

MILITARY MEDICAL ETHICS

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SECTION IV: MEDICAL ETHICS IN THE MILITARY

Section Editor:

THOMAS E. BEAM, MD

Formerly Director, Borden Institute

Formerly, Medical Ethics Consultant to The Surgeon General, United States Army



Robert Benney

Shock Tent

circa World War II

Art: Courtesy of Army Art Collection, US Army Center of Military History, Washington, DC.

Chapter 13

MEDICAL ETHICS ON THE BATTLEFIELD: THE CRUCIBLE OF MILITARY MEDICAL ETHICS

THOMAS E. BEAM, MD^{*}

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^{*}Colonel (Retired), Medical Corps, United States Army; formerly, Director, Borden Institute, Walter Reed Army Medical Center, Washington, DC 20307-5001 and Medical Ethics Consultant to The Surgeon General, United States Army; formerly, Director, Operating Room, 28th Combat Support Hospital (deployed to Saudi Arabia and Iraq, Persian Gulf War)



Robert Benney

The Battle of the Caves

Anzio, 1944

The painting depicts battlefield medicine in the Mediterranean theater in World War II. These soldiers, with their wounded and medical assets, have taken a position in a cave. The medical corpsman is doing the best he can for his patient in the chaos and close quarters of the battle.

Art: Courtesy of Army Art Collection, US Army Center of Military History, Washington, DC. Available at: <http://www.armymedicine.army.mil/history/art/mto.htm>.

INTRODUCTION

All members of the healthcare team, whether civilian or military, confront ethical challenges on a daily basis and feel some of those tensions as they go about their jobs. During peacetime, military health professionals see the same issues as do their civilian colleagues, although day-to-day military medicine presents some additional ethical challenges due to the issues raised by mixed agency, which is the problem of divided loyalties discussed previously by Howe in Chapter 12, *Mixed Agency in Military Medicine: Ethical Roles in Conflict*. However, it is on the battlefield that the greatest ethical dilemmas arise. The mixed agency issues are accentuated on the battlefield because the physician has a legal obligation to place the interests of society (and the military mission of protecting and defending that society) above those of the soldier. There are simply no comparable situations in the civilian sector, despite frequent comparisons to inner-city emergency rooms on “any Saturday night,” because the weaponry, circumstances, and participants are so different in combat.

This chapter will examine the elevated stress of the battlefield, the moral dilemmas encountered there, and the unique situations in which military medical personnel must function. The military physician must consider return-to-duty issues that, perhaps more than any other, exemplify the essence of mixed agency. Battlefield triage will be examined and models will be presented. The especially difficult issue of battlefield euthanasia will be extensively explored. The chapter will also visit the participation of physicians in the interrogation of prisoners of war. As is evident from these topics, the battlefield confronts the medical professional with a variety of profound ethical challenges.

Indeed, it is impossible to imagine a more challenging environment in which to practice medicine than on the battlefield. It is the antithesis of the ideal medical setting. It is violent. It is noisy. It is chaotic. It is in constant flux. And it is unpredictable. Lack of creature comforts is the least of the problems faced. Noise levels prevent normal aspects of patient care (Figure 13-1). Rapid movement, often on little or no advance notice, requires treatment facilities to be set up and taken down very quickly. Patients can arrive before preparations are completed. Medical personnel, as well as patients, suffer from the fatigue and filth (Figure 13-2).

There are also unique moral dilemmas involved in decisions on the battlefield, decisions that may have to be made in the midst of a violent and cha-

otic scene. Added to the unpredictable nature of the battlefield will be the predictable constraints necessitated by the logistics of combat. There will be very limited medical resources on the battlefield. For the modern battlefield, medical personnel will carry their initial supplies, including medications, with them. There will be uncertainty of resupply.¹ In these circumstances, medical personnel will be unable to expend large amounts of IV fluid or blood (or potentially even antibiotics or pain medications) on any single casualty.

The plan for rapid evacuation of casualties from the battlefield to hospitals to the rear also may be difficult to implement.² Successful evacuation depends on air superiority, numbers of wounded not exceeding capability to transport them, and a generally favorable flow of battle. If the battle is going against US forces, it is less likely that air superiority will have been achieved, that air assets will be employed to transport wounded, or that these air assets will be able to safely get to the forward facilities to provide the evacuation spaces. In this fluid battlefield, it is not at all unlikely that the enemy will overrun some forward hospitals and capture medical personnel.

Although captured medical personnel are afforded certain rights by the Geneva Conventions,³ (including the opportunity to continue to treat their wounded prisoners of war, relief from other duties in a prisoner of war [POW] camp, and their rapid repatriation as soon as their medical duties are reasonably completed), it is not at all certain that all



Fig. 13-1. This mass casualty situation occurred following a helicopter crash during Operation Desert Shield in 1990. It shows the chaos and resulting noise that often accompany this kind of event.

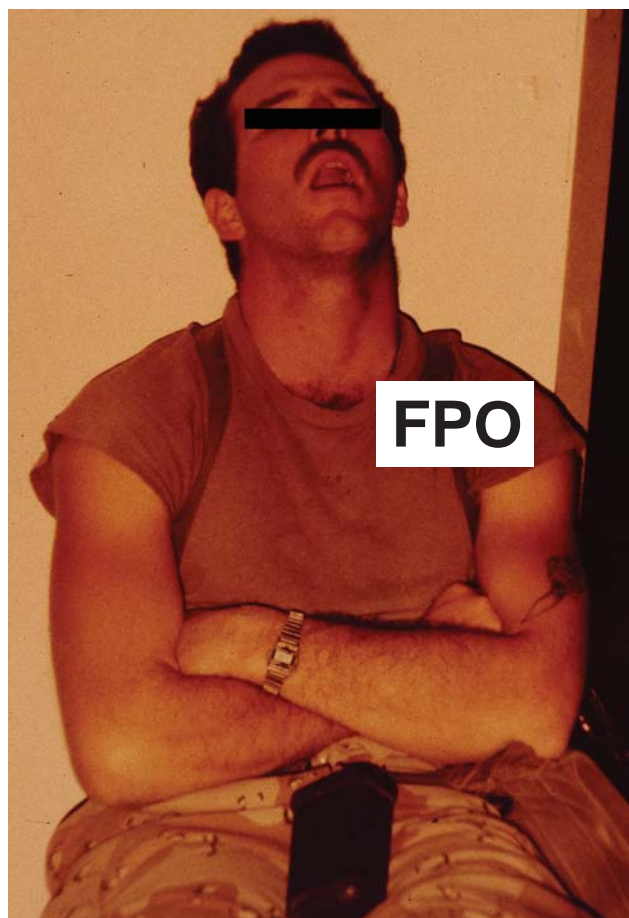


Fig. 13-2. This paraprofessional member of the 28th Combat Support Hospital during combat operations in Iraq (Operation Desert Storm, 1991) shows the effects of fatigue and lack of time for personal hygiene. Events leading to his exhaustion involved protracted convoy operations into Iraq and immediate establishment of the hospital, which was followed by continuous treatment of war casualties for more than 72 hours.

enemies will respect these accords. This, therefore, places the medical personnel in the position of not knowing how they would be treated if captured. This uncertainty might also affect how they react

RETURN TO DUTY CONSIDERATIONS IN A THEATER OF OPERATIONS

A tension that is faced by nearly all deployed physicians is the issue of returning a minimally injured patient, or one suffering from combat stress reaction, to combat. This includes the issue of conflicting duties to the individual patient as well as to the line commander (mixed agency), which have been discussed in detail by Howe in Chapter 12.

to an enemy encounter. This is particularly acute in the morass of misinformation typically associated with armed conflict. Often the atrocities attributed to the enemy are exaggerated and embellished. Nonetheless, there is occasionally accurate cause for concern, because noncombatants have been killed or otherwise mistreated and not afforded their rights under the Geneva Conventions.

Triage issues involving priorities in treating US troops, allies, local civilian population, and enemy troops further heighten the difficulties experienced. In addition, line commanders may request the use of medical evacuation assets to remove troops killed in action (KIA) from the battlefield. This will obviously create difficulty for medical personnel attempting to clear the area of wounded. Moral dilemmas also arise in considering euthanasia on the battlefield, participation in interrogation of prisoners of war, and utilization of medical knowledge to achieve a political end or to extract information from an enemy soldier. Issues also arise when one is in command of a unit,⁴ which heighten the issues of mixed agency, as addressed by Howe in Chapter 12. Facing all of these issues at the same time may prove too great a stress for medical personnel. Decisions that are made while experiencing this stress and facing these uncertainties may not be the ones made if one had the time to carefully weigh and evaluate all factors. It is imperative, therefore, for all military healthcare professionals to consider these issues prior to actually being in the “heat of battle.” Pulling a few rotations through a Saturday night emergency room is in no way comparable to the battlefield, nor an adequate substitute for training purposes.

First, and foremost, is the issue of the soldier as a component of a team, rather than as an individual, and therefore the question of returning him to duty. In most civilian medical contexts, the patient’s job responsibilities are not usually the determining factor in recommending medical treatment. In the military, particularly on the battlefield, the soldier-patient’s team responsibilities may, however, assume primary importance.

There are, however, other very difficult issues of balancing the medical indications for treating the injuries or combat stress reaction at the first available medical treatment facility in an attempt to maximize the good done for the individual patient and his or her organization, while also recognizing that some patients may desire evacuation.

Getting Minimally Wounded Soldiers Back to Duty

This concern can occur in the sick or minimally wounded soldier who presents for care. The physician may experience internal conflict between a desire to protect the patient from additional trauma and the duty to support the needs of the command. This is the classic mixed agency issue. The line commander may need to have this particular soldier, with his specific skills, back to continue to fight. In addition, allowing him to avoid combat is antithetical to the concept of justice—treating similar persons in a similar manner. If one soldier is allowed to leave the theater, this will force another soldier to assume his responsibilities, thereby causing an inequity of duties. It is also likely that the remaining soldiers will be exposed to greater risk due to the loss of a member of the unit, and the likelihood of any one of the remaining soldiers becoming a casualty is greater.

A greater harm may occur if it becomes well known that minimal injuries or a mild illness is the “ticket” home. There may be an avalanche effect on other members of the unit that would greatly affect the combat readiness of the command, far more than just the individual soldier’s presence or absence from the battle. This is referred to as the “floodgate phenomenon” and can render an entire unit ineffective for combat. If this were to occur, the ultimate outcome of the battle, or even the war, could be in jeopardy and many more casualties could follow. This knowledge may help strengthen the resolve of the physician in dealing with the soldier who is minimally wounded or appears to be a combat stress casualty. However, if this same patient is brought in again with serious wounds or is killed in action, the physician certainly may feel some sense of guilt for the patient’s injury or death. An even more difficult situation might arise if these wounds were self-inflicted. In this case, the physician would very likely feel personally responsible for the soldier’s death or injury. This would almost certainly affect future return to duty decisions made by this physician. It is impossible to resolve this issue without significant preliminary thought and evaluation. Even with the most optimal support and proactive approach, this tension may lead to an inability to continue to provide care and the physician may become a psychological casualty himself.

Combat Stress Disorder

One of the areas where issues other than pure mixed agency operate is in combat stress disorder.

Clearly, under current Army doctrine⁵ the earliest and closest treatment is in the patient’s best interest. The concept of beneficence would mandate this course of action. During World War I and World War II, for instance, it was noted that soldiers experiencing combat stress reaction could often be returned to combat in 24 to 48 hours, if they were appropriately evaluated and treated when they appeared at the aid stations. A reassuring “chat” with the physician or mental health professional, in which it was noted that theirs was a normal response to the horrors of war, was key. In addition, soldiers were provided, when possible, with a shower and “three hots and a cot” (three hot meals and a cot for sleeping). This approach came to be known as PIES (proximity to the battlefield; immediacy of intervention after symptom onset; expectancy of recovery to full duty capability; and simplicity of treatment).⁶ The history, development, and application of these principles is fully explored in *Military Psychiatry: Preparing in Peace for War*⁷ and *War Psychiatry*.⁸

However, if the patient is considered to have full capacity for making decisions and indicates an unwillingness to return to combat despite a PIES intervention, the response might be to allow that patient to participate in making those decisions, including the decision to be removed from the battlefield. In time of conflict, this may have a negative effect on both the patient and the physician. The patient likely will be subjected to a court-martial for refusing to return to duty. The physician may also be subjected to disciplinary proceedings for his actions. In addition, it is likely to have very negative effects on unit morale and may also contribute to an evacuation syndrome in which numerous other soldiers present with the same complaints.

In the guise of respecting the patient’s autonomy, the physician may be tempted to diagnose the patient as having a more serious psychological disorder and to medically evacuate him from the theater. This course of action contains its own pitfalls. Although it “protects” a patient either from further combat or from the legal ramifications of refusal to fight, it carries an extreme psychological price tag.

During Vietnam, for example, many physicians, including psychiatrists, inappropriately evacuated casualties, especially during the latter stages of the conflict when the Vietnamization policy (letting the Vietnamese fight their own war, thus minimizing American casualties) was put in place. Many of these soldiers developed psychological sequelae as a result of the questionable circumstances of their

premature departure from their fellow soldiers. This psychological morbidity is due to the soldier-patient's self-perception of failure or his feelings of guilt at having his comrades injured or killed while he has "escaped."^{9(p119)} This can lead to conflict within the physician, who may feel uneasy in his paternalistic role of "knowing" that he is treating the casualty with the "four Rs" (reassure, rest, replenish, and restore confidence) even if the soldier consistently and apparently rationally requests evacuation.

Army doctrine stresses the need to override these soldier requests to be removed from combat. As long as the soldier has not committed "serious misconduct," the soldier will best respond to treatment in proximity to his unit with the full expectation that he will return to the unit. Therefore, in this situation, the ethical dilemma is not only that of mixed agency but also the conflicting principles of beneficence (weak paternalism) and respect for the patient's autonomy.

A related issue is whether the patient with combat stress reaction is able to be fully autonomous. If it is possible to declare this patient at least temporarily incapable of participating in decisions, it greatly relieves this tension. The patient who is in the acute phase of a serious combat stress reaction is unlikely to be able to process all information and details well and may be incapable of participating in decision making, at least for that short interval until he responds to treatment.

A more difficult issue would be a patient who continues to request evacuation, even after the expected brief course of "therapy." Is the physician justified in this circumstance in returning the soldier to his unit over the soldier's expressed and continued desire? Should the benefit from the expected ultimate response to the doctrinally correct expectancy of treatment determine the appropriateness of overriding those wishes? How does the physician balance these seemingly exclusive courses of action? How autonomous is a soldier who is being sent into battle? Not very. Clearly the very fact that this person is being *ordered* to participate in combat raises a serious question of his being truly autonomous. The best response may be to attempt, as far as is possible, to respect the somewhat limited autonomy of the person, while understanding that as a soldier, by his implicit acceptance of his role, he has given up a portion of his right to be fully autonomous.

An additional stressor for the physician is the knowledge that if returned to his unit, the soldier may be injured or killed. This can be extremely difficult for the physician to accept. He is likely to

question if it is better to be severely wounded or killed or to go through life with the psychological morbidity following an improperly treated combat stress reaction. Would this patient have been better served by allowing him to be medically evacuated or to have been counseled to seek administrative return from the theater? Is it better to undergo a court martial and to be punished judicially (recognizing that he would be very unlikely to receive the death penalty) but to be physically intact and able to go about his life. It is truly difficult, if not impossible to generalize these decisions, but rather it is better to attempt to elucidate the principles and identify the morally relevant criteria for decision making.

"Preserve the Fighting Strength"

In the previous edition of the Army's medical doctrinal manual, FM 8-55,¹⁰ *Planning for Health Service Support*, the return of soldiers to duty was given high priority (Exhibit 13-1). This is congruent with the AMEDD (Army Medical Department) motto, "Preserve the Fighting Strength," especially if the primary role of a physician is interpreted as supporting the command, possibly at the expense of the individual patient. However, in the most recent edition of FM (Field Manual) 8-55,¹¹ medical battlefield rules are presented (Exhibit 13-2). In this schema, return to duty is in last place. Of greater importance are keeping a medical presence with the soldier, keeping the command healthy, and saving lives. Even providing "state of the art care" is ranked above returning soldiers to duty.

This shift in priorities places the needs of the individual soldier ahead of the duties to the command. It must be noted, however, that the 1994 version of FM 8-55 indicates that this listing of priorities is provided in the context of assisting physicians when priorities are in conflict, specifically in the realm of designing and coordinating health service support (HSS) operations. Although this ranking is, perhaps, conducive to a more comfortable position for many physicians, it does somewhat blur the role-specific duty of the military physician to the command and to the overall mission as discussed by Howe in Chapter 12.

Informed Consent

On the battlefield, it is unlikely that truly informed consent can be obtained. The model for the soldier before he is wounded is certainly not one of informed consent, which could be summarized as:

EXHIBIT 13-1

RETURN-TO-DUTY CONSIDERATIONS DURING THE COLD WAR

The 1985 edition of Army Field Manual 8-55, *Planning for Health Service Support*, discussed the battlefield scenarios expected in a conflict with the former Soviet Union. The following excerpts are provided to give the reader a sense of the climate at that time for medical service providers.

PREFACE

This manual provides guidance to health service support (HSS) planners at all levels within a theater of operations (TO). It presents the basic steps associated with planning: principles of planning, the staff estimate process, and base development. It includes rates and experience factors used in planning. The manual then addresses planning for HSS centered around nine essential functions. The nine functions are evacuation; hospitalization; health service logistics; medical laboratory services; blood management; dental services; veterinary services; preventive medicine services; and command, control, and communications. Using this process will insure a complete and coordinated HSS plan. This plan will ultimately result in the effective delivery of health care and the efficient use of scarce resources.

* * * * *

Section I. THE AIRLAND BATTLE CONCEPT

1.1. General

The Army's basic concept is AirLand Battle....It emphasizes success on the modern battlefield centered around four basic tenets: initiative, depth, agility, and synchronization. These tenets will apply wherever we face an echeloned force built on the Soviet model or in other military operations anywhere in the world.

* * * * *

1.3. General

Health Service support plays a key role in developing and maintaining combat power. This fact was recognized by Major Jonathan Letterman, Surgeon of the Army of the Potomac during the Civil War. He noted:

"A corps of Medical officers was not established solely for the purpose of attending the wounded and sick; ... the labors of medical officers cover a more extended field. The leading idea, which should be constantly kept in view, is to strengthen the hands of the Commanding General by keeping his army in the most vigorous health, thus rendering it, in the highest degree, efficient for enduring fatigue and privation [*sic*], and for fighting. In this view, the duties of such a corps are of vital importance to the success of any army, and commanders seldom appreciate the full effect of their proper fulfilment [*sic*]."

1.4. Planning for HSS

In the AirLand Battle, the extended battlefield stretches HSS capability to the maximum. It presents an unprecedented challenge to the health service support planner as well as to the tactical commander who is charged with fighting the battle. While the *responsibility* for what is done and what is not done is the commander's alone, he must rely on his staff and his subordinate commanders to execute his decisions. He must also look to his HSS planners and medical commanders to anticipate his plans and decisions so that they may continue to sustain his command in the absence of orders and communications....

* * * * *

1.5 FOCUS OF HEALTH SERVICE SUPPORT

As previously stated, the AirLand Battle offers significant challenges to the tactical commander and the health service support planner. As the battlefield becomes increasingly lethal, sus-

(Exhibit 13-1 continues)

Exhibit 13-1 *continued*

taining the health of the fighting forces, long a role of the US Army Medical Department, becomes a critical factor in the success or failure of friendly forces. Proper planning enhances the capability of medical units to provide effective HSS and ultimately increases the chances for survival of the soldier on the battlefield. Forward support describes the character that health service support must assume. Thus, the focus of the thrust of HSS is to maximize the return-to-duty rate to conserve the human component of the combat commander's weapons system.

Source: US Department of the Army. *Planning for Health Service Support*. Washington, DC: DA; 15 February 1985. Field Manual 8-55: 1-1-1-5.

You are requested to take that hill. If you do, you will subject yourself to enemy machine gun fire. You may be killed or wounded. If you do not charge that hill, you may be subjected to the ridicule of your comrades and may even be tried under military law and possibly sentenced to death.

Of course this isn't the appropriate time or the place for informed consent. The soldier is *ordered* to "take that hill," and that is that.

The physician, as well, will not be able to comply with the ideal of informed consent. For truly informed consent to occur, the patient must be free of coercion, be capable of understanding the courses of action available, and be free to act on the decision.^{12(p143)} In combat there are forces that are coercive to the patient in making his decision, including limited supplies, limited personnel for providing care, limited evacuation assets, and the possibility of enemy action. The patient will suffer from all the same difficulties in understanding the courses of action as do civilian patients in an elective setting, but will have the additional difficulties seen in any emergency situation compounded by the exigencies of combat. In addition, he will very possibly not be freely able to act on his request. It truly may not be available to him. If the patient requests evacuation and no assets are available, or if supplying them would compromise the mission, this course of action is not really available to him. If the patient desires a surgical operation in an environment that is not potentially contaminated, has no chance of enemy action during the procedure, and a guarantee that he will not be moved during his convalescence, this will also be unavailable to him. Again, the best to hope for is that there will be some semblance of informed consent offered to the wounded, but it will be clearly far less than that expected in the civilian sector, or in the military during peacetime.

Beneficence for the Soldier in Combat

Beneficence for the individual is a hallmark of care in the civilian arena.^{12(p260)} It generally translates into the military arena, although it may have to be altered due to circumstances on the battlefield. Although the desired action might be to do everything possible for the individual patient, including protecting him from any potential harm, this may not be possible in many situations. On the battlefield, it is difficult to determine exactly what is the beneficent action. Sometimes the action that seems most likely to help the patient may, on further reflection (or in retrospect), be exactly the worst decision for him. Sometimes the patient is better off with his unit, even if this may place him at further risk for injury. There are significant benefits from the unit cohesiveness and support he may derive from his comrades.

It is also possible that the soldier may not request appropriate care (or may choose inappropriate care) based on his impression that this may improve his chances of being removed from the dangerous situation. In a case such as this, there may be justification for an increased amount of paternalism, particularly if the requested course will limit the soldier's combat effectiveness. The decision to treat the soldier, potentially against his wishes, is one that concerns all physicians in uniform. However, it should rarely arise except in combat or in situations requiring advance preparation for combat such as the current anthrax and smallpox vaccination programs. Although the option to treat without consent is available to the military physician through the chain of command,¹³ it is not usually exercised. The reasons for this option being infrequently exercised are explored more fully in Chapter 27, A Proposed Ethic for Military Medicine. In peacetime military medical care, the paradigm is essentially that of the civilian model during normal operation,

EXHIBIT 13-2

MEDICAL BATTLEFIELD RULES

The 1994 edition of Army Field Manual (FM) 8-55, *Planning for Health Service Support*, explains the medical battlefield rules, and reflects the impact of the breakup of the former Soviet Union. The United States is the sole remaining superpower in a world in which, at least for the foreseeable future, its military will more likely deploy to “operations other than war,” rather than total combat. The 1994 edition of FM 8-55 provides additional guidance to help the military medical professional resolve system conflicts when they arise. This allows the professional a greater exercise of autonomy than seen in previous editions of this FM.

PREFACE

This manual provides guidance to health service support (HSS) planners at all echelons of care within a theater of operations (TO). It contains a digest of the accepted principles and procedures pertaining to HSS planning. Information in this publication is applicable across the spectrum of military operations. It is compatible with the Army’s combat service support (CSS) doctrine.

....

1.1. The Army’s Keystone Doctrine

Field Manual 100-5, the Army’s keystone doctrinal manual, describes how the Army thinks about the conduct of operations. It is a condensed expression of the Army’s participation in diverse environments in terms of what the forces does in operations other than war (OOTW) and how the Army conducts war.

1.2. Range of Military Operations

- a. The US seeks to achieve its strategic aims in three diverse environments.
 - (1) *Peacetime*. During peacetime, the US attempts to influence world events through those actions which routinely occur between nations....
 - (2) *Conflict*. Conflict is characterized by confrontation and the need to engage in hostilities short of war to secure strategic objectives. Although the American people, our government, and the US Army prefer peace, hostile forces may seek to provoke a crisis or otherwise defeat our purpose of deterring war by creating a conflict. At the point where diplