shortening the war—or even that the existence of such weapons would be psychologically debilitating enough to the enemy that the conflict could rapidly come to an end. If this is a terrorist regime, then national security could legitimize the development of the weapons or, regardless, such weapons might serve the greater good—including the citizenry, present and future, which falls under the dissolved evil regime—and therefore be morally justified. But, despite the moral considerations that would count in favor of such weapons development, there are contrary considerations that would inveigh against it. In particular, the development of weapons could violate the physician obligation of non-malfeasance since those weapons would be used to harm some individuals. What, then, should physicians do? Are they morally permitted to participate in weapons development?

Before moving on to a more general discussion of these challenges, let me point out some other specific contexts in which such challenges arise. Many of these are covered in this volume, but I will briefly mention them in this section. In particular, we could see the above frameworks also applying in the following: physician involvement in torture (Unit 2) and battlefield triage/medical neutrality (Unit 4). Starting with torturous interrogations, it could easily be the case that such interrogations serve important military objectives, and that medical knowledge could make the interrogations more expedient, perhaps by conducting them in ways that invoke physical or psychological vulnerabilities of the interrogatee. Again, though, any application of medical knowledge that makes the interrogatee worse off than s/he otherwise would have been could be viewed as problematic when viewed through the lens of medical ethics. Therefore, this is another instance of the dual-loyalties conundrum.

Finally, consider some of the issues that physicians might face on the battlefield. In particular, I have battlefield triage and medical neutrality in mind. The scenario in these cases is that there is some number of individuals in need of medical attention such that the demand for such attention exceeds the supply. Some decision, then, must be made about how those resources should be allocated. Medical obligations would suggest that these decisions should be made on medical grounds alone: resources should be invested in ways to optimize (medical) outcomes. Just to take an example, imagine that there are two wounded soldiers, one of ours and one of the enemy and that there are only resources to tend to one of them. Imagine, further, that the enemy is slightly worse off, though both are very much in need. Medically, it could easily be the case that treatment should be provided to the enemy, since he is less likely to survive absent medical care. The other soldier, however, is on our side. Should the physician tend to the enemy, despite the fact that this could lead to the death of an allied comrade? Or, more generally, should physicians exercise (political) neutrality when making medical decisions? What if the injured enemy were a high-ranking officer who could be an important strategic asset? It could be the case that resuscitating such an offer could, ultimately, lead to the realization of various military objectives; we could further stipulate that such objectives had moral significance. If the physician chooses to save the enemy officer over our private, is this fair? If such an officer were less in medical need then, despite the military advantages, then it would seem medical virtues would mandate the treatment of the private, though this could have adverse consequences for key military objectives. These questions can become even murkier when we abstract away from “micro” decisions (e.g., save this person or that one) and try to achieve some clarity about the general triage practices that should be endorsed; in any case, such situations can clearly manifest the dual-loyalties concern.

3. Addressing the Challenge

In the previous section, I introduced the notion of the dual-loyalties challenge and showed how it could be instantiated in various contexts: weapons development, torture, and battlefield triage/medical neutrality. In this section, I want to consider various ways to remediate the challenge, and I take it that there are, conceptually, four different options here. First, we could hold that medical and non-medical values are commensurable and that, in any given case, we just have to make adjudications about which pull more strongly. Second and third, we could hold that these values are incommensurable, but that one or the other set of values does not apply. One option is that non-medical obligations are patently irrelevant to medical decision making; the other is that medical obligations are inappropriate in these contexts. Fourth, we might say that the values are incommensurable, yet all apply. It is not clear to me how this fourth option is a solution to the challenge as it merely posits intractability. And I think, therefore, that it is simply implausible: we all believe that there are right and wrong courses of action in the scenarios mentioned in §2, and I want to suggest that
we all believe this because one of the first three options listed must be correct.

The first option is the one that might seem the most straightforward: we acknowledge the existence of conflicting obligations, and then we just have to figure out which set carries more weight (while accepting the countervailing force of the contrary). So we could say, for example, that it is prima facie bad for physicians to develop weapons while, at the same time, allowing that complicity in weapons programs could nevertheless be justified if the stakes were high enough. As more lives hung in the balance, as the enemy regime were more evil, or as all other options had been exhausted, we might postulate increasing moral merit in physicians developing these weapons. Absent such features, though, perhaps there would not be sufficient countervailing moral weight for physician involvement in such a program given their medical obligations.

This line is not without problems, both epistemic and metaphysical. Regarding the epistemic ones, we simply do now know how many lives might be at stake, or what the consequences will be of us having (or not having) chemical or biological weapons. Metaphysically, we might meaningfully ask how many lives are worth a single transgression against non-malfeasance, and thence beckons the specter of incommensurability. The epistemic worries, though, are just that, epistemic: whether we know the relevant stakes, it hardly follows that there does not exist some proper course of action, and we then have to do the best we can to determine what it is. The commensurability problem is a difficult one as well, and people choosing this approach to resolving the challenge will surely owe us an account of their thinking in this regard.

Let me also point out another answer that might present itself here, which is more empirical than conceptual. In setting up the above challenges (in §2), I made various suppositions, and people might simply deny that any of these is reasonable. For example, in the torturous interrogation case, I asked that we consider an interrogation that advanced the greater good, despite its transgression of medical virtues. It is certainly an open possibility here to deny that such an interrogation is possible, perhaps by denying the plausibility of any sort of utility forecast that would justify the interrogation. In the torture debate more generally, this is a common line, though I think that there are responses. This approach, then, admits of the commensurability of the conflicting obligations while, at the same time, denying that there will ever be much pull coming from one of the directions; a quick look at the literature would suggest that the non-medical obligations are more commonly thought to be the impotent ones. Regardless, I think that this is the approach that is most intuitive, though there is some work to be done regarding how the commensurability would be understood.

Second, we could resolve the challenge by saying that one of the two directions (necessarily, as opposed to contingently) exerts no pull. The more common direction that this would take is to deny that extra-medical considerations can have any impact on medical considerations. This strategy is one that we might attribute, in a different context, to Michael Walzer. Walzer has postulated “spheres of justice” exist such that we can only make distributions of resources within some sphere based on considerations internal to it, rather than to some distributive logic that would be motivated from some other sphere. In applying that structure to our context, it would therefore be inappropriate to make decisions regarding medicine by appeal to extra-medical considerations: medicine occupies its own sphere of justice and, therefore, medical decisions must be based on medical considerations alone. Note, then, that this view is patently one of incommensurability: it does not matter, for example, whether there are tremendous extra-medical benefits to be gained through some action that violates tenets of medical justice since the former are inadmissible regarding considerations of the latter. On this view, there is no dual-loyalties challenge since there are no dual loyalties in the first place: physicians must make medical decisions based solely on medical considerations and chains of command, national security, and the greater good are impotent against such considerations. While Walzer did not explicitly apply his framework to this present context, such an application is nevertheless fairly straightforward.

This view is not without problems, though many people will nevertheless find it compelling. As far as I can tell, the most pressing objection would have to do with how we individuate different spheres. As I laid it out in the previous paragraph, the medical sphere was conveniently insulated from the non-medical realm, and this insulation provided a solution to the dual-loyalties challenge. However, this structure could receive pressure in either of two directions. First, we might wonder whether this medical sphere is too small. In fact, the reason it offers a solution to the dual-loyalties challenge is that it is precisely of the scope that would do so and, therefore, might be thought to be idiosyncratic or ad hoc. What is so special about medicine such that it gets its own sphere of justice? The postulation of such a sphere almost seems to be question-begging against “greater good” considerations, since it eliminates those considerations out of hand (e.g., by asserting a sphere which they cannot penetrate). We could certainly carve up the spheres differently, and maybe “greater good” could be some such sphere, of which medicine were a proper part. Regardless, it would seem that the postulation of some sphere needs to be motivated in some way, and it is not clear to me what the motivation for a medical sphere would be. Conversely, maybe the medical sphere is too big (as opposed to too small). If there is a medical sphere, there could very well be sub-medical spheres: just as some features set off the medical sphere from others, features within it might be used to set off facets of it itself. The problem would then be that this conception of spheres could lead to a sufficiently high number of them such that they would not be useful in particular cases. Regardless, the proponents of spheres will have to say something about why there is a sphere of medicine and why it does not either get subsumed under a bigger sphere or fracture into multiple smaller ones; only such a compelling story here would preserve the merits of this answer.

Finally, we could resolve the dual-loyalties challenge in the third way, which is again to deny that there are dual loyalties at all. While the spheres of justice approach negates the relevance of extra-medical obligations, a converse approach holds that only extra-medical obligations are admissible and that medical obligations do not apply. Again, this line would deny that there is a dual-loyalties challenge since there would not be competing obligations at all. This is undoubtedly the least popular of all the options and, as far as I can tell, I am the only person who defends it. The idea here is that medical obligations apply only to physicians and that there is conceptual space for medically trained military functionaries who are nonetheless not physicians. Physicians are members of the medical profession, and this carries with it various moral features. For example, they have taken an oath to abide by various features of that profession, including providing care for those in need. But we could easily imagine medically trained personnel who are not members of this profession: they may never have taken the oath or ever planned to provide positive medical services. Rather, they could use their medical training in an adversarial way, such as through the development of weapons or through participation in hostile interrogations.
I want to suggest that medical obligations do not apply to these people, whom I take to be something other than physicians. The contrary view would have to hold that, regardless of these people’s non-participation in the medical profession, the obligations nevertheless attach to them. I think that this line is problematic for various reasons, and provide those arguments later in this volume. A second critique of this position—which came out as a response to my paper and is therefore not considered within it—is that the people that I would otherwise exempt from medical obligations are, in fact, physicians: they have taken the associative oaths and are members of the medical profession. I do not disagree with this claim, but it does nothing to erode the conceptual space that I aim to delimit. Rather, it seems completely possible to me that military physicians could opt out of the profession, and that some of their obligations would thereafter dissolve. (Some, however, would not, such as the obligation to preserve confidences obtained through participation in the profession.) Furthermore, there is no reason that these personnel had to take whatever oaths would ground medical obligations: we could easily imagine a medically trained force that completely rejects these values altogether.

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In this introduction, I have discussed briefly the issues that motivate and constitute the volume. In §2, I introduced the notion of the dual-loyalties challenge, which is further discussed in Unit 1. I also introduced some particular issues in which this challenge is manifest: physicians and torture (Unit 2); physicians and weapons development (Unit 3); and physicians on the battlefield (Unit 4). Each of these units comprises papers which explore the associative dimensions in greater detail, and display a range of different perspectives thereof. In §3, I discussed various options to resolve the dual-loyalties challenge; these are also variously considered throughout the following essays. At the end of the volume, I have included three appendices, which are statements published by the World Health Organization and the American Medical Association regarding physician involvement in armed conflict.

Thank you for your interest in this project; I hope that you find the following essays engaging and provocative!

Endnotes

1. This paper was originally published in Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Dordrecht: Springer, 2008), 3-11.

2. I thank Marcus Adams for comments on the penultimate draft of this paper.

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13. See, for example, Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty, *Dual-loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms*. Excerpts reprinted in this volume, pp. 15-38. See also the other essays in Unit 1.

14. In my own view, this conclusion does not follow since I think that non-malfeasance should be understood in an aggregative mode: if physicians harm a few people such that more people are not harmed later—through, let’s say, continued military conflict—it seems to me that such an act is not just licensed, but rather required by an appeal to non-malfeasance. This is an unpopular view that I will not develop here, but see Allhoff (2003) for related discussion.

15. In fact, this is precisely the view taken by the AMA in its report. See pp. 261-71, this volume. For a dissent, see my essay, pp. 91-104.


19. In the book (and in subsequent literature), this topic is explored, though I take it to continue to be one that assails the position.


21. I acknowledge that, despite this contention, the title of this volume nevertheless invokes “physicians.” I do this most proximately for ease of use, but also in recognition of the consensus view on this issue.

References


No Dual Loyalty: The Profession of Medicine Comes First

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The subject of this panel, the so-called “problem of the dual loyalty of military physicians,” seems to arise in at least three contexts: 1) where a military physician is ordered by an appropriate superior to use medical knowledge, skill, or judgment to aid in torture or other cruel, inhumane, or degrading interrogation; 2) where such a physician is ordered by an appropriate superior to use medical knowledge, skill, or judgment to help enhance the destructiveness of new weapons; and 3) where such a physician is ordered to use non-medical criteria (something more than simple triage) to determine whom to treat medically or how to treat them. These contexts certainly ask us to think more carefully than we usually do both about medicine as a profession and about whether military medicine differs from civilian medicine in any fundamental way. Let us begin this rethinking by getting clear about the term “dual loyalty”—a term with at least three distinct senses in part because “loyalty” itself has at least two senses important here.

In one sense, loyalty is simply the moral obligation to give an unusually strong but still reasonable benefit of the doubt when evaluating the conduct of a specific person, organization, theory, or other entity to which one is connected in some morally significant way. We might call this “epistemic loyalty.” In this sense, I show loyalty to my country by assuming, even in the unlikely case, that the government is right when it orders me to perform an act I consider morally objectionable. Military physicians certainly can have dual loyalties in this sense—an epistemic loyalty, say, both to employer (the military) and to profession (medicine). But the epistemic sense of dual loyalty is not our subject. In the three contexts in which the physician’s dual loyalty is said to be a problem, there is no reasonable doubt about the relevant facts (what is ordered) or about what the physician’s profession requires. There is no room for epistemic loyalty.

In another sense, dual loyalties are a certain sort of substantive obligation to specific persons, organizations, or other entities not owed universally, obligations presupposing that epistemic questions have been resolved (or, at least, bracketed). To be loyal in this sense is to have unusual concern for the welfare or projects of the object of one’s loyalty (and to be disposed to act on that concern). In this sense, for example, loyalty to a friend may oblige me to take time from work to help her move when I would not feel obliged to do the same for a stranger.

To have dual loyalties in this sense is simply to have more than one set of the relevant special relationship. Loyalty is divided among several objects. Because divided loyalties are more or less independent of one another, they cannot be our subject today (or, at least, not our primary subject). All of us, including military physicians, seem to have a great number of special relationships of this sort. We do not need to ask which comes first because, in general, our ordering of them does not matter. The obligations do not clash at all or, at least, do not clash in a systematic way. They are not as such “a problem.” Divided loyalty is simply a normal feature of everyday life.

In a third sense of dual loyalties, however, the ordering of loyalties does matter. Loyalties in this third sense have a decided tendency to clash. We might call these “dueling loyalties” (to distinguish them from the more common divided loyalties). Physicians certainly seem to have dual loyalties in this sense, for example, when both a husband and a wife are patients of the same physician. The physician’s obligation of confidentiality to each may, at any time, conflict with the physician’s obligation to provide the best medical services to the other. The physician may, for example, learn while treating one patient that he has a deadly disease the spouse, also a patient, is likely to catch unless precautions are taken. If the patient refuses to inform his spouse, the physician will have to choose between betraying the confidence of one patient and betraying the health of the other. The physician cannot be loyal to both.

It is, I think, this sense of “dual loyalties,” dueling loyalties, which is our subject today. We are asking what a physician is to do when she owes loyalty both to her employer, the military (or government or country), and to her profession. We are asking what the physician is to do when these loyalties seem to clash in a systematic way. My answer to that question is that a military physician should do what her profession requires. The physician, not a mere human being, puts on the uniform. The physician serves the military by carrying on as usual. There is, in effect, no problem of dueling loyalties here, only a misunderstanding of what the military asks of a military physician.

How can that be? Isn’t the duel obvious? For example, both the AMA Code of Ethics and several international declarations forbid physicians, every physician, from aiding in torture in any way. Yet a physician in the U.S. military, like any other military officer, is supposed to obey any lawful order. Must the physician not choose between his obligation as a physician and his obligation as a military officer? Is this not a clear example of dueling loyalties (a necessary consequence to the clash of roles)?

My answer is: No. I am not, please note, saying that, all things considered, the physician need not choose between these two obligations, that is, that the obligations, though clashing prima facie, do not actually clash. The obligations do not, I believe, clash even prima facie. My point now is in part a legal one. Any order to a military physician to ignore a professional obligation is automatically unlawful (both prima facie and actually) and therefore without even prima facie authority. The order is unlawful because it is, as described, an order to ignore a professional obligation. No military officer, however well-intentioned, has the legal authority (much less the moral authority) to order a physician to act contrary to a professional obligation. Professional obligations are, in effect, part of military law. They limit what an officer can lawfully do—and therefore what loyalty to the military requires.

Given how much care has already been devoted to working out various compromise answers to the problem of dual loyalties, this fiercely uncompromising answer may seem
quixotic—especially insofar as it appeals to law rather than morality. Yet, it is, I think, the obvious conclusion to draw from a few facts that are themselves more or less obvious—and a much more enduring conclusion than the appeal to law may suggest. Let me explain.

What I just said depends on what I mean by “military physician.” I am, of course, including surgeons—as has been the custom for the last hundred and fifty years. Indeed, I am including anyone with an MD licensed to practice medicine in the U.S. For purposes of simplicity, I shall ignore osteopaths, nurses, physical therapists, and other professionals sometimes included in the capacious term “health-care professions” who are also part of military medicine. But nothing I say here depends on that simplifying exclusion. All the health-care professions have much the same obligations in contexts associated with the dual-loyalties problem for the much the same reason. My argument depends not on the exact terms I use so much as on the relation of various institutions to one another.

A military physician must be a licensed MD (or OD). That is a formal qualification for the office. One cannot become a military physician simply by demonstrating all the knowledge, skill, and judgment characteristic of a civilian physician. To be even a candidate for military physician, one must (truthfully) claim to meet civilian standards of degree and license. Of course, that was not always true. Only a few centuries ago, the British military trained its own health-care personnel, most notably, military surgeons. And something similar could—in principle—be true of the US military tomorrow. The organization of military medicine is a contingent fact, not a conceptual truth, but a plain fact nonetheless. For now, the military seeks licensed MD’s—even when medical knowledge, skill, and judgment are needed for rough interrogation, weapons development, or the care of enemy wounded. Physicians who have lost their license to practice might serve well in any context of dueling loyalties we have identified. A veterinarian might serve as well in some of those contexts. Animal flesh and behavior are not so different from human. Yet, the military does not go beyond the medical profession in such contexts. Why not?

One reason, no doubt, is that public opinion would not allow it. For example, bringing a veterinarian into an interrogation room to check the health of the person under interrogation would not serve the same purpose as bringing in a (licensed) physician. The physician is brought in to guarantee a certain level of humane treatment, the level of humane treatment a physician should insist on. That is, the point of using physicians rather than someone else with medical knowledge is to assure the public that a certain standard of care is being met. No one but a physician can assure the public of that because the public trusts physicians to maintain those standards but does not trust veterinarians, unlicensed healers, or the like to do. Physicians can only have that trust as long as they are thought to maintain their customary standards. Conduct must constantly refresh that public trust.

This first reason for the military to want physicians involved presupposes a conflict between what the public wants and what the military wants. Such conflicts do exist if “wants” has its occurring sense (what I now happen to want). If, however, we think of “wants” in the sense of “really wants,” that is, what is wanted when one is at one’s rational best, such conflicts are at least rare. So, for example, the military has good reason to want certain of its normal impulses blocked, not simply to preserve good relations with the public but because the military itself (at its rational best) recognizes that certain impulses are too often morally wrong or at least not in the military’s own long-term interest. That is my second reason for rejecting the idea of dueling loyalties—that the military physician is there in part to protect the military from itself—is there, in effect, to disobey certain orders.

I must, I think, say a bit more about this second reason because it seems to be overlooked not only in most discussions of dual loyalties but in most discussions of conflict between professionals and their employer or client. Consider, for example, why the military should be a profession. A professional military is not necessarily a better fighting force than a mercenary band or ad hoc force of civilian volunteers such as a guerrilla army. A professional military is, however, more likely to submit to civilian control, to limit the destruction it inflicts to what is necessary, and otherwise to help preserve the conditions for making peace, maintaining a stable government, and enjoying the freedoms of ordinary civilian government. In the long-run, the public is more likely to support a professional military than a fighting force of mercenaries or guerrillas. And, in the long run, those serving in a professional military are likely to feel better about what they do. They will have avoided many of the excesses to which other forms of military organization are liable.

The military’s reliance on physicians for military medicine seems to have the same sort of justification as our government’s reliance on a professional military—and as the military’s own reliance on other professions—lawyers, auditors, engineers, architects, and so on. Indeed, the military’s reliance on physicians for military medicine seems to have the same justification as does any large civilian organization’s reliance on professions for much of what it does. Professions are a check on ordinary decision-makers. Each profession brings its own special knowledge, skill, and judgment—its own civilian ways of doing certain things to the military. It is those civilian ways of doing things that make it reasonable to recruit them rather than leaving the domain in question to ordinary officers.

One problem with the way the dueling-loyalties problem is usually put is that it assumes that the superior is right about what is in the interests of the military, government, or country, and that the physician who refuses a direct order is choosing moral or professional obligations over the interests of the military, government, or country. But, in fact, that assumption is—as a rule—indefensible. So, for example, the government official who thinks that torture would serve the country but wants to have a physician present must be confused. What point is there to having a physician present if not to act as a physician is supposed to act, that is, refuse to be present—or to require, as a condition of presence—that the torture stop and not resume? The military physician who, exercising ordinary medical judgment in those circumstances, refuses the order of a line officer or government official is not failing to act as a military physician should. Quite the contrary. The physician is plainly doing the job the military assigned, acting as a physician rather than a mere officer. There are no dueling loyalties here.

Endnotes

1. According to AMA Opinion 10.01(4) requires: “The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.” AMA Opinion E-5.05 requires in part: “When a patient threatens to inflict serious physical harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, which may include notification of law enforcement authorities.” I’m assuming that “threat” refers to the sort of thing one can report to a law-enforcement agency with a reasonable expectation of action and that the case as described here, involving merely a failure to take precautions, would not qualify. If my assumption is wrong, I would, of course, have to offer another illustration,
one doubtless less dramatic. As I read these two provisions together, the term “public interest” is sufficiently general to justify either keeping the confidence or revealing it—either of which would benefit one patient at the other’s expense.

2. (Opinion E-2.067) For those medical ethicists who prefer certain eternal “principles” (autonomy, beneficence, non-maleficence, and justice) to the specific statements of the profession itself, I would say a) that I have no objection to the principles as a mnemonic for physicians at the bedside and b) that my only objection to their substitution here is that the brevity that makes them convenient at the bedside forces a generality unhelpful in this context. So, for example, there is an AMA Opinion explicitly settling what is medically appropriate in each case of dual loyalties: E-5.05 for torture (quoted in text above); E-2.078 for weapons research; and E-10.01 and E-10.015 for use of non-medical criteria. Getting from the “principles” to these Opinions is not a simple deduction but a complex interpretation the conclusion of which is about morality in general rather than the medical profession in particular. In effect, the conclusion from eternal principles cannot answer the dual loyalties question insofar as that question is concerned with the relation of military discipline and professional obligation.


4. The only possible exception seems to be psychologists whose main association is the American Psychological Association (APA). Yet, while the APA Code of Ethics does not contain a clear prohibition, a task force asked to resolve the question reported in August 2006 “that any APA member who participates in torture or the cruel, inhuman or degrading treatment of people, or who enables use of information gleaned in health or mental health-care relationships to the detriment of a person’s safety and well-being, stands in violation of our ethics code” (www.apa.org/monitor/feb06/pc.htm December 1, 2007).

5. Here, for example, is the U.S. Army’s statement of requirements for an Officer appointment in the Army Medical Corps (healthcare.gov/army.com/medical, December 4, 2007):

- Meet the prescribed medical and moral standards for appointment as a commissioned Officer
- Be a United States citizen
- Be a graduate of an American Medical Association (AMA) or American Osteopathic Association (AOA) accredited medical school
- Have a current unrestricted license to practice medicine in a state of the United States, District of Columbia, Puerto Rico or a territory of the United States
- Be 21-46 years of age (physicians 47 years of age or older may apply for an age waiver)

6. For more on this way of thinking about the role of professionals in large organizations, see my “The Special Role of Professionals in Business Ethics,” Business and Professional Ethics Journal 7 (Summer 1988): 51, 62.

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Abusive Interrogation of Detainees in the War on Terror: Whether It “Works” Isn’t Really the Issue

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Should any American soldier be so base and infamous as to injure any [prisoner]. . . I do most earnestly enjoin you to bring him to such severe and exemplary punishment as the enormity of the crime may require. Should it extend to death itself, it will not be disproportional to its guilt at such a time and in such a cause... for by such conduct they bring shame, disgrace and ruin to themselves and their country.

- George Washington, charge to the Northern Expeditionary Force, Sept. 14, 1775

Some of the earliest critics of torture, as early as the Middle Ages, were doctors who—though apparently unmoved by its cruelty—became convinced it was ineffective.1 In more recent history, following World War II, physicians have been key players in the banning of torture under international law. Until recently, it had been widely believed that physician ethics provides an important brake on the use of torture during wartime—and perhaps it still does. Physicians are categorically prohibited from participating in torture,2 and they have several unique characteristics that might make them especially likely to see, recognize, and be able to call a halt to abuse.

But in this paper, I will speak only peripherally of the special role of physicians. Instead, I want to address head on the broader consequentialist justifications for abusive interrogations of detainees in the war on terror. Consequentialist justifications undergird all defenses of abusive interrogations, but these justifications relate to medicine only tangentially, by virtue of the fact that medicine is likely to be involved in any routine use of abusive interrogations and therefore the subversion of medical ethics—and consequences therefrom—must be considered in any consequentialist calculation of the results of implementing a policy that allows abusive interrogations. I’ll return to this briefly later, but as the quote I began with suggests, I start my consequentialist analysis with a story not from medicine, but from the history of military ethics.

Washington’s new way. For 227 years, until shortly after September 11, 2001, the U.S. was at the forefront of advancing international standards to promote and protect prisoners’ rights during wartime. General George Washington started us on this path when he granted quarter to all British soldiers, writing, “treat them with humanity, and let them have no reason to complain of our copying the brutal example of the British Army in their treatment of our unfortunate brethren who have fallen into their hands.”3 At the time, offering quarter to captured enemy soldiers was only an option, not an obligation of international law. Prisoners could also be beaten, mistreated, or even summarily executed and the capturing force might not be acting outside social norms for warfare. Washington, taking to heart the American promise of universal human rights... We hold these truths to be self-evident: That all men are created equal; that they are endowed by their Creator with certain unalienable rights... rejected this way of thinking. He is credited with changing the common rules of warfare with regard to the humane treatment of detainees.

He wrote to the British General Thomas Gage to call specific attention to the difference in how Americans were treating their detainees, compared to the British. Captured Americans were considered traitors to Britain, and many died in captivity. For example, all thirty-one of the prisoners taken by the British at Bunker Hill died, or were killed, in captivity. But Washington ordered his soldiers not to follow this example. He then wrote to Gage, “Not only your Officers, and Soldiers have been treated with a Tenderness due to Fellow Citizens, & Brethren; but even those execrable Parricides whose Counsels & Aid have deluged their Country with Blood, have been protected from the Fury of a justly enraged People.”4 In other words, even those Americans who were traitors were being treated kindly by their captors, despite widespread calls of “an eye for an eye.”
Long before the Geneva Conventions, and without even a reciprocity agreement with England, why would Washington provide such care to enemies, including traitors? He enumerated several important reasons—both consequential and deontological or religious in nature. First, of course, was the moral duty to treat others as one would wish to be treated and to live up to ideals that our nation’s founders had made more explicit than ever before, and had publicly claimed underlay the new nation. But in addition to living up to a duty or a promise, Washington also had a list of consequentialist rationales for taking this unusually humane stance. As Scott Horton notes, by treating detainees with humanity and dignity, Washington sought to “shame his British adversaries and demonstrate the moral superiority of the American cause.” As his letter to Gage implies, he also hoped to influence the treatment of his own captured soldiers. He hoped to rally international support for the rebellion and make his own people see themselves as good and righteous (this largely worked and by the end of the war Washington himself was widely admired throughout Europe including, remarkably, in England). He even anticipated that British prisoners—treated with attention and care and surprised that what they had been told of the colonists was wrong (the colonists were fighting a guerilla war and were portrayed as little better than animals)—might come to embrace the American cause. This expectation was fulfilled—nearly all of the surviving prisoners of Trenton, for instance, settled in America and attained citizenship, many after U.S. military service. But most importantly, as Horton wrote, “Washington makes clear that he took this approach because of his experience in the wilderness, and the lessons he learned there: soldiers who mistreated prisoners, who took up cruel practices, were bad and unruly soldiers—the discipline and morale of the entire fighting force was undermined by such conduct.” So, for Washington, treating prisoners well was warranted on moral grounds, but it was demanded on practical and military grounds. David Hackett Fisher summarized this in his Pulitzer prize winning biography of Washington, noting that Washington created “a new way of war that grew into an American tradition. And [he] chose a policy of humanity that aligned the conduct of the war with the values of the Revolution.”

As a result Washington’s new way of war, for more than two hundred years any questions of how to define torture during interrogations had not posed much of a problem for the U.S.—our military proudly set a worldwide example not merely by declining to torture our captives, but by treating them with humanity and dignity—and this strategy has gotten good results, both through raising the moral standing of our nation and by obtaining excellent intelligence, even when compared to regimes such as the Nazis and Soviets, who used abusive interrogations and torture frequently.

This long tradition has been dramatically undermined in the last seven years, ostensibly because Washington’s new way no longer produces the needed results in today’s conflicts. This raises inevitable questions about whether the results of changing how we treat prisoners have been worth the cost.

I intend to argue not only that the results have not been worth the cost, but that, in fact, the consequentialist question—the need for results—is not what is really driving the torture debate. When considered on purely consequentialist grounds, abusing detainees during interrogation is not a defensible policy. Consequentialist defenses of abusive interrogations instead should be seen as a smokescreen, perhaps unintentional, hiding a much deeper set of, largely unrecognized, human motivations that are not easily amenable to philosophical analysis.

Consequentialism and its complications

The irrelevant question. The torture debates have sometimes revolved around an irrelevant question. Namely, do abusive interrogations ever work to educe valuable information?

Opponents of abusive interrogations have sometimes played into this consequentialist trap, when they say that torture “doesn’t work.” That is too simplistic. Of course some people when tortured will produce true and valuable information—so it can “work” in this sense. Admittedly, this limited admission ignores the fact that information educed through abuse is less likely to be reliable, it’s harder for torturers to gauge the truth of the information they collect, it’s less likely to be admissible in court, and so on. But to say that any information educed through torture must be false would be absurd.

Opponents don’t use these exact words, of course, but it’s what the proponents of abusive interrogations hear when an opponent says something like, “abusive interrogations don’t work because they provide unreliable information, cause false confessions, and produce even greater intransigence in some prisoners who might eventually have cooperated if treated humanely.” This statement is not the same as saying “abusive interrogations never work,” but it sounds sufficiently close because the opponent hesitates to weaken his argument by adding a qualifier, like that these tactics “generally” or “usually” don’t work. But this reticence to accept that abusive interrogations might, occasionally, result in good information is heard by proponents as the absurd claim that all information obtained through abusive interrogations is useless. Hearing this, proponents must feel a surge of glee, since they can refute this claim with a single anecdote of useful information resulting from an abusive interrogation. And they do have such anecdotes.

The Bush administration claims that abusive interrogation of Abu Zubaydah caused him to give up information leading to the capture of Omar al-Faruq, Rahim al-Nashiri, Ramzi bin al-Shibh, and, and eventually, Khalid Sheikh Mohammed (KSM). KSM in turn, after waterboarding, reportedly gave information useful in thwarting a plot to blow up skyscrapers in the U.S., and he provided names of a number of other terrorists. If one claims that abusive interrogations never work, these are some of the cases proponents will bring up.

But one shouldn’t set policy by anecdote, in part because there are anecdotes on both sides. Opponents of abusive interrogations have their own favorite anecdotes. For example, Ibn Al-Shaykhal-Libi, interrogated in Egypt under rendition, coughed up bogus evidence about Iraq’s WMD program and links between Saddam and Al Qaeda, which Colin Powell then used to justify invading Iraq to the U.N. and the world, much to his later shame.

Rather than arguing an irrelevant question that can be answered by a single anecdote, we should be considering a question that is relevant in the policy arena. After all, that’s what is at issue: not, “Might abusive interrogation ever be justifiable in some rare circumstance?” but “What should be our policy regarding abusive interrogations under current circumstances?” Likewise, the issue is not whether abusive interrogations can ever produce useful information, it is whether we should adopt a policy that allows abusive interrogations. “Great cases, like hard cases, make bad law,” said Oliver Wendell Holmes. Just because abusive interrogation sometimes produce useful information, and might even be justifiable under ticking bomb scenarios, doesn’t mean it’s a good idea to adopt them as policy. I think driving ninety on the highway can sometimes be morally justified, but that doesn’t mean I think it should be legal. Adopting something as a policy has a lot of practical and moral implications, far beyond whether it might “work” in one specific situation or another.

By the way, as a side note on the ticking bomb scenario, former FBI agent and 9/11 whistleblower Colleen Rowley...
have ultimately been released without charges—in fact, in of the prisoners abused at Abu Ghraib turned out not to be these interrogations. Military reports indicate that 70-90 percent is proven to be guilty—not least because waiting for such an only to the guilty. It is impossible to ensure that everyone abused pressure, systems of abusive interrogation

In the first instance, some captives will not hold a great deal of useful information, with a subsequently greater reduction in attacks, than would be seen if only non-abusive interrogation methods were allowed. Whether this is true will depend on three key factors. First, one must interrogate individuals who hold useful information. Second, these individuals must give up more and better information in the face of abusive interrogation than they would otherwise. And third, it will depend on the consequences of establishing the systems and processes needed to conduct abusive interrogations in a routine way. Let's briefly examine each issue in turn.

Interrogate those with useful information
In the first instance, some captives will not hold a great deal of useful information. Well-organized forces will sequester useful information to make captives less valuable. As a result many captives, though clearly enemies, might provide very little useful information to make captives less valuable. As a result

For example, how does adopting a policy that allows abusive interrogations affect the number of people interesting in attacking us, or their level of motivation and willingness to attack civilian targets? How does it affect our relations with our allies and their willingness to share intelligence with us, or to turn over detainees to us for interrogation? How does it affect our public image, our self-image as a nation, and general support for our cause? As Washington did, we must even consider how mistreatment of detainees will affect military morale, troop cohesion, and effectiveness.

The hypothesis to be tested, then, is whether adopting a policy allowing abusive interrogation techniques produces more useful information, with a subsequently greater reduction in attacks, than would be seen if only non-abusive interrogation methods were allowed. Whether this is true will depend on three key factors. First, one must interrogate individuals who hold useful information. Second, these individuals must give up more and better information in the face of abusive interrogation than they would otherwise. And third, it will depend on the consequences of establishing the systems and processes needed to conduct abusive interrogations in a routine way. Let’s briefly examine each issue in turn.

Interrogate those with useful information

In the first instance, some captives will not hold a great deal of useful information. Well-organized forces will sequester useful information to make captives less valuable. As a result

More importantly, given their nature and use under time pressure, systems of abusive interrogation cannot be confined only to the guilty. It is impossible to ensure that everyone abused is proven to be guilty—not least because waiting for such an adjudication would ruin the ostensibly time-sensitive nature of these interrogations. Military reports indicate that 70-90 percent of the prisoners abused at Abu Ghraib turned out not to be terror suspects. More than half the detainees at Guantanamo have ultimately been released without charges—in fact, in more than six years, there hasn’t been a single completed trial of a Guantanamo detainee (David Hicks, the Australian held there, pled guilty and served nine months in Australia). Recent estimates are that only 8 percent of Guantanamo detainees are even suspected of being members of Al Qaeda. But whatever the specific numbers at the moment, the point is that to do a consequentialist analysis one must calculate the harms of abusing some number of innocents, since these will offset any benefits obtained through abusive interrogations.

Two harms related to abusive interrogations of the innocent deserve special mention. First, it is possible that some innocent victims of abuse, or those who care about them, will subsequently become our enemies as a result of their suffering wrongly at our hands. A Department of Defense analysis supports this hypothesis, noting that America is losing the battle for the “hearts and minds” of the Arab world in part as a result of our use of abusive interrogation techniques.14 This loss must be incorporated into any realistic consequential analysis.

Second, innocent victims of abuse may not have the commitment or training to withstand abusive interrogations and may be even more likely to provide false information to avoid further abuse, which raises questions about the reliability of information obtained through abusive interrogations. This leads directly to our next consideration.

Obtain more and better information
With regard to providing useful information, many of those most highly trained in interrogation disdain the use of abusive techniques as unreliable, at best, and highly counter-productive at worst. Why this is true is of special interest to a consequentialist analysis.

The fundamental hypothesis that underlies the use of abusive techniques during interrogations is the following: under sufficiently painful conditions, anyone can be “broken.” But this may not be true. Allow me a personal example that I've written about before. My grandmother died a painful death due to pancreatic cancer, but late in her illness she refused pain medication, partly in the belief that her suffering had been set for her by God. Her religious belief helped her turn unbearable pain into a rite of passage. Given this, one must wonder why a devoutly religious potential suicide bomber would “break,” rather than die, under torture. After all, there are many ways to interpret pain. It can be experienced as a religious sacrifice, a trial, or as an heroic rite of passage. And these interpretations may even reflect reality. In Iran during the 1960s and 70s, it was endurance of torture, more than direct service to the cause, that marked those who eventually rose as political leaders.17

The historical record confirms that those who believe in their cause often do not “crack” under torture. According to J.M. Arrigo, in an examination of 625 instances of torture in France between 1500-1750, between 67-95 percent of victims never confessed, “on the rack, under repeated drowning, crushing of joints, and the like.”18 She also writes that the German Gestapo had “nothing like precise knowledge of the resistance movement” despite that “all forms of torture were used without hesitation.” And during the Vietnam War, only about 5 percent of the 400 airmen captured eventually issued anti-American propaganda statements, including under torture. Reportedly, many made things up, such as Sen. John McCain who has said he provided his captors with the names of the Green Bay Packers’ front line.19

Most recently, experience has again suggested mixed results, at best, using humiliation and abuse. While humiliation has been said to “break down” detainees, it has also been mentioned as a reason for detainees to hold back. According to one CIA operative, KSM was water-boarded with “a red-headed female supervisor” in the room. This “was humiliating to him. So he held out,” this officer told ABC News, apparently without irony.20

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The consequences of establishing a system for abusive interrogations

Of course, non-systematic (unmonitored, unregulated) use of abusive techniques is possible, but the risks of this are assumed to be very high and no public proposals for the *ad hoc* use of abusive techniques have been made. Instead, great pains have been taken to assure the public (and presumably the interrogators involved) that abusive interrogations have only taken place under carefully considered circumstances, with high-level approvals that would preclude legal questions. In short, we have been assured that abusive interrogations are not the result of rogue agents, they are the result of a specific (and ostensibly lawful) decision to allow them—hence a series of additional consequentialist considerations come into play, related to the systems and processes that need to be in place to carry out a policy allowing abusive interrogations.

In prior work I have noted that a policy allowing abusive interrogation techniques requires substantial alterations to our traditional military, medical, and social systems. While the use of these techniques is generally proposed only for so-called “ticking bomb” situations, which presumably are pretty rare, in reality any system to support the use of these techniques will entail more regular use—as we have seen in the current war. Presumably, the effective use of abusive techniques, just like non-abusive interrogation, requires skill, patience, constant innovation, and practice. Because interrogators must hone their skills, a reliable source of new potential informants is required, raising the risk that innocents will be interrogated. Since information to prevent attacks is the goal, not the death of the subject, careful medical monitoring is required, which requires the subversion of medical ethical norms. Moreover, the enemy will respond to known techniques, so innovation in methods must occur, which will demand medical and psychological expertise in the form of research on new methods. Apart from medical ethics, post World War II traditions of military ethics and international law must also be overcome because they forbid any inhumane treatment of captives. If secrecy about the program is desired, then the dual problems of disposal of victims and perpetrators also arise. And if the program is not secret, then it should be expected that our soldiers will be treated likewise, and worse, when they are captured. It should also be expected that our public image will suffer and, as noted earlier, additional enemies will be generated while those who might previously have been mere critics will turn into enemies and those who previously would have been enemies will feel justified in using increasingly heinous methods against us. There are hypothesized short and long term implications for the abuser, which might need to be addressed. And many other issues. In short, an elaborate system to support the use of abusive interrogation techniques is required, each facet of which has its own set of short and long term consequences—from the after-care of interrogators to the challenges of limiting the use of abusive techniques to allowable circumstances and to rebuilding civil standards following the conflict.

What drives defenders of abusive interrogations? When all of the short and long term consequences of establishing a program of abusive interrogations are taken together, the weight of the evidence is clear: in any reasonable consequentialist analysis, as a policy matter, abusive interrogations are unreliable and counterproductive in many important ways, and therefore should not be allowed. When the Department of Defense itself has investigated this question, that has been their conclusion: “The use of force is a poor technique, as it yields unreliable results, may damage subsequent collection efforts, and can induce the source to say whatever he thinks the interrogator wants to hear.” When World War II interrogators have spoken out, it has been to denounce abusive interrogations as unreliable and counterproductive—and they know something about mounting a war against a formidable foe that used abusive interrogations while we strove to maintain humanitarian standards. A long string of interrogators have said, in essence, we don’t need or want the authority to abuse detainees…we’ll do better and prevent more terrorist attacks without it. The advisory board for the Office of the Director of National Intelligence, the Intelligence Science Board, studied the issues recently and one member summarized the findings by writing, “the scientific community has never established that coercive interrogation methods are an effective means of obtaining reliable intelligence information.”

So, given this rather widespread agreement among experts that consequentialist arguments do not support abusive interrogations, and given that defenders always claim the need to use these techniques because they are effective when other methods aren’t, what could be driving these persistent defenders? There are at least five possibilities.

First, perhaps some defenders are simply unaware of the data and the weight of expert opinion. This is possible, and probably common among the general public who haven’t examined the issue in any depth. Indeed, in at least one instance, a group of modestly informed members of the public showed substantial changes in their views following an impartial educational session. But I have corresponded with several who admit that most experts publicly disagree with their position, yet they cling to the belief that abusive interrogation are sometimes useful (if rarely) and therefore should be allowed in policy. Despite what seems clear to most others, they disagree. Further explanations are needed.

Second, some defenders might be aware of the public stance of experts and the publicly available data lined up against them, but they believe there are secret data that would support their position and that in private, more experts would support them. Such defenders perhaps trust that the President is in possession of information that justifies abusive interrogations, even at the cost of our international standing, at risk to our soldiers and human rights around the world, and despite the many harms this policy has already caused. They believe there must be secret evidence that these bad consequences have been worth it. Such trust is unwarranted, in my opinion, but strong faith is not dependent on facts and therefore is impossible to fully refute. Nevertheless, I suspect that relatively few defenders hold such credulous, faith-based policy beliefs.

Third, and a more likely possibility, is that defenders have been told repeatedly that abusive interrogations work, though TV shows and the claims of the Bush administration, and once one has heard something as fact, it is extremely hard to later disregard it—even when one is told the prior information was wrong. Lawyers are well aware of this tendency—unreliable evidence cannot be admitted and, if mentioned in court, jurors are told to ignore it. But they can’t and the lawyers know it. Hence, they will bring up inadmissible evidence, only to have the judge rule it as such…but by the time the ruling has occurred, it is too late. The jurors (and judge) are now aware of the evidence and they will weigh it during their deliberations.

In this regard, most of us had never given the issue of torture much thought prior to 9/11. Persons raised on the pop-culture “lessons” of *NYPD Blue*, *Dirty Harry*, and *24*, and the early public statements of the Vice President, may have “learned” early on that roughing up detainees is the best, or even the only, way to extract information from terrorists. The dark side must be met with dark force and “the gloves” have to come off, etc. Now, despite all evidence to the contrary, this early belief is nearly impossible to shake.
Even for myself, while I oppose any policy allowing abusive interrogations, I have to admit that my gut tells me that it should work. It just seems so plausible that if someone refuses to talk, you can force them to do so by, well, force. I know this gut feeling is wrong...but that doesn't mean I can turn it off.

Fourth, there are also a number of psychological studies that show people tend to seek out information that reinforces their pre-existing beliefs, and to ignore information that refutes them.27 This is called a “confirmation bias,” or “an agents’ tendency to misinterpret ambiguous evidence as confirming his current belief.”28 As Nicholas Kristof writes, “This tendency afflicts both liberals and conservatives, but a raft of studies shows that it is a particular problem with conservatives.” He notes, among other examples, a 2004 study showing that conservative blogs link to each other “more frequently and in a denser pattern” than liberal blogs.29

Finally, there are a number of ancillary emotions that might be driving our revulsion to abuse when detainees refuse to talk. One might reasonably hypothesize that we are, collectively, disempowered by the notion that a detainee might know something—some fact that could lead to lives being saved—and this builds on our underlying anger, fear, and hatred toward terrorists. So we seek information, but we also seek vengeance and a way to regain control over the situation. Reverting to violence is a release for all of these emotions and a way to reclaim power and a sense of control, limited though this control may be.

For those who study torture, the notion that it derives more from the need to control and dominate the victim than any desire for information is not a surprise. Much of torture is not even interrogational on the surface—it’s to obtain confessions, for propaganda, to terrorize other potential victims, and so on. But to American defenders of abusive interrogations, the notion that we might abuse prisoners for non-interrogational purposes is fundamentally unacceptable. We are different. Others might use torture for intimidation and to wrest confessions—even false ones—but we use it only to obtain verifiable information. To prove that we are different, defenders note that we limit allowable abuses—we might waterboard, or use stress positions, or sleep deprivation, but we don’t wrench out fingernails. This presumably proves that we don’t torture because we are evil, we do it only when necessary to gather information that might prevent even greater harms.

For such defenders, it is very important to draw distinctions—and they are easy enough to see—between how Americans have conducted abusive interrogations and the severed fingers of Americans and other captives in Iraq.30 Beheadings by fundamentalists, such defenders might argue, are clearly not the same as waterboarding, they are immeasurably worse.

I see no problem in accepting these distinctions—they are very different and beheadings are worse. But these distinctions do not logically help to defend abusive interrogations. The existence of even greater evil does not justify an evil act unless, perhaps, the lesser evil can be used to prevent the greater evil. But we have seen that the latter is not true, hence perpetrating a relatively smaller evil during interrogation in response to a grave evil on the other side is merely punishment, or retribution...it’s not an interrogation. In other words, if a detainee is responsible for a beheading, this might support a moral argument to abuse that prisoner out of revenge, but not as an interrogation strategy. And, except as group punishment, it certainly wouldn’t support an argument to abuse other prisoners during their interrogations, including some who may be innocent.

In summary, defenders of abusive interrogations continue to assert, against the weight of the evidence, that it “works.” Some might be misinformed, others might be convinced on the basis of pop-culture “lessons” which they find difficult to unlearn, still others probably just trust the Bush administration and distrust the interrogation experts who have spoken out on the issue. But I suspect that what underlies many persistent beliefs in the effectiveness of torture are more fundamental motivations, emotions unrelated to interrogation per se and the desire for control. These motivations will be very difficult to change through a dispassionate analysis of facts and, sad to say, discussion of moral theories will probably be even less persuasive.

Endnotes

Triage Priorities and Military Physicians\textsuperscript{1,2}

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1. Introduction

When resources are limited, physicians are faced with the difficult decision of having to choose to prioritize the care of some patients over others. Triage is the principled manner by which physicians make these decisions. Civilian physicians in emergency room settings must triage patients when necessary, especially when faced with an acute influx of individuals needing care. Unlike their civilian counterparts, military physicians appear to face unique difficulties when standard triage methods conflict with current military objectives. As a result, it seems that military physicians are forced to choose between two competing loyalties—the goals of the chain of command and the well being of their patients.

In this paper, I will first outline briefly the general triage practices that are common in both civilian and military contexts. The triage procedures which are of current interest, of course, are not these general practices that both civilian and military triage procedures share; rather, of primary interest are those procedures which military commanders mandate during severe battle conditions. In these extreme situations, military protocol mandates the reversal of normal triage procedures, with the least wounded being treated first so that they can rapidly return to the battlefield. It is during these times that tension between two competing loyalties seems to occur.

After discussing the battle conditions under which these triage procedures are recommended, I will argue on the grounds that military commanders possess fiduciary obligations that these triage procedures during extreme battle conditions are not only morally permissible but, moreover, that in certain cases they are required so that military commanders may fulfill their obligations. Furthermore, I will contend that, given seemingly subtle differences between the civilian-patient-physician relationship and the relationship into which military physicians enter with those needing medical attention, there are instances in which it is appropriate for the military physician to act in accordance with the chain of command’s desires and not enter into this relationship. We should perhaps view the military physician in these circumstances as acting in a different role than the civilian physician, i.e., acting to maintain the strength of the fighting force. In other words, the relationship into which military physicians and the wounded that are in need of treatment enter is dissimilar enough to warrant the difference in care priorities during extreme battle conditions.

2. Triage as a Principled Decision Procedure

The term ‘triage’ itself has no ethical implications.\textsuperscript{3} In its early uses it simply referred to the sorting or culling of goods into different categories according to quality, e.g., coffee and wool.\textsuperscript{4} The early uses of the term in agricultural contexts provide a background for the use of “triage” in medical contexts today—patients are sorted, not according to quality, but according to their medical condition or according to some other priority. This is the only aspect that medical triage appears to share with the term “triage” in its early use. For example, triage of a product such as wool involves none of the outside influences that seem to impact medical triage, e.g., shortage of supplies or physicians. Additionally, concerns in medical triage over the impartiality of the “sorter” are not shared with triage in its agricultural use. With medical triage, sorting is just the first step of the process; ethical dilemmas come after the sorting process is complete when decisions about whom to treat first must be made.

Before examining the similarities between military and civilian triage procedures, it would be beneficial to note first that most triage contexts do not involve a dire shortage of resources.\textsuperscript{5} Most civilian hospitals in the U.S. and other established countries staff enough physicians to handle basic care needs and, as a result, triage is chiefly employed to prioritize the care of some patients over others in a manner which responsibly allocates resources. These triage methods have an implicit egalitarian goal, namely, attending first to the care of the individuals most in need of medical attention.\textsuperscript{6} In other words, it would be impossible for a hospital to have a one-to-one patient-physician ratio, so triage priorities are set to regulate the distribution of resources. Under these care levels, those most in need of medical attention are assisted first.\textsuperscript{7} The same follows for the majority of military treatment facilities, whether on the battlefield or not.

Military medicine and its use of triage, at least the type practiced outside of extreme battle conditions, shares much in common with this sort of civilian triage. Most triage procedures

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in both contexts prioritize the well being of individual patients, without concern for some larger overall goal. When there are sufficient medical resources or even a slight scarcity, patients with the most severe injuries or illnesses are treated first, and those with less severe conditions wait until medical personnel are able to treat them. Most have experienced this triage procedure when visiting an emergency room; if an illness is not considered "severe" there may be a wait of several hours before a doctor administers treatment. This system of prioritizing patient well being when the level of resources is sufficient (or at least not dire) seems so intuitively appropriate in these contexts that I will not argue for it. The difficulty in these procedures, however, lies in deciding what exactly counts as "most severe." At first glance, this decision appears to be impacted by a variety of elements.

There are numerous competing factors that appear to surround general triage practices. Here are just a few: the staffing level of physicians and nurses, the availability of medical supplies and medicine, and the number of beds available in a given treatment site. These will all vary from facility to facility, but the one aspect of general triage decision making which ought to remain constant whether resources are sufficient or slightly scarce is that individual patient well being should be the highest priority. Therefore, the decision over what is considered "most severe" will often involve a detailed assessment when multiple patients require care. This medical decision is mapped out well for practitioners in various triage guidebooks. When there is no dire shortage of resources there will be a level of priority assigned by the individual assessing the incoming patients, but there will most likely not be a significant risk that lives will be lost due to patients waiting for treatment.

In general, there are three primary categories in both military and civilian triage procedures into which patients are placed once they have been evaluated: those who will live without medical care and require only minor treatment; those who will die whether or not they receive medical care; and those who will die if they do not receive medical care. These categories, since only dependent on medical diagnosis, are not the direct cause of ethical dilemmas. There may be debate, of course, at the borders of each category about which medical conditions merit placement into one or the other. For example, say patient A has a condition that is viewed as life-threatening and patient B has a condition viewed as close to life-threatening (how close is close?). The individual assessing the two patients assigns a probability of survival and then treats each of the patients accordingly, with the person more in need of care being treated first. Perhaps A has a 20-25 percent chance of survival and B has a 30-35 percent chance of survival.

These issues surrounding which patient is placed into which group are, however, medical and diagnostic dilemmas and not ethical ones. Ethical dilemmas arise, rather, in how each of these categories is given priority in terms of treatment. In general practice, military and civilian procedures give priority to the last group of patients, i.e., those who will die if they do not receive treatment. Ethical dilemmas seem to arise when, during battle conditions that commanders believe warrant it, military physicians must reverse triage procedures and give priority to the first group, i.e., patients who will live without medical care and who only require minor treatment. In the next section, I will discuss military guidelines relating to three levels of battle conditions and the triage procedure used for each.

3. Military Triage and Battle Conditions
As mentioned above, many military triage practices model the egalitarian triage practices used in most civilian contexts. If a soldier requires medical treatment while on a tour of duty or while stationed at a base, his or her individual medical needs will be the primary factor taken into account. Sometimes, however, medical resources are not sufficient to prevent the death of those in need of care, so decisions must be made about who will be treated first (and likely live) and who will be denied care or have care postponed (and likely die). These are difficult decisions that no one would ever desire to make, but they must be made when resources are insufficient (in these cases, it is not often whether or not some will die, but rather how many and which ones). Before discussing the ethical dilemmas surrounding military triage, it is first important to consider various levels of battle conditions and the triage procedures which are recommended during each. Here I will highlight the triage procedures the U.S. military employs, but much of what is said could also apply to countries in NATO and to other developed nations.

Rather than relying on a single principle to guide the decision of which group of wounded soldiers should receive care first, some distinguish battle conditions and the objectives of the chain of command during these battle conditions as relevant. The appeal of a “one-size-fits-all” triage prioritization system seems fairly obvious. Having a triage procedure that operates on one primary principle for deciding whom resources should be devoted to first would seem to simplify matters. The opposite, in fact, appears to be the case.

One such example is Gerald Winslow’s study on triage where he argues against triage guided by utilitarian principles and seeks to develop an overall egalitarian principle to serve as the foundation for triage procedures. Throughout the book, Winslow critiques the use of utilitarian principles, but in the end allows for at least some aspects outside of the medical needs of individual patients to enter into triage prioritizing. For example, Winslow argues that those operating under a Rawlsian view would most likely favor egalitarian principles, but that they would also allow for the possibility that those with special skills (e.g., doctors) might be treated first in mass-casualty situations. This would clearly violate the egalitarian principles for which Winslow argues. Here Winslow is careful to not label such an exception to his egalitarian views as utilitarian; instead, he claims that this is a way of coming “...as close as possible to equal treatment in the long run” and not any sort of maximizing principle.

Whatever the case may be, Winslow’s concession to the admissibility (and perhaps necessity) of a principle other than an overall egalitarian principle muddies the water a great deal. Since in a given situation one must evaluate whether it is appropriate to act contrary to what appears to be an egalitarian need, it seems that this addition risks collapse into utilitarianism, or at least into a general triage procedure that mostly follows egalitarian values but allows utility to be considered in special circumstances. Whether or not this is the case, it appears that rather than attempting to find a “one-size-fits-all” triage model for use by military physicians, it would be better to explicitly separate cases in which egalitarian models are to be preferred from cases in which utilitarian models or other models might be appropriate.

In one such model that separates cases where utilitarian concerns should drive the priority assigned to each group after the initial triage sorting, Thomas Beam describes three battle conditions which current military guidelines have established as relevant to triage procedures; each of these uses a different triage model. These levels of battle conditions are as follows: non-austere battle conditions, austere battle conditions, and extreme battle conditions. The first battle condition, the non-austere, is the battle condition most common for the U.S. military, and in it patients are treated according to egalitarian triage priorities. In this setting, as described above, there is no
dire shortage of resources and physicians are able to consider individual patients’ welfare above all other external or overall concerns.

In the second type of battle conditions, the austere battle conditions, Beam argues that physicians should act to save as many soldiers as possible. This triage model, Beam claims, is utilitarian in emphasis, and the primary good sought is saving as many lives as possible. As a result, those who will be most easily treated receive priority (e.g., those with only superficial or minor wounds), and the care of those requiring more attention is delayed. This is analogous to the approach taken in many civilian mass-casualty scenarios. Here Beam argues the good achieved by using this triage method seems clear: maximizing the number of total lives that are saved. Whether one should appeal to utilitarian concerns to justify such a triage prioritization in a military context will be discussed in more detail in §4.

One ambiguity that might arise from this second level of battle conditions and the triage procedure corresponding to it is the question about what exactly counts as a “life saved.” Is the quantity of life the primary concern? In other words, should only the number of soldiers who live after treatment count as the good achieved by changing which group receives treatment first? Or, should physicians work to also improve the quality of the lives those they are treating will lead? This would involve a goal beyond just having a high quantity of soldiers who live after treatment. For example, imagine an instance where a soldier has been in contact with an explosive mine and needs to have her leg amputated. Should a physician work primarily to save her life, e.g., perhaps immediately amputating the leg and treating the life-threatening aspect of her injuries (and then move on to treating others)? Or, should a concern for the quality of the soldier’s life also be influential in making a decision?

Certain procedures such as amputation will require less time than others, so should more time be devoted to exploring options other than amputation before performing the procedure? Adding quality of life (i.e., future quality of life after treatment) as a consideration might mean attending for a longer time to the treatment process so that the soldier will be more likely to walk rather than have to use a wheelchair. In some instances, attending to the quality of life might run contrary to the quantity of lives preserved. Perhaps beyond considering these individually, the good achieved by changing the priority of which triage group to treat first in the mass-casualty/austere conditions model might be some combination of both the quantity of lives saved and quality of the life to be enjoyed by those saved. This triage procedure will not be the primary focus in this paper, but the appeal to principles of utility used to justify it will be discussed in §4.

The third level of battle conditions, what Beam calls extreme conditions, prioritizes the care of those who require only minor medical treatment, i.e., those who will live without medical care and require only minor treatment, over all others needing treatment. It is this level of military triage that is used most infrequently by the U.S. military. Beam recommends applying a triage model that is utilitarian in intent during these battle conditions, but it has a different good in view, namely, preserving the strength of the fighting force. Rather than focusing on the number of lives saved (or, perhaps, on the quality of life as well), this triage procedure seeks to maximize the number of soldiers treated so that those soldiers can return to the battlefield as soon as possible. There are a number of conditions that must be met before a commander will decide that battle conditions are extreme and that these triage procedures should be used.

A condition for initiating this sort of triage reversal is that those who are most easily able to return to battle will not only live after treatment (a good) but primarily that their return to battle (as a result of the treatment) will work to the advantage of current military objectives and make a significant difference in winning the present battle. For example, imagine a battalion (approximately four hundred soldiers) facing an enemy force of about 550 soldiers and that each force is equipped with comparable weaponry. After several hours of fighting, fifty soldiers in the battalion are wounded. Most of these wounds are life-threatening; in fact, imagine that forty out of the fifty are severely wounded and that the other ten have only superficial wounds. Although it depends on the number of physicians traveling with the battalion, in most cases this would qualify as neither an extreme nor an austere battle condition. If you imagine the same scenario, but that instead of fifty being wounded there are three hundred wounded and of these only fifteen have life-threatening injuries (perhaps some fit into the category of those who will die whether or not they receive treatment). Also, assume that the battalion will be overrun in the field if the physicians are unable to quickly treat those with superficial injuries. This latter situation is one which it seems would be classified as an extreme battle condition and, all else being equal, would warrant a reversal of triage prioritization under current military recommendations.

This triage prioritization reversal during extreme battle conditions creates an ethical dilemma because it is not only the group of those who will die regardless of whether they receive care who are placed aside so that those only superficially wounded can receive care first, but it is also the group of those who will die if they do not receive medical care that is no longer given priority. In most battle conditions, this latter group receives priority for medical treatment, but during extreme battle conditions this group no longer receives priority of care, and as a result many of these soldiers who were severely wounded in battle may die. Were it not for such triage prioritization reversal, these soldiers would most likely live. This dilemma will be discussed in more detail in §4.

An example to which many refer in discussions of military triage concerns an actual application of this triage model during World War II. In this example, James Howie, the former director of the Public Health Laboratory Service in Britain, discusses a time during World War II in North Africa when British military officials were faced with a difficult decision regarding triage prioritization. During the spring of 1943, while British troops in North Africa were preparing to invade Italy and Sicily, many in the ranks contracted gonorrhea after visiting local prostitutes. The debate was whether penicillin should be used to treat these soldiers who had contracted gonorrhea rather than to treat soldiers suffering from battle wounds—the goal being to return to health as many soldiers as possible so that they could resume training for the imminent invasion. Several factors heightened the tension: at this time penicillin research was still in its early stages and researchers (e.g., Cairns and Florey) were focused on learning how to treat wound victims with the medicine; the availability of penicillin was scarce and any use of the medicine was intensely scrutinized and required approval from the director of pathology at the War Office; and, most obviously, the potential political ramifications of distributing the medicine to soldiers who had acquired gonorrhea before administering it to soldiers who had been wounded while fighting for their country.

Additionally, it was well known to researchers at the time that penicillin was highly effective in the treatment of gonorrhea, but it was uncertain how effective it would be in treating many of the wounds incurred during a battle. Howie recounts that during this debate he was working as the deputy...
wounded are cared for first. The following quotation outlines the conditions triage model should be discussed, and it will be the triage models that countries in NATO recommend directly to international medical care guidelines, extreme battle conditions. This principle from the Geneva Conventions aims to outline priority in the order of treatment to be administered. “Only urgent medical reasons will authorize triage. Additionally, the Geneva Conventions (I and II) are fairly explicit on this view often envision physicians as being required to consider any principle other than medical need. Those supporting this view would be broadly applicable to other areas of military bioethics. For example, whether a military physician, if asked by a commanding officer, should participate in actions such as torture or coercion by medical means would be another area to which, mutatis mutandis, this argument might apply. Furthermore, medical codes and ethicists alike are mostly opposed to any system of triage prioritization that appeals to any principle other than medical need. Those supporting this view often envision physicians as being required to consider only their patients’ medical needs when administering care. Additionally, the Geneva Conventions (I and II) are fairly explicit on this issue: “Only urgent medical reasons will authorize triage in the order of treatment to be administered.” Although this principle from the Geneva Conventions aims to outline international medical care guidelines, extreme battle conditions. This type of triage prioritization reversal employed during extreme battle conditions will dominate the remaining discussion in this paper.

At this stage, triage procedures in general as well as the current triage priorities that the U.S. military actually uses in various battle conditions have been discussed. There has not been, however, any reflection on whether or not these procedures are the ones that ought to be used. This is, of course, the primary aspect that makes triage and the priorities assigned after the initial sorting interesting for ethicists. These are the procedures that military officials and field manuals recommend adopting; whether these are morally permissible, however, is a different question altogether. This will be discussed in the next section.

4. Utility, Obligations, and Triage Priorities

Since the extreme conditions triage model has been rarely employed by the U.S. Military and since the conditions under which it should be used are limited, one might question whether it is a worthwhile area for ethics to investigate. Although the present analysis will be refined in scope (focusing primarily on those wounded from fighting and needing medical care), the argument I will make for a military commander’s obligations will be broadly applicable to other areas of military bioethics. For example, whether a military physician, if asked by a commanding officer, should participate in actions such as torture or coercion by medical means would be another area to which, mutatis mutandis, this argument might apply. Furthermore, medical codes and ethicists alike are mostly opposed to any system of triage prioritization that appeals to any principle other than medical need. Those supporting this view often envision physicians as being required to consider only their patients’ medical needs when administering care. Additionally, the Geneva Conventions (I and II) are fairly explicit on this issue: “Only urgent medical reasons will authorize triage in the order of treatment to be administered.” Although this principle from the Geneva Conventions aims to outline international medical care guidelines, extreme battle conditions. This type of triage prioritization reversal employed during extreme battle conditions will dominate the remaining discussion in this paper.

Not only do the U.S. and other NATO countries reverse triage procedures during certain battle conditions to salvage as many soldiers as possible and return them to battle, but there are also priorities about which individuals among the wounded are cared for first. The following quotation outlines these priorities and the opinion of some about them:

[T]raditionally U.S. combat casualty care has been directed toward U.S. casualties first, allies second, civilians third, and enemy fourth. This is a time for reevaluation of ethical and moral principles and a reaffirmation that if the most seriously injured casualty is, in fact, an enemy soldier, he goes first. In the section that follows, I will argue that the current U.S. (and other NATO countries) military triage guidelines that involve breaking Geneva Convention protocols with respect to treatment priorities and triage procedure reversal are both warranted and morally required on the grounds that military commanders have fiduciary obligations to win battles. In §5, I will argue that military physicians and the individuals whom they treat do not, in certain circumstances, enter into a patient-physician relationship, and that this difference warrants triage reversal should the chain of command require it.

Before arguing for these fiduciary obligations that military commanders possess, it will first be useful to address the ethical theory to which Beam appeals in his discussion of triage priorities and battle conditions, namely, utilitarianism. Beam mentions that the triage models employed during austere battle conditions as well those employed during extreme conditions would be appropriate under a utilitarian analysis. As he states regarding the latter, “The defense of the decision to treat the minimally wounded could be made on the basis of a utilitarian approach.” At first glance, it may seem intuitively appropriate to appeal to utilitarian calculi to justify such decisions regarding triage. After all, whether or not a battle will be won may hinge on whether or not triage priorities are adequate to the needs of the chain of command. And surely, winning a battle is better than losing a battle, right?

Attempting to account for these triage prioritization decisions under a utilitarian model, however, would be a difficult task and, even if one were able to do so, the application of such triage prioritization reversal would only be acceptable for a utilitarian in a few, limited circumstances. Since for a utilitarian the “good” choice is the one which will, in the end, result in the most total aggregate happiness, to justify a triage prioritization reversal a pure utilitarian account would not only have to account for the happiness of the combatants but also for everyone who might be affected by the triage reversal. As a result, a utilitarian would be able to reverse triage only if he were sure (or at least believed it highly probable) that the decision to do so would likely effect more good than not.

Furthermore, a utilitarian view would not only have to account for the total aggregate happiness resulting from a particular decision to reverse triage but, moreover, for the happiness resulting from winning the battle at hand and, on a larger scale, for the happiness resulting from winning the war (if that were the goal). Additionally, he would have to consider the happiness of enemy belligerents and their families and all those who would be affected by the result of the battle and, ultimately, the war. Furthermore, for a utilitarian to even go to war in the first place there would have to be so great an evil that would be avoided by fighting a war that it seems doubtful that, given the overwhelming likelihood of a large amount of resulting unhappiness, a war would ever be fought. In a utilitarian framework, in fact, it is sometimes better to lose a battle if it will create more total aggregate happiness than winning. For these reasons, it seems that a utilitarian approach would not be best to defend the extreme battle conditions triage model unless one simply assumed that the army in question only fought wars that were likely to create more total aggregate happiness. Rather than attempting to analyze triage prioritization decisions through a utilitarian framework, I suggest that we view military commanders as possessing fiduciary obligations. I will argue that it is the principle of “fiduciary obligations” that should guide military decisions, both on the battlefield and off. It is to this principle that a military officer or military medical
commander should appeal when determining whether to reverse triage procedures. To support my claim that military commanders possess fiduciary obligations, I will look to business ethics literature dealing with the obligations possessed by a corporate executive. The corporate executive, then, will serve as an analogue for a particular military commander entrusted with decisions regarding triage priorities.

There has been much discussion in the business ethics literature about the duties of corporate executives and the duties of the respective businesses they manage. In business ethics there are some who believe that businesses are obligated to assist the persons living in the communities in which they operate. This “assistance” might include philanthropic contributions to publicly accessible goods, such as libraries or schools. It also might take the form of scholarship programs or donations to charitable causes. Whatever the case may be, under this view a business, through the leadership of the corporate executive, is morally obligated to contribute some of its profits for the betterment of society. A second perspective regarding the obligations of a business might be that it is permissible for businesses to contribute to social causes and welfare. So, while it may not be necessary for a business to use a portion of its profits to provide such support, the business is not prohibited from doing so.

A third view on business involvement in social causes is that a business, led by a corporate executive, is permitted to contribute to social welfare only if doing so will increase the profits of her company. The justification provided for this condition is that businesses, and more specifically the corporate executives, have fiduciary obligations to their shareholders. These obligations are the result of the shareholders of a business trusting the business and the corporate executive with their money with one goal in mind, namely, generating profits for the business and a financial return for the shareholders. This view on the social obligations of business is expressed most clearly by Milton Friedman in the following quotation:

...there is one and only one social responsibility of business—to use its resources and engage in activities designed to increase its profits as long as it stays within the rules of the game, which is to say, engages in open and free competition, without deception or fraud.29

Under this view, then, it is inappropriate for a corporate executive, acting on a corporation’s behalf, to contribute to a social cause unless doing so would contribute to the corporation’s profits since these funds are entrusted to him by shareholders for a specific purpose. In a sense, as Friedman argues, if an executive does this he is using someone else’s money for a cause to which they did not intend to contribute. These fiduciary obligations result from the corporate executive being entrusted by the shareholders with the financial resources they have contributed.

This view of the obligations of business, and specifically the obligations of a corporate executive, is applicable to decisions made in a military context. Rather than being entrusted with financial resources so as to make profits, military commanders are entrusted with the duty to win wars. Thus, they possess fiduciary obligations to accomplish this goal without attending to other possible goals they as individual persons might have, unless doing so would enable them to better accomplish their primary obligation, namely, winning wars.30 In the argument that follows, I will suggest that military decisions in general should be followed, I will suggest that military decisions in general should be.

One question that might arise in the analogy being made between the obligations of corporations and the obligations of military commanders is related to who the shareholders might be. Are the shareholders who have entrusted military commanders to win wars the governmental officials of a particular country? Would this include just the executive of a country (for example, the president) or perhaps the larger, often more representative body such as the congress or parliament? Or further, would the shareholders include each citizen of the country that has entrusted the commander with the objective of winning the war? Rather than focus exclusively on Friedman’s shareholder model, it is important at this juncture to discuss a different model for explicating the obligations businesses and corporate executive possess, namely, the stakeholder model.31 This contrast between shareholder theory and stakeholder theory will be relevant in deciding to whom military commanders are obligated and by whom they have been entrusted to win wars.

Rather than view businesses and corporate executives as having obligations only to their shareholders, stakeholder theory expands the purview of those to whom businesses have obligations. R. Edward Freeman defines a stakeholder as “any group or individual who can affect or is affected by the achievement of the firm’s objectives.”32 Shareholders are, of course, also stakeholders, but stakeholder theory greatly enlarges the group of persons to whom corporate executives have duties to include the following, among others: governments, suppliers, consumer advocates. Under Friedman’s view, the only group of individuals an executive must consider is the group of shareholders that have entrusted her with making profits; under Freeman’s stakeholder view, however, a corporate executive must consider any stakeholder, i.e., any person who has a “stake” in the matter, who might potentially be affected by or potentially affect the attainment of corporate goals.

It should be clear from the outset that there are a number of ways to understand the phrase “any group or individual who can affect or is affected by the achievement of the firm’s objectives.” Does this really mean any group or individual? How should we understand the terms “affect” and “affected”? These questions and others like them that relate to where exactly the line should be drawn about who is and who is not a stakeholder have caused a great deal of debate over the applicability of stakeholder theory.33 In fact, it certainly seems possible for almost any person or group to be included as a stakeholder under Freeman’s definition,34 perhaps even a competitor’s business. The goal of this essay is, of course, not to defend a particular interpretation of stakeholder or shareholder theory but rather to make use of the insights or perhaps shortcomings of each in evaluating the decisions that must be made by military commanders.

One might object to the possibility of a coherent shareholder theory on practical grounds. That is, it would seem nearly impossible to make calculations about the effects one’s decision might have on every single person or group potentially affected. Thus, there must be some (practical) limit to who is considered a stakeholder and who is not. Must the business person in Taiwan consider each and every person her choice might affect? Analogously, must the military commander consider each and every person his decision will affect? This requirement to consider all stakeholders in each decision, or at least the ones believed to be most closely affected by a particular decision (how close is close?), it seems, would create a practical impossibility.35

The more serious objection against stakeholder views, at least the sort of stakeholder theory for which Freeman argues,
is metaphysical. It seems that giving all stakeholders equal weight in decision making fails to recognize the fundamental purpose for engaging in business activity, namely, to better one’s economic position. Persons cooperate in business ventures for the purpose of creating a surplus in which they may share, a surplus that would not have existed if each individual cooperating in the venture had attempted to produce without the cooperation of others. For these reasons, it seems that giving the distant individual who has a “stake” in the matter—but who has not financially or otherwise contributed to the venture—equal weight misunderstands the point. Thus, I side with a shareholder view which makes a business, and analogously a military commander, required to fulfill its fiduciary obligations to their shareholders. For the corporate executive this means generating profits with the money entrusted to him by the shareholders; for the military commander this means winning wars using the means and resources entrusted to her by the shareholders.

So, this leads to the following question: Who are the shareholders who have entrusted the military commander with the task of winning wars? The answer for this, it seems, would depend upon the nation who has entrusted the military commander with winning wars. For the U.S. this would be a combination of the three branches of power, the legislative, the executive, and the judicial, as each relates to the ability to engage in war. In each particular situation, those parties who have authorized the war and empowered the commanders to do what is necessary to accomplish the goal of winning the war would count as the shareholders to whom the commander has fiduciary obligations.

These fiduciary obligations that I am arguing military commanders possess oblige commanders to do what is required to accomplish the task for which they have been appointed. In most instances regarding which triage model should be chosen, it seems clear that the triage model selected would be egalitarian in design. When resources are sufficient to treat first those most needing care without breaking the obligation to win the war, it is appropriate to have medical need determine who receives priority. Furthermore, having a triage system in place which, most of the time, prioritizes individual medical need seems necessary to maintain the morale of the fighting force. Thus, under the fiduciary obligations principle I am suggesting, having an extreme conditions triage model all the time would actually hamper the commander’s ability to fulfill his obligation. This provides further support for the view expressed above that it seems best to have multiple options available for triage prioritization, some which are egalitarian in focus and others that are not.

Regarding the extreme battle conditions model, should a commander believe he must reverse triage to win the war, then he is required to enact a triage reversal that will enable him to fulfill his obligation. This, unfortunately, may involve the deaths of those needing treatment. But reversing triage will only be done in the circumstances where it is necessary to do so. To refuse to reverse triage procedures when it is necessary to do so, perhaps by appealing to some other principle like medical need, would be for the military commander to squander the resources entrusted to her by the shareholders (the supporting nation, government, etc.) for the explicit purpose of winning a war. If a military commander refuses to reverse triage procedures and as a result loses the war, then she has violated her obligations to her shareholders.

If one grants the existence of fiduciary obligations possessed by military commanders, what remains to be discussed is physicians’ participation in triage activities that seem to violate what many believe is a basic responsibility physicians possess. This responsibility is that physicians should place the well being of their patient as the highest priority in decision making. In the section that follows, I will argue that physicians are able to support and participate in these triage procedures whether as physicians serving on the battlefield or as military medical commanders.

5. The Military Physician’s Relationship with Those Needing Treatment

Many believe that physicians, both military and civilian, should always act with the goal of improving the health of those presenting themselves for medical treatment. This “duty” that physicians have for these individuals’ needs is often mentioned in discussions of torture during which physicians are present (or even assisting). So, while they may support the fiduciary obligations that military commanders possess, they may not support the view that a physician should act in any other way than to help those in need of medical care. The following quotation from an article by Jerome Amir Singh is illustrative of this view:

Military physicians should always remember that while captured terror suspects are detainees of a government they are first and foremost patients of the physicians and they are owed a duty of care. The duty of care must supercede any blanket notion of loyalty, obligation, allegiance or patriotism that the physician may feel is owed to his or her station.

Where exactly this “duty” originates is not immediately clear. Singh notes that this principle quoted above is in line with views espoused by a group called Physicians for Human rights, but this is hardly an argument for the existence of these obligations on the part of physicians. It certainly seems possible that this duty may be the result of individual rights that persons possess; perhaps this duty should be grounded in each person’s right to life. It may also be possible that this duty results from medical knowledge that physicians possess. Each of these possibilities will be discussed below.

From the perspective outlined in §4, individual rights clearly play a large role in the fiduciary obligations that military commanders possess. For these fiduciary obligations to have any weight, we must presuppose that the shareholders each possess a right to their resources that they contribute, and further that they have certain rights within the relationship between them and the agent they have entrusted with their resources. Although the rights of shareholders clearly play a role in that argument, in this section I will argue that in certain instances it is permissible that the rights of individuals presenting for treatment may be violated, and as a result that physicians should participate in triage reversal when a military commander commands it.

One primary reason for discussing physician participation in reverse triage procedures is that many ethicists believe that doing so fundamentally contradicts the duties a physician has to those in need of medical treatment who present themselves to him as patients. Furthermore, in the opinion of the AMA Code of Medical Ethics physicians have “...ethical obligations to place patients’ welfare above their own self-interest and above obligations to other groups.” It is first important to note that the AMA Code of Medical Ethics is not intended to cover every possible ethical dilemma that a physician might face; rather, it is a collection of ethical guidelines that are open, in some areas, to various possible interpretations. Furthermore, although the annotated version contains references to legal codes and journal articles relevant to each opinion, statements in the code themselves represent the opinion of the AMA and its constituents and are not, as such, explicit moral arguments.
Furthermore, while legal precedents may be important in developing an opinion on a particular issue, in certain cases legal considerations may diverge from moral considerations. With these caveats in place, it will now be useful to discuss some ambiguities regarding the patient-physician relationship that the AMA Code describes.

The AMA Code states that “[a] patient-physician relationship exists when a physician serves a patient’s medical needs, generally by mutual consent between a patient and a physician” (300). The Code continues to state that “[p]hysicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship” (305). Furthermore, “both the patient and the physician are free to enter into or decline the relationship” (281). Given these conditions on the patient-physician relationship, there are two questions relevant to the issue of military physicians and the issue of triage. First, does a patient-physician relationship exist between a military physician and the individual needing care, and if so does it exist in only the instances where the physician agrees to consider the patients’ medical needs as that which dictates triage prioritization (e.g., in non-austere battle conditions)? Second, if a physician can freely choose not to enter into a patient-physician relationship with someone requiring care is this how we should understand the situation of military physicians who must reverse triage?

It will be useful to consider the second question before the first. Since physicians are free to enter into the patient-physician relationship, it seems that we might allow for instances where a physician may use his medical knowledge for a certain purpose but not be in a patient-physician relationship while doing so. In other words, it does not seem that the knowledge an individual possesses is what obligates one to consider a patient’s needs above all else; rather, it is the decision to enter into a patient-physician relationship, which, as the AMA Code notes, is a contractual decision on the part of both the physician and the patient. This being the case, it seems that since physicians affected by reverse triage procedures are aware that in certain instances, when mandated by the chain of command, medical need will not be the primary consideration for medical care, these physicians are not de facto entering into patient-physician relationships in these instances; rather, they are choosing to use their medical knowledge to help accomplish the goals of the chain of command (i.e., fulfilling fiduciary obligations by winning wars).

Regarding the first question, it does seem useful to describe the military physician as choosing to enter into a patient-physician relationship in the triage model recommended by non-austere battle conditions. In these situations, patient medical need is valued above all else and there is an understanding of this between the individual needing care and the physician. But, it should be noted that just as battle conditions are ever-changing and dynamic it is certainly possible that a patient-physician relationship begun during non-austere battle conditions may need to change to a non-patient-physician relationship. In this circumstance, the individual being treated may be de-prioritized, and his care may be delayed.

This should come as no surprise, though, since in civilian situations we can imagine the patient-physician relationship as dynamic as well. For example, one of the situations explicitly identified by the AMA Code in which a physician may decide not to enter into a patient-physician relationship with an individual is one in which the treatment requested is “known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient” (305). In such a situation, we can easily envision a physician initially choosing to enter into a patient-physician relationship and administering treatment. After assisting the patient, however, the physician discovers that the patient desires a treatment that is scientifically invalid. At this point, the physician may withdraw from the patient-physician relationship.

Having discussed these abilities that physicians have to choose not to enter into the patient-physician relationship, it is now necessary to discuss what happens to the rights of the individual soldier whose medical care is de-prioritized when triage is reversed. What of his right to life? Is this decision unfair to him? Here it is important to note and respond to a prevailing view in bioethics, the view Michael Walzer makes most clear in the important work Spheres of Justice. Using a principle of distributive justice as a guide, Walzer believes that elements of need in a particular situation “…generate a particular distributive sphere.” Since healthcare has its own particular criteria of need, Walzer argues that applying needs from other spheres to the sphere created by the needs in healthcare situations would be inappropriate. In this line of thought, Walzer notes that “…the market is…the chief rival of the sphere of security and welfare.” Relating Walzer’s view back to triage in military decisions, it seems he would argue that allowing any need from a different sphere to influence the medical decision would be inappropriate.

People do have rights, but how we understand these rights can widely diverge. Walzer’s system is derived from a generally egalitarian standpoint, namely, that each person’s needs in each situation must be considered in the decision about the distribution of goods. There are certain situations, though, in which it seems appropriate for the rights of certain individuals to be violated so that a greater number of rights may be preserved. For example, imagine a situation in which the strength of a military force has been significantly decreased due to 150 soldiers being wounded. Of these 150 wounded, imagine that 140 have been wounded only superficially and, with a minor amount of medical treatment, will be able to quickly return to the battlefield. The other ten wounded are those who will die unless they receive immediate treatment.

In this scenario, though, it seems appropriate to consider the lives of the soldiers still fighting in the battlefield as well as the soldiers needing medical attention. Imagine that there are two hundred soldiers still fighting in the battlefield, and imagine that according to the military commander’s judgment if the superficially wounded soldiers are not returned as soon as possible the fighting force will be overrun on the battlefield. In this situation, I argue that it is important to violate the right to medical care (and the right to life) of the lesser number of individuals, hoping to preserve the rights of the larger group. So, it’s not that rights should be violated tout court, but rather that in certain situations it may be appropriate for rights to be violated so that the rights of a larger number may be preserved.

For these reasons, it seems that military physicians and military medical commanders are morally permitted to participate in triage reversal procedures when the chain of command requires it. Rather than elevating decisions such as triage reversal to a macro-level as Gross does (see n. 40), viewing the military physician in this way, i.e., as individuals acting with medical knowledge to preserve the strength of the fighting force, provides a realistic picture of both the medical commander’s participation that occurs in military strategizing and the physician’s role as one acting to serve the needs of the chain of command.

6. Conclusion

The present paper has endeavored to provide support for triage models that make use of considerations other than medical need to determine who receives priority of care. Examining

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these situations through the lens of the fiduciary obligations model, I have argued that commanders must consider the reason which shareholders have entrusted them with resources, namely, so that they will win the war and as a result accomplish something that each individual could not have accomplished by herself. Furthermore, it is by no means clear that physicians possess special ethical obligations merely as a result of their possessing medical knowledge. Perhaps qua persons they do possess obligations, but holding specialized knowledge does not create special ethical obligations. Additionally, since doctors may choose when to enter into a patient-physician relationship, perhaps we should view the relationships between military physicians and those whom they treat differently.

This essay has primarily focused on the priority of care administered to soldiers returning from the battlefield. Other areas to which this view could be applied would be the case of POWs and indigenous civilians needing care who are part of the country in which a war is taking place. In each of these situations, it seems that a commander’s fiduciary obligations should be the primary governing principle for decision making.

Endnotes

1. This paper was originally published in Fritz Allhoff (ed.), *Physicians at War: The Dual-Loyalties Challenge* (Dordrecht: Springer, 2008), pp. 215-36.

2. I would like to thank Fritz Allhoff and Shannon Bernard-Adams for their feedback and criticisms of this paper. I have benefited immensely from their comments and suggestions.

3. Some argue that the term "triage" has an implicit utilitarian connotation and prefer to use what they believe are more neutral terms. See, for example, John F. Kilner, *Who Lives? Who Dies?* (New Haven, CT: Yale University Press, 1990). I will use "triage" throughout this paper since it is the more widely used term. Any ethical implications that the term appears to possess are an artifact of discourse.


5. I will only be examining triage procedures relating to incoming patients with acute (not chronic) injuries or diseases. Many other situations require triage, e.g., the allocation of organs to those in need of transplants or the priority of treatment for chronic conditions such as kidney dialysis, but these will not be the focus of my discussion of general triage procedures. I am using the term "dire" to denote a situation in which patients will die as a result of the priority for care they are given. Most of the time in general contexts someone will not die, all else being equal, due to the care priorities given after the sorting process.

6. James F. Childress ("Triage in Response to a Bioterrorist Attack," in *In the Wake of Terror*, edited by J.D. Moreno [Cambridge, MA: MIT Press, 2003], 77-93, here 80) argues that triage is fundamentally utilitarian, with the only distinction being between medical utility (what I am here calling an egalitarian concern) and social utility. For this discussion, I will operate under the assumption that triage based on medical concerns is egalitarian since it places priority on an individual’s medical needs.

7. Of course, there are varying levels of triage for different situations. Triage during ordinary E.R. intake is quite different than E.R. intake after a disastrous plane crash with fifty victims needing immediate care. The point here is just that in ordinary situations where the level of care is sufficient to prevent patient death (perhaps not sufficient to give the best quality of life to each person, though) the triage procedure employed is generally egalitarian and gives first priority to those most in need of care.

8. This prioritization of the treatment for those most in need of medical care even occurs in ICU admissions practices where resources in civilian contexts are often scarce. Patients who are less in need of ICU care often turned away. See, for example, Robert Baker and Martin Strosberg, "Triage and Equality: An Historical Reassessment of Utilitarian Analyses of Triage." *Kennedy Institute of Ethics Journal* 2:2 (1992): 103-23, esp. 106-10.


10. These broad categories are generally expanded into, perhaps, five categories or more (see, for example, Bowen and Bellamy, *Emergency War Surgery*). Since the primary focus of this paper is the ethical issues surrounding military medical triage and not the medical aspect involved in evaluating patients, these three general categories are adequate.

11. Hereafter, I will refer to this as a "triage reversal" because the group that receives priority in terms of medical care under this triage model is the group that normally receives care last.

12. See, for example, Bowen and Bellamy, *Emergency War Surgery*, part 3, chapter 2.


15. Ibid., 153. Just after this sentence, though, Winslow admits that while this strategy, which he states rests on the "difference principle" he discusses, "may produce identical strategies" to a utilitarian model, he claims that they each "clearly exemplify different perspectives" (Ibid.).

16. Michael L. Gross (*Bioethics and Armed Conflict* [Cambridge, MA: MIT Press, 2006]) argues along similar lines regarding military triage. Here Gross notes that British soldiers have distinguished between mass-casualty triage and conventional triage (Ibid., 144-48), noting that mass-casualty triage appeals to principles of "salvage" and "utility."


18. Ibid. Here Beam notes the following: “This is the model that is most frequently seen and that occurred throughout the Persian Gulf War for most units, including American hospitals for Iraqi POWs.”


22. Ibid., 1631. This case is also recounted in Henry K. Beecher, *Research and the Individual* (Boston, MA: Little, Brown, 1971), 209-10. Additionally, some question whether this case should be considered a canonical case of military triage. See, for example, the discussion in Baker and Strosberg, "Triage and Equality," 120.


26. Beam seems to assume such a view. For example, regarding the extreme battle conditions model he states, "...the 'greatest good for the greatest number' would allow the decision [to reverse triage] to be made, not for the benefit of the individual patient, but for the good of the unit, the army, or the country." ("Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics," 384). Here Beam assumes that the wars in which this model would be applied would be wars in which more good would be created by winning them than not. What of the unhappiness of the enemy combatants and their countrymen? Beam does not mention this issue, but instead he seems to assume that the only happiness or good in question is the good of the army making the decision and its sponsoring country.


32. Freeman, Strategic Management, 25. Also, see Freeman's discussion on 46-7.

33. For an example of such a critique see Kenneth Goodpaster, "Stakeholder theory," [http://www.icrc.org]
to battle would have a negative effect on morale ("Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics," 384). Throughout the paper, I have assumed that military commanders are provided resources by the shareholders so that they may win wars. Wars are only won, of course, by winning battles, and it is in battles that triage may or may not be reversed. So, the military commander, often one who is experienced in making decisions such as these, must make a decision on a battle-by-battle basis about what to do so that the overall war will be won.


35. For another example of such a connection with individual rights being presupposed by cooperative activities such as business ventures see David Gauthier, Morals by Agreement (Oxford: Clarendon Press, 1986), esp. 221-23.


41. Mitchell et al. surveyed the literature on stakeholder theory in 1997 and found 27 different definitions that each attempt to define who stakeholder is (Ibid., 858), displaying just how difficult it is to determine with a high degree of precision who counts as a stakeholder. With this in mind, Freeman notes that rather than being a theory in the sense that we normally understand the term 'theory,' "[Stakeholder theory] is ...a genre of stories about how we could live" and also "[Stakeholder theory] is part of a narrative about how we do and could live." ("The Politics of Stakeholder Theory," 413 and 418, respectively). While interesting for discussion and perhaps useful as a heuristic, it is unclear how these views of Freeman's on stakeholder theory as a "narrative" provide definite direction as to what a business should or should not do.

42. Furthermore, viewing the obligations of military commander through a stakeholder theory would require him to not only consider those positively affected by the battle such as the government which has entrusted him to protect its interests but also consider the belligerents whom his decision will affect. Applying a stakeholder model to the way in which a military commander should make decisions, then, would seem to mistake the purpose of fighting a war, namely, to win and by doing so accomplish what each individual could not have done on her own.

43. See Sundaram and Inkpen ("The Corporate Objective Revisited," 354-355) for a discussion of the difficulty and conflict that arises from having multiple goals driving a business, goals which in some cases may contradict the reason shareholders have invested in the company.

44. Bean mentions that always having a triage model in place that gave priority only on the basis of one's ability to return to battle would have a negative effect on morale ("Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics," 384).
References


Medical Neutrality and Political Activism: Physicians’ Roles in Conflict Situations1,2

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Physicians should speak out about their values. The word ‘profession’ means, from the Latin, ‘speaking forth.’ Public avowal of values has been a distinctive feature of the professions from before medieval times.3

1. Introduction

Physicians in conflict situations juggle myriad duties and experience many ethical dilemmas in caring for the sick and wounded. Issues of how to triage care, allocate resources, and knowledge of injustices committed against patients by warring parties are among these concerns. Medical neutrality—care given based on criteria of medical need and urgency—has been strongly instantiated as a core value in the moral fabric of medicine and international medical ethics. Yet, physician political neutrality or activism regarding war crimes and injustices against people wartime physicians serve has been met with controversy. Medical neutrality, political neutrality, and political activism can be construed as types of moral goods in the practice of medicine. I argue that medical neutrality in the provision of care and political neutrality in conflict situations are not equivalent goods. Physicians have duties to provide care on the basis of medical neutrality, but they also have an obligation to be politically active in certain conflict situations and report allegations and abuses revealed during either the clinical encounter or in the field.

First, I review a short history of medical neutrality in medical ethics as well as offer a defense of it. Next, I discuss political neutrality, and I argue that there exists the obligation for physician political activism (e.g., reporting human rights abuses). At the same time, I argue that physicians must practice medical neutrality using ethical and public health-based arguments that combine physicians’ duties to preserve equal respect for all persons (clinical role) while maximizing the protection of individuals living in communities (public health role). I conclude by examining pragmatic implications of such an approach and the risks and benefits it might pose. Here I explore different ethical dilemmas military physicians and physicians working with humanitarian groups experience.
in wartime. Throughout the essay, I focus the discussion on physician professional duties *qua* physicians because I argue that all physicians are bound to the same core professional principles despite differences in their affiliations.

2. Standards and Principles of Medical Neutrality

The principle of medical neutrality is in many ways an uncontroversial and relatively straightforward domain of international medical ethics. Medical neutrality has two distinct meanings: one refers to *impartiality* in providing medical care and another refers to *protections* due to health care professionals by all warring parties in armed conflict situations. Medical neutrality construed as a professional obligation requires that physicians impartially treat the wounded and injured, whether friend or foe, on the basis of medical need and urgency. Need and urgency are impartial criteria because they are not related to the non-medical affiliations of the patient. Need-based care can refer to treating those needing urgent care quickly or treating as many needy patients as possible. Thus, as a form of triaging care, these criteria represent one way of treating all persons equally and distributing medical care justly, values at the core of this version of medical neutrality. Medical neutrality understood as a protective ethical duty in conflict situations requires that warring parties not harm any medical professionals or interfere with their health care work. While the protective concept of medical neutrality in human rights, humanitarian, and professional literature is stated clearly, an understanding of medical neutrality and physician impartiality in the provision of care in armed conflict varies. This essay focuses on the impartiality notion of medical neutrality.

The Geneva Conventions serve as the benchmark for both forms of medical neutrality. The overall purpose of the four Geneva Conventions of 1949 is to protect the victims of war, especially the sick and wounded. The four conventions differentiate between combatant and non-combatant status and the level of protection and medical care these persons are entitled to in conflict situations. For example, according to the 1949 Conventions, civilian non-combatants are entitled to receive physical protection from warring parties but are not guaranteed the same level of medical care to which wounded or sick combatants of either warring party are entitled. Additional Protocols I and II (1977) ended the distinction between combatants and non-combatants by expanding the definition of “wounded and sick” to include civilians in addition to military combatants. Additional Protocol I, Part II, Article 10 states:

> In all circumstances [the wounded, sick and shipwrecked, to which ever Party they belong] shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.\

While not as authoritative as the Geneva Conventions, other international standards include the Declaration of Tokyo of 1949 and the World Medical Association Regulations in Times of Armed Conflict. In the Declaration of Tokyo, “a doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor’s fundamental role is to alleviate distress...and no motive, whether personal, collective or political, shall prevail against this higher purpose.” The World Medical Association (WMA) has put forth other statements including: “[u]nder all circumstances, every person, military or civilian, must receive promptly the care he needs without consideration of sex, race, nationality, religion, political affiliation or any other similar criterion”; and “[i]n emergencies, physicians and associated medical personnel are required to render immediate service to the best of their ability. No distinction shall be made between patients except those justified by medical urgency.” The WMA states that “[m]edical ethics in times of armed conflict is identical to medical ethics in times of peace, as established in the International Code of Medical Ethics of the World Medical Association. The primary obligation of physicians is to their patients; in performing their professional duty, their conscience should be their guide.” According to the WMA statement and the concept of medical neutrality as impartiality (i.e., age, gender, religion, political affiliation, and class are completely irrelevant criteria) a decision to treat a less urgent case would be unethical.

Many understand this interpretation and application of impartiality as a type of distributive justice in medicine and a moral duty in triage situations. In this sense, medical neutrality itself is a type of justice, and one argument suggests that all physicians are bound to honor it always, especially in times of armed conflict. A counterargument would posit that it is in armed conflict situations that medical neutrality may be least just in the provision of care and that other non-health-related criteria become salient because of duties to state, political affiliations, bonds of kinship, and sympathies for a particular cause of one of the warring parties. These criteria, although relevant in parts of our lives, are not values intrinsic to the ethical duties delineated from the profession of medicine. I align with the former position based on the argument that physicians have professional moral duties *qua* physicians to protect the sick and wounded based on need and urgency alone, i.e., medical neutrality as impartiality.

The concept of medical neutrality can be defended on the basis of equal respect for persons and for treating persons as ends in and of themselves. Equal respect for human persons is best achieved through a just distribution of health care in conflict situations based on a combination of medical need and urgency. Using this as the only relevant criteria in medical decision-making is a reflection of philosopher John Rawls’ “veil of ignorance” in the sense that impartiality in triaged medical care is in the best interest for all individuals unaware of whether or not they will ever need urgent care. Using this understanding, impartiality represents an egalitarian approach to justice in the provision of medical care (though philosophers debate the relationship between egalitarianism and the veil of ignorance). According to Additional Protocol I, civilians and military personnel are not separated in the needs-based pool. Therefore, depending on how need and urgency are construed, the implications of this policy mean civilians could be entitled to receive a greater amount of care from military physicians than military personnel themselves. Do military physicians have a *prima facie* duty to their own soldiers? Perhaps according to military policy but not according to the Geneva Conventions and other professional statements regarding the duties of physicians. We shall return to this tension for military physicians shortly.

A right to an equal chance at health care in triage situations exists by extension of an inviolable equal respect for persons. This “right” may appear to be a charitable or unjust position when justice in other non-health related dimensions is considered, such as crime deserving punishment. For example, there may be an intuitive disconnect for some physicians in conflict situations to treat a combatant urgently needing medical attention who has perpetrated gross crimes against humanity when a civilian or combatant from a friendly warring party presents for care with less urgency. An example of this type of ethical conflict for physicians would be a humanitarian group-affiliated physician in the Darfur region of Sudan treating an injured member of the Janjaweed militia when a civilian...
The former is ethically acceptable; the latter is not. Military and needing medical care based on non-health related criteria. is ethically different than refusing to treat a person urgently. Refusing to participate in controversial treatment, however, may be appropriate in some circumstances when the patient's relationship with the patient in the first place. In peacetime, this may be bound to within the profession itself.

Physicians are bound to a fundamental duty to treat people equally. Depending on physician affiliation, the goals of practicing medical neutrality and triaged care will be different. The U.S. Army's Borden Institute, which publishes the textbooks of military medicine, states that “the goal of combat medicine is to return the greatest number of soldiers to combat and preservation of life, limb, and eyesight in those who must be evacuated.” 10 The language of the U.S. military’s conception of military medicine is clearly and understandably one of utility. Physicians have a moral duty to “turn in” that individual, simply report that genocide is occurring, or be silent? What relevant principles guide a moral assessment of medical treatment and political activism in armed conflict situations?

There are at least three conceptions of physician duties in armed conflict that address medical and political neutrality in the provision of care. First, physicians could be impartial in the provision of medical care and publicly politically neutral concerning geopolitical affairs that impact the populations they serve. On this account, physicians could presumably provide a maximal amount of people with need-based medical care without being perceived as taking sides by warring factions. Second, physicians could be impartial in the provision of care and, bound by a moral duty to promote health and human rights, report war crimes and abuse directly or through partnered human rights, humanitarian, or military groups. Third, physicians could be medically biased in the provision of care based on allegiances and/or personal conscience and report or not report war crimes and abuses on the same basis. I concentrate on arguing for the position against the first one, since the third one is widely considered unethical.

3. Medicine Neutrality and Political Activism

The practice of medicine in an armed conflict environment presents a constellation of duties and responsibilities for physicians that they might not encounter during peacetime. That is, physicians normally politically uninvolved in peacetime may need to actively promote values in medicine during wartime, such as human rights related to health. The international declarations of physician conduct in wartime do not address these other duties, such as reporting war crimes that impact health, because reporting abuses is a related but distinctly different issue than medical neutrality. A duty to be politically active arises out of the core principle of beneficence—doing good work to foster the happiness of individuals and society. This principle does not only apply to the physician-patient encounter when physicians treat sick and wounded patients; it applies to physicians’ duties to prevent further harm and maximize health through appropriate political activism in a manner which will depend on the situation at hand. For example, H. Jack Geiger et al. report, “participation of health workers in the defense of human rights now includes investigation and documentation of health effects in threatened populations as well as individual victims.” 16 From this perspective of physician involvement in wartime, political activism is directly coupled with knowledge that impacts public health and patient care. Arguments for


decision-making. 10 When all things are equal, randomness in medical care allocation decisions may seem most fair on one hand and a logical extension of medical neutrality, but such randomness completely neglects human experience and relationships in an unrealistic way, both of which may offer moral guidance in this unique situation. Certainly one could make the case that non-medical criteria should always factor into the equation of need based care at the outset, but this would clearly violate the requirements of justice and equal respect for persons to which physicians should be bound to within the profession itself.

The American Medical Association’s Code of Medical Ethics states in Opinion 10.05 (1): “Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship.” According to this opinion, it seems physicians can then choose whether or not to enter into a relationship with the patient in the first place. In peacetime, this may be appropriate in some circumstances when the patient can be referred to another physician. But this prerogative is limited in that the Code states that physicians need to respond to the best of their ability in an emergency situation, cannot discriminate based on many non-health-related criteria, and must render care when operating under a contractual agreement that requires them to treat. 13 Physician refusal to provide care or a particular treatment that they find unethical for personal or religious reasons is permissible in some situations. 14 Refusing to participate in controversial treatment, however, is ethically different than refusing to treat a person urgently needing medical care based on non-health related criteria. The former is ethically acceptable; the latter is not. Military and humanitarian groups may try to place institutional parameters on the way physicians distribute care and create contractual obligations that may compete with medical ethical duties, but physicians qua physicians still have fundamental professional obligations to respect all persons equally.

We now return to the implications of impartial care as defined above as a duty of physicians. If physicians are truly impartial, they may be at times aiding enemy efforts or contributing to the prolongation of war, depending on whom they treat and how treatment impacts the patient’s ability to participate in conflict. Physicians may become aware of information from patients in these settings that reveals crimes committed or future conflict. Former Human Rights Watch executive director Aryeh Neier, writes, “I had discovered fairly early in my tenure that, both for better and for worse, physicians had a significant role in dealing with abuses of human rights.” 15 Are there settings, such as armed conflict, where physicians have concurrent personal moral duties to act outside traditional medical professional roles through political activism? What might be at stake if they do so? If a physician treats a patient perpetrating crimes of genocide, does that physician have a moral duty to “turn in” that individual, simply report that genocide is occurring, or be silent? What relevant principles guide a moral assessment of medical treatment and political activism in armed conflict situations?

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political activism are based on utility just as much as arguments for political neutrality are based on utility in the sense that physicians will want to protect the health of as many people as possible (including themselves) and treat them equally. I am arguing that the utility of political activism outweighs that of political neutrality.17

The argument for public political neutrality suggests that physicians as politically neutral agents maximize the amount of care they can provide to the wounded and sick. Generally speaking, this is the model the International Committee of the Red Cross follows. Political activism compromises the safety of physicians and their patients, because activism itself can incite harm from warring parties against “activist” physicians. Generally speaking, groups such as Médecins Sans Frontières (Doctors Without Borders) and Doctors of the World are more politically active. Physician political neutrality may allow physicians to better protect already vulnerable patients and themselves, a position which could potentially be jeopardized through political activism. Physicians practicing impartiality in health care delivery and political neutrality attempt to maximize health for the most people. Additionally, by providing need-based care, it may be more likely that opposing factions will view medical personnel as neutral and treat them as such (medical neutrality in the protective sense). Kevin Gibson argues that, in general, medical and political neutrality in the medical field promotes trust, and that this neutrality involves distance from the substance of the dispute and the values involved.18 He also allows that true neutrality is elusive if not undesirable in particular situations, an important point to highlight for the purposes of my defense of political activism.

For example, in an armed conflict situation it may be prudentially wise for physicians to stay politically neutral. Yet, this neutrality does not necessarily aid in the prevention of health crises in the first place whereas reporting human rights abuses impacting community health might do so. The prevention of ill health should be a primary goal alongside restoring health. The decision to remain politically neutral is an assessment of the relative risks and benefits all involved parties can expect, rather than as a result of a deontological principle.19 While there are many pragmatic reasons for remaining neutral, it is a position that fails to encompass the wider duties of physicians. Respecting persons and treating them equally entails preventing further harm to the populations being served—not just mitigating present health crises—and reporting crimes against humanity as a form of political activism serves towards this end. Preventing health crises, war being an example, is a professional and moral duty for physicians, as I will explore more shortly under the framework of a physician role in public health purveyor. Physicians should be as concerned with preventing health care emergencies as with the medically neutral provision of care in armed conflict, especially when the information they know leads to the prevention of injury.

Even though physicians themselves are not actively committing war crimes or destroying infrastructure, they are arguably morally culpable in their silence regarding human rights abuses, especially as the gravity of abuses escalates in armed conflict. The risk brought to one’s own life by political activism exists in tension with a duty to do so when such activism may positively impact the lives of many. Certainly the prima facie obligation to help others is contingent upon risk to oneself, but professionalism in medicine requires physicians to assume greater risks in certain situations. Of course, the goal for medical professionals is to promote the health of all, including their own. If they were to jeopardize their lives through activism, their absence would leave patients even more vulnerable. The important point to highlight in this deliberation is that physicians, due to the moral nature of their profession to serve patients, take on greater risks to their own safety and health depending on the environment in which they practice medicine.

To the degree that respecting persons equally entails protecting the health of patients, political activism by physicians in armed conflict situations reflects maximizing the contribution to population health and safety if such activism can be expected to reduce further human rights abuses, war-related malnutrition, and structural degradation of society. For example, the MSF-France operational section board (MSF has operational section boards in five countries, including France, that directly control field projects and thirteen non-operational sections that provide support, including the U.S.) made a controversial call for an armed intervention to stop the Rwandan genocide, an action it had never taken before in its history.20 The potential implications of political neutrality versus activism were also highlighted by this situation. That is, “...some MSF doctors in Rwanda defected to the ICRC, feeling that the Red Cross’s discretion would offer them more safety.”21 Depending on the type of political activism expressed, the choice to become politically active or not raises salient concerns—a sense of life or death in the case just mentioned. But as I have already argued, physicians may in fact prevent more sick and wounded patients from presenting with need and urgency in the first place through strategic political activism. The sense of international silence and inaction may have been too overwhelming for the MSF physicians in Rwanda as human rights abuses continued unabated. This, in part, may have been among the arguments for MSF-France to go public and urge for intervention at great expense.

If physicians are responsible for promoting public health and war can be viewed as a public health problem, then overlapping ethical duties physicians have to populations during war bolsters a case for physician political activism as a form of justice in medicine. Joanna Santa Barbara argues:

So compelling are the needs of people either acutely affected by an ongoing war or struggling to rehabilitate a war-torn society once hostilities have ended, that knowledge, energy, and financial resources applied to prevention are sparse. It may be useful to consider the phases of war over time, and to apply the public health concepts of primary, secondary, and tertiary prevention to these phases.22

War, when looked at as a public health problem, is akin to an epidemic of disease. The abuses perpetrated as a weapon of it pose health threats to individuals and society. War often brings about the degradation of infrastructure, diminished food and water supply, and an increase in crimes such as rape, all of which can cause the spread of disease, foster malnutrition, and ultimately lead to increased morbidity/mortality rates. Physicians need to conceive of war as a disease and respond accordingly in a way similar to coordinating a public health response. If war is a disease, then addressing war is a professional obligation which could entail that physicians take on the additional personal risks that political activism in armed conflict may create. Reporting human rights abuses should be attempted in a manner that protects the safety of patients and health care personnel as much as possible, but the imperative to report exists nonetheless. The benefits of appropriate political activism can outweigh those of political neutrality for physician political neutrality stands no chance of preventing the ills of war when physicians withhold knowledge that could reduce harm.

4. Pragmatic Issues for Physicians in Conflict Situations

While I attempted to argue for both medical neutrality and physician political activism as part of physicians’ professional
duties, human experience needs to be taken into account in the assessment of what physicians do as opposed to what they should do, since idealized thought experiments are rarely instantiated in the real world. After all, I am essentially arguing for a position that likely puts physicians’ lives even more at risk than they have been in the first place in light of the difficult demands of justice and beneficence placed upon them. That said, in viewing war as a public health crisis, the notion of physicians acting additionally as quasi-human rights police, in the sense that they report a variety of war crimes in the effort to protect others, is a radical but logical extension of physician duties.

Up until this point, we have concentrated on the work of physicians affiliated with humanitarian groups and military forces. Political activism through human rights agencies is another example of physicians practicing the duties of their profession. Although their work is not as clinically based as it is for physicians in humanitarian outfits, physicians affiliated with human rights groups articulate a crucial moral voice of the medical profession that promotes the health and human rights of victims of armed conflict. These physicians are oftentimes positioned to be a more effective voice for the profession than physicians who are juggling both requirements of medical neutrality and political activism in conflict situations. Two examples of such organizations include Physicians for Human Rights (PHR) and International Physicians for the Prevention of Nuclear War (IPPNW). PHR investigates and addresses human rights violations rather than participating in organized medical care. IPPNW’s mission statement states that “IPPNW is committed to ending war and advancing understanding of the causes of armed conflict from a public health perspective.”

Physicians of PHR experience a different kind of risk in conflict situations and war torn societies as they practice political activism through forensic investigations of human rights abuses in these places. For example, a recent PHR investigation team evaluated the use of rape as a weapon of war in Darfur, which brought upon the team the risks of being in that region at a volatile time. Although, as workers through a human rights agency, they do not practice clinical medicine in armed conflict areas, they do complete psychological and medical evaluations of survivors of torture through a political asylum network in the U.S.

Jennifer Leaning describes what many physicians experience as tensions between adherence to human rights standards and the humanitarian requirement to maintain access to populations in need. She provides the example of human rights investigators seeking evidence about events witnessed by humanitarian workers when such information may jeopardize personal or group security in the field. It may be no surprise then that many aid workers are not able work in the field for long periods of time because of a sense of personal moral or ethical ambiguity. The difficulty seems to be greatest for humanitarian group physicians, but they also encounter unique dilemmas. They must honor international conventions if their country has signed onto them, e.g., Geneva Conventions. In following the Geneva Conventions, military physicians part of a warring party provide medical care to their own and enemy combatants in accordance with the principle of medical neutrality. While humanitarian physicians may have qualms about treating patients that may in turn harm others in conflict situations, military physicians do not experience this dilemma in the same way. The enemy combatant patient becomes an enemy prisoner-of-war (EPW) and to the extent that one less enemy combatant on the field alleviates further war and human rights abuses, physicians in the military may have less about which to be conflicted compared to non-military physicians who provide impartial care to patients who may be future perpetrators of war crimes.

At the same time, the military physician almost certainly experiences pressure to prioritize care based on non-health related criteria, such as whether or not a combatant is from a friendly warring party or an enemy warring party. Nonetheless, the military physician has professional duties qua physician to practice impartiality in medical care. The impartial practice of medical neutrality by military physicians is a challenging ideal in reality. Victor Sidell and Barry Levy suggest, as long as physicians in the service of the military continue to be a part of the military, they will be susceptible to divide people into “us” and “them” rather than into categories of patients needing attention based solely upon their medical needs. It is our opinion that military physicians cannot, as members of the armed forces, live up to the expectations and responsibilities of the Geneva Conventions.

They conclude that it is impossible and morally unacceptable for a physician to serve both as a physician and a soldier in the U.S. military forces and unlikely in other military forces. In a response paper to Sidell and Levy, Edmund Howe cites a report that U.S. military physicians have stated that they would violate an obligation to treat EPWs equally. That military physicians “cannot” live up to international expectations and the aforementioned ethical principles seems to disrespect the autonomy and capability of the military physicians to follow what are difficult and lofty requirements of practicing in the medical profession. Rather than remove them from the military as Sidell and Levy would have, Howe argues that the attitude present among physicians who would prioritize care using non-health related criteria requires structural change in the U.S. military policy and punishment for those who undermine need-based care.

If only urgency and need are considered in the triage of care equation, then in the hypothetical event that EPW injuries overwhelm the ability of military physicians to provide for their own soldiers, it is certainly not of utility to their military force to treat EPWs. But need-based treatment in this circumstance, while difficult, is a reflection of the type of justice demanded of physicians. This example highlights the discord between intuitive feelings and allegiances on the battlefield and transcendent moral reasoning, a tension I am not inclined to mitigate by arguing that other non-health-related criteria...
should in fact become relevant with the exception of the “all else being equal” case I mentioned earlier. What is in conflict for the military physician in the provision of care is a sense of competing commitments—commitments to overarching, fundamental moral norms (e.g., treat persons equally) in tension with varying commitments and obligations that originate from human experience and the unique bonding relationships found in environments such as the military.\(^3\) An intuition that need and urgency as sole criteria are unfair in the triage situation comes from of a sense of commitment to fellow soldiers and citizens. Arguably, there exists a natural inclination to help persons based on these non-medical factors, but the professional requirements of medicine in terms of justice and beneficence as outlined in this chapter hold highest the larger moral imperative of equal respect for persons.

Physicians affiliated with humanitarian groups often have less physical protection around them that can make political activism and impartial care a more daunting experience compared to military physicians. Some groups may retaliate against physicians in humanitarian groups for treating patients impartially, e.g., when a physician treats a patient of one faction in conflict with members of another proximate faction. Humanitarian organizations tend to be less “activist” (i.e., publicly denouncing human rights abuses) than human rights organizations, and the mandates of human rights groups often place humanitarian group physicians in moral quandaries as to their responsibilities in armed conflict situations.\(^3\) Different groups have different mandates as well. The ICRC participates in the process of forming international humanitarian law\(^5\) and making other agencies, governments, etc., aware of humanitarian crises\(^6\) but it is purposefully neutral in other ways as an “impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance.”\(^7\) Due to their neutrality, they likely conceive of themselves as maximizing the amount of care that they can provide in conflict situations in ways that other groups are often unable and perhaps more likely to not be kicked out of a country than more politically active groups.

Compared to the ICRC, MSF occasionally opts against political neutrality in hostile or conflict situations. The example of MSF in Rwanda, which I have already discussed, goes against a principal pillar of humanitarianism, but more accurately reflects the medical neutrality/political activism model for which I argue. For many MSF physicians (and indeed many other physicians in other groups), speaking out and acting out are inextricably linked so that protesting local human rights violations locally and abroad complements the provision of medically neutral care.\(^8\) The physical costs of speaking out are often tragic for physicians in any organization that speaks out. Retaliation from different factions has resulted in the deaths of many MSF aid workers,\(^9\) for example, including in the Darfur conflict most recently.\(^8\) Rather than remain neutral and silent about human rights abuses, MSF has occasionally withdrawn from volatile situations, (e.g., North Korea in 1998 and Ethiopia in 1985) a controversial move from a humanitarian perspective to be sure.\(^4\) My point here is to provide an example of the complexity and risks involved when physicians execute their multiple duties in the most extreme scenarios.

5. Conclusion

In this essay, I have argued that physicians are bound to practice medical neutrality in the provision of care on the basis of core ethical values of equal respect for all persons, beneficence, and justice. I then attempted to delineate the duty for physician political activism as a commitment to patients and as a moral value intrinsic to the profession of medicine. There exists a rich debate about whether physicians and organizations should be political neutral or activist and the impacts of such a choice, but I have argued that physicians have a duty to raise their voices against the disease of war in the most strategic and appropriate manner given their role as healers and public health professionals. Although different contracts impinge on the practice of medicine either through military, humanitarian, or human rights agency affiliation, I have attempted to make clear the universal ethical duties of physicians in armed conflict situations regarding medical neutrality and political activism.

MSF is an example of one group among others that, while juggling medical neutrality and political action, seems to model the moral argument of dual responsibilities to medical neutrality and political activism that I want to make for physicians practicing in armed conflict situations. In trying to connect ethical theory with public policy, I have sought to argue that the moral duty to provide medically neutral care may require calling upon other professional duties, such as political activism, in armed conflict. Speaking and acting out are inextricably linked and morally imperative when the overarching norms of respecting persons as equals in the medical setting and protecting populations from further harms can complement one another despite the risks in doing so.

Some argue that “the proper purpose of government may be served by dealing with rogues, liar, and cruel tyrants. That of medical organizations cannot be advanced on the same basis.”\(^2\) Prudentially, I agree that having different agents working simultaneously for a just distribution of goods—health, human rights, punishment, etc.—is ideal. Physicians, like many other health care professionals, often have a multitude of ethical dilemmas to mediate in medical settings even without armed conflict—they alone cannot stop genocide by their silence or in speaking out. They pay a price for doing so when other agents that could end war do not. Yet, my final conclusion is that physicians have primae facie professional obligations to provide impartial care and speak out against or report human rights abuses in order to promote public health and the reverence of life for each person in communities suffering the ravishes of armed conflict.

Endnotes

1. This paper was originally published in Fritz Allhoff (ed.), Physicians at War: The Dual-Loyalties Challenge (Dordrecht: Springer, 2008), 237-53.
2. I would like to thank Fritz Allhoff and Michael Gross for their valuable comments on earlier drafts. I also thank a fellow medical student, Saranya Kurapati, former national student coordinator for Physicians for Human Rights, for her comments. This essay is dedicated to the courageous physicians and health care workers who have paid with their lives trying to defend and restore health to the victims of armed conflicts around the world.
10. For a more thorough discussion of the calculus of triage, see Gerald R. Winslow, Triage and Justice (University of California Press, 1982).
17. For more discussion over the spectrum of professional activism see Wynia et al., "Medical Professionalism in Society."
42. Bortolotti, Hope in Hell: Inside the World of Doctors without Borders, 243.

References
Therapy

Anonymous

The following was submitted anonymously in response to the poem “Therapist” that appeared in the last issue. Further contributions to the thread are welcomed; any therapists out there who’d like to submit one titled “Patients” on the same format?

A path through the jungle
Dim light in a tunnel
That one sentence that ties
Past to a possible future
And you walk out the door
You’ve forgotten every word

The Real Flaws in the Stem Cell Research Enhancement Act

Yvette E. Pearson
Old Dominion University

Whether federal funding for human embryonic stem cell research (hESCR) should be expanded has been the subject of extensive public debate since President Bush announced in August 2001 that federal funds would be available only for research involving embryonic stem (ES) cell lines created prior to August 2001. Bush’s decree did not outlaw hESCR or the creation of new ES cell lines; instead, his policy strictly limited federal funding to research that would not require the destruction of additional human embryos. Consequently, funding for the creation of new ES cell lines and hESCR using unapproved ES cell lines is currently provided by private organizations and several state governments. Though hESCR is forging ahead without the approval and support of the federal government, some proponents of hESCR have expressed concern about “mounting evidence that American scientists are losing ground to other countries with less-restrictive policies,” and many, including Elias Zerhouni, director of the National Institutes of Health, are keen to alter federal policy to increase federal support for hESCR. At this early stage in the game, many scientists are concerned with figuring out whether hESCR itself will go anywhere and whether pursuing it will continue to be worthwhile. Many also believe that pursuing hESCR will shed light on the relative value of hESCR compared to other types...
of stem cell research, including research on somatic (“adult”) stem cells and, more recently, induced pluripotent stem (iPS) cells.

In an attempt to expand federal funding for hESCR, U.S. Congress passed the Stem Cell Research Enhancement Act of 2007 (SCREA). As expected, Bush vetoed SCREA. Unfortunately, however, the veto seemed to be based on Bush’s general opposition to the destruction of embryos rather than careful scrutiny of the text of the legislation. Indeed, there was little public discussion of the actual content of the bill. Instead, most of the discussion centered on the moral status of embryos and the usual “hESCR or bust” rhetoric—i.e., hESCR is our only and final opportunity to discover the means of eradicating incurable diseases—and accusing hESCR opponents of indifference to the suffering of others. SCREA had clearly assumed the moral permissibility of using blastocysts—at least those leftover from in vitro fertilization (IVF) attempts—for hESCR. Though nobody would deny the relevance of questions about the moral status of embryos, SCREA did not aim to sort through this complex issue. Those who believe that the destruction of blastocysts is morally wrong, regardless of the means, circumstances, and motive for creating them could reject the bill out of hand and thereby exclude themselves from further discussion of it. However, this still left many people at the table, including the IVF-leftovers-only group and those who also support the creation of embryos for the express purpose of hESCR. Still, the only scrutiny of the bill came from those who had dismissed themselves from the table through their opposition to the destruction of any blastocysts. A critical assessment of the bill by proponents of hESCR was conspicuously absent. Instead, the focus was on the obsolescence of current federal policy.

Though the expansion of federal funding for hESCR might be a good idea, it is not reasonable to pass just any bill that appears to support hESCR. Since I am not opposed to hESCR, my opposition to SCREA is not rooted in a desire to thwart progress in this area of research. Instead, my objections to SCREA have to do with the actual text of the bill, particularly §489D(b)(1)-(3), which is titled “Ethical Requirements.”

Given the persistent reassurance that Bush would veto the bill, one might have expected legislators to realize that they had nothing to lose by formulating and passing a more honest bill in favor of increased funding for hESCR. What would a more honest bill look like? First, it would not restrict funding to hESCR that uses embryos leftover from IVF attempts. Many proponents of hESCR have pointed out that, despite their abundance, IVF “leftovers,” will probably be neither adequate nor ideal for use in hESCR. Instead, the ideal blastocysts are those created using gametes of young, healthy donors under controlled laboratory conditions that will minimize the possibility of contamination and ensure high quality ES cell lines. To suggest, as the bill does, that the primary (or ideal) source of blastocysts for hESCR is or will be IVF leftovers is naive at best and at worst entirely dishonest. The use of IVF leftovers for hESCR while continuing to object to the creation of blastocysts for hESCR apparently makes some individuals feel better, but ascribing a different moral status to blastocysts initially created for IVF than those created for the sake of hESCR is problematic. Neither the means nor the motive for bringing blastocysts into existence determine their moral status, even if these factors will ultimately determine whether blastocysts develop into embryos, fetuses, children, or adults. Whatever the moral status of a blastocyst qua blastocyst, it is not determined by the manner in which it was created or the purpose for which it was created any more than a child created via IVF or somatic cell nuclear transfer (SCNT or “cloning”) has a different moral status from a child created the “old fashioned” way in virtue of its beginnings. If research that entails or benefits from the destruction of blastocysts is permissible, legislators should create a bill that permits federal funding for hESCR using blastocysts created expressly for that purpose instead of making dubious distinctions based on their origins.

A straightforward piece of legislation would also dispense with §489D(b)(1), which implies that the existence of leftover embryos is somehow beyond the control of those who create them. Currently, excess embryos are created deliberately in an attempt to minimize the numbers of times women have to undergo the arduous process of egg extraction. Provided patients are adequately informed that they may eventually be saddled with a decision whether to use, store, donate, or destroy remaining embryos, saving them the trauma of an additional round of hyper-ovulation and egg extraction is good practice. However, the emergence of companies such as StemLifeLine (SLL), which claims that using their service “to develop a personal stem cell line is like buying insurance for the future,” raises new concerns. SLL has been marketing its services directly to consumers via the Internet since May 2007, and they claim that they will work with fertility clinics and clients to create stem cell lines from their IVF leftovers. As Holm has pointed out, a fertility clinic can produce as many embryos as the supply of eggs allows, knowing that many of the embryos created will never be transferred to a woman’s uterus. A fertility clinic can make reasonable efforts to ensure that there will always be surplus embryos, but SCREA suggests that a surplus is merely an unintended byproduct of attempts to procreate via ARTs. Furthermore, if there is an incentive to create extra embryos—something collaboration with SLL would provide—it is virtually guaranteed that there will always be leftovers and quite likely that the number of leftover embryos will increase to advance the interests of fertility clinics. It is easy to imagine that fertility clinics might view their agreements with companies and institutions doing hESCR and other types of embryo research as an additional opportunity to increase their own profits. This is not intended as an indictment of all fertility doctors; instead, I am claiming that the opportunity to profit from embryo sales to hESCR labs may be very difficult to pass up. Given the summer 2007 reminder in the form of the delivery of two sets of sextuplets, it is easy to see that the lure of profit can sometimes induce moral myopia as well as poor medical judgment.

According to §498D(b)(2) of SCREA, embryo donation should not be considered until after “consultation with the individuals seeking fertility treatment, it was determined that the embryos would never be implanted in a woman and would otherwise be discarded.” It is a good idea to refrain from broaching the topic of embryo donation until after the couple has made final decisions regarding whether they intend to make further attempts to achieve a pregnancy via IVF, especially if the person with whom the consultation takes place is also their fertility doctor, because a couple desperate to have a child might be particularly vulnerable and susceptible to agree to just about anything if they believe—rationally or not—that it will improve their odds of ending up with a “take-home baby”. Nonetheless, this provision remains problematic not only because of the degree of control that doctors have over the number of embryos produced but also because of the dubious implication that patients in such circumstances are making a genuinely free choice. But for the arguably deliberate—though not necessarily ill-intentioned—creation of “surplus” embryos, the individual or couple would not be placed in a position where they are required to make the decision whether to freeze, donate, or discard their unused embryos. This scenario might be likened to the case of a barber giving a client a horrible haircut and then offering options regarding how one might deal with the unfortunate state of affairs (e.g., wear a hat for the next month,
shorten it, add hair extensions). Even if a person would not normally be inclined to shave her head, extreme dissatisfaction with the hideous haircut might lead her to opt to buzz it all off. Assisted reproductive technology (ART) patients would probably prefer not to be put in the position of having to make the decision with which they find themselves tasked.

Another significant problem with SCREA is in §498D(b)(3), which requires that “the individuals seeking fertility treatment donated the embryos with written informed consent and without receiving any financial or other inducements to make the donation.” First, there is a large and obvious loophole here, insofar as there is no prohibition against the fertility clinic director or individual doctors receiving “financial or other inducements” from a company like SLL to whom they might provide blastocysts. Second, since we are not yet sure where hESCR is going, it is not clear what would constitute genuine informed consent. Although people’s reasons for donating embryos for research vary, one of the reasons is that they want to do something useful or helpful with their spare embryos but think it irresponsible to permit an embryo to develop into a child with whom they would have no social relationship and under circumstances that would prevent them from ensuring that the child’s basic needs are met. So, instead of donating their spare embryos to be transferred into the uterus of an unknown woman, they choose to donate them for research in the hope that those suffering from diseases or impairments might benefit. As Holm points out, however, it is possible for hES cells to return to reproductive use through a number of means, including somatic cell nuclear transfer (SCNT), the creation of gametes, or tetraploid complementation (also known as “embryo rescue”). Without making embryo donors aware of these possibilities, consent to donate would not count as genuinely informed consent. Moreover, given Lyerly and Faden’s observations, if prospective donors are informed of the possibility of ES cells returning to reproductive capacity, patients’ willingness to donate embryos for hESCR would likely diminish. In addition to these concerns, there are many unknowns at this point regarding hESCR, which means that informed consent in this context is impossible, at least for the time being. Hence, while inserting an informed consent clause into SCREA is “bioethically correct,” it is farcical.

In addition to the foregoing concerns about the very possibility of informed consent in the context of emerging technologies like hESCR, Cohen points out that there are significant inconsistencies among current guidelines for obtaining informed consent from ART patients. In particular, she notes that the guidelines prescribed by the American Society of Reproductive Medicine (ASRM) for fertility doctors are inconsistent with the informed consent guidelines recommended for those conducting hESCR. For example, Cohen notes that ASRM guidelines require someone other than the ART doctor to broach the topic of embryo donation, while the National Academies of Science Guidelines for Human Embryonic Stem Cell Research imply that the ART doctor should be the one to obtain informed consent. Guidelines regarding whether or when ART doctors or researchers should discuss embryo donation with prospective donors and what information they should provide donors are also ambiguous. Problematically, however, SCREA assumes that clear informed consent procedures related to soliciting embryo donations are already in place.

I am not opposed to hESCR, nor am I a zealous proponent of the research. Most importantly, however, regardless of the benefits that might accrue from hESCR, our society should not support legislation like SCREA, which fails to offer substantial and consistent regulation of hESCR. Although SCREA seems to have been formulated based on post-August 2001 NIH guidelines, perhaps in an attempt to show some degree of solidarity with the Bush Administration, the NIH guidelines are inadequate insofar as they provide guidance only for the “prelude to hESCR.” As such, SCREA, like the NIH guidelines, fails to restrict the conduct of hESCR. At minimum, SCREA should have attempted to close gaps and resolve inconsistencies among existing regulations and guidelines related to hESCR. Without significant modifications, SCREA would not ensure ethically sound conduct of hESCR, as it addresses only the origin of stem cells and not how precisely they may be used. Given that hESCR will continue in the United States, regardless of the Bush administration’s opposition to it, it is important to implement federal regulations to govern hESCR so that we can avoid finding ourselves in a scenario that we might describe as “blastocysts gone bad.” Though regulations can be implemented without providing additional federal funding, the regulatory pill might be easier for the public to swallow if it is accompanied by increased federal support. Nearly thirty years ago, Leon Kass dismissed the “he who plays the piper picks the tune” rationale in favor of providing federal support for embryo research, convinced that government regulation was not required to ensure a “sensible practice of in vitro experimentation.” His assessment appears to have been mistaken. We are currently reaping the consequences of a refusal to provide federal funding and oversight of IVF-related embryo research with the current state of our ART industry, which some have referred to as the “wild west of medicine.” We should heed the lessons of the past and implement regulations governing hESCR. If the expansion of federal funding is likely to reinvigorate the implementation of adequate regulation of hESCR, then legislators should pursue it in a straightforward fashion, keeping in mind that practices and policy are products “not only of what people and institutions do but also of what they do not do.”

Endnotes

1. Technically, five-day, approximately 200-cell blastocysts or “pre-embryos,” not full-fledged embryos, are destroyed for the purpose of embryonic stem cell research, but the word “embryo” is often used as shorthand in discussions of hESCR to refer to pre-embryos, including blastocysts as well as the products of IVF, which are often frozen prior to the blastocyst stage.


11. Lyerly and Faden, 47.
12. Lyerly and Faden, 47.
14. Lyerly and Faden, 47.
15. Cohen, 203-06.
17. Cohen, 199.

**Commentary on “The Real Flaws in the Stem Cell Research Enhancement Act”**

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While the Stem Cell Research Enhancement Act (SCREA) was ultimately vetoed by President George Bush, examining the bill can shed light on the ethical concerns and impacts of human embryonic stem cell research (hESCR). In her essay “The Real Flaws in the Stem Cell Research Enhancement Act” Yvette Pearson argues some important ethical aspects have been overlooked by proponents of hESCR and should have been addressed before advocating SCREA. Pearson overall is right to point out morally significant facts and nuances of hESCR and certainly not just any bill that appears to support hESCR should be advocated. However, there are further important ethical concerns that also need to be addressed. Before explaining additional moral features that need to be considered, it is worthwhile to at least briefly account for what Pearson puts forth to be part of the moral issue in the bill.

Pearson correctly points out that SCREA focuses on embryos from leftover *in vitro* fertilization (IVF) attempts. This ethical aspect of the bill she indicates dismisses embryos created specifically for the purpose of research which are actually considered more ideal since they could be “gametes of young, healthy donors under controlled laboratory conditions that will minimize the possibility of contamination and ensure high quality of the ES cell line.” Pearson also wants to emphasize that the SCREA is not an honest bill in part because of this and that an honest bill “would not restrict funding to hESCR that uses embryos leftover from IVF attempts.” She argues the bill instead should permit funding for not only those blastocysts arising from IVF attempts but also blastocysts created explicitly for that purpose.

Her reasoning here is partially based on the ethical consideration of blastocysts. While Pearson does not go into what the moral status of a blastocyst may be, she emphasizes “neither the means nor motive” for creating blastocysts should affect their moral status. If it is determined that a blastocyst can be destroyed for the purpose of hESCR, then legislation should not make an artificial distinction of blastocysts such as why the blastocysts were created or by what means. Although here I believe there are some additional moral aspects that Pearson should consider. First is that even if the moral status of a blastocyst is not in question, choosing blastocysts to be discarded from IVF may be morally preferable to creating blastocysts specifically for research purposes. Granted there are scientific reasons to prefer blastocysts created with hESCR in mind. However, potential moral issues Pearson mentions that arise for IVF blastocysts could be far worse when creating blastocysts for research purposes only.

For instance, she mentions the issue of informed consent of donors is difficult given the current state of hESCR and the unpredictability of outcomes for the donated gametmes. If it is granted that IVF patients may have difficulty consenting for their discarded embryos, this would be far worse for those only donating for the purpose of research. Issues Pearson also raises with regard to possible financial motives of those who would be illiciting consent such as a medical professional in IVF cases. Yet this would also be further problematized if the only motivation was financial when getting consent from someone only donating for research purposes let alone the additional question of the motivation of the donor. So the same moral exploitive potential mentioned for IVF cases would also affect research blastocysts to the same extent if not more so.

Probably even more significant is the basic fact that the IVF embryos would otherwise be destroyed if not used for hESCR. Conversely research embryos simply would not exist but for the desire to create them for the ends of hESCR. As mentioned previously, Pearson focuses on the idea that the moral status of blastocysts should not differ based on “neither means nor ends.” But it may not be the moral status of the embryos that makes the moral difference for many people.

In general it seems *prima facie* morally preferable to destroy blastocysts for research that were already going to be destroyed then to create blastocysts specifically to be destroyed. Perhaps this seems just to be an argument based on responsible use of resources so as to merely not be wasteful. Yet there is also the Kantian line of argumentation which would point out if say a blastocyst was given the moral status of at least potential personhood one should not treat them as a means merely by creating blastocysts only for the purposes of research. Using the IVF blastocysts, however, would be more likely to avoid this since the purpose behind their creation was procreative.

Certainly if blastocysts are to be preserved due to their moral status then they should not be destroyed whether an IVF blastocyst or a research-only blastocyst. But the converse is not necessarily the case, even if one blastocyst is deemed to be permissible to destroy one cannot therefore conclude that all blastocysts can be destroyed. It is also important to note that the moral status of blastocysts is indeterminate for many and that this gives some people reason to prefer simply using IVF blastocysts that will be discarded anyway rather than creating more blastocysts.

I agree with Pearson that the reason for creating blastocysts or the purpose for a blastocyst does not affect a blastocyst’s moral status, and that any hESCR legislation that is passed should take this into consideration. It is the fact that the reason for creating blastocysts and the ends for which blastocysts are to be used are significant moral aspects that makes IVF blastocysts still preferable even if blastocysts are all given the same moral status. Hopefully any future legislation similar to SCREA will not only give thought to the moral status of blastocysts but also address the concerns Pearson raises with distinct consideration to the source of blastocysts whether from IVF or specifically for research as well as other important issues such as informed consent.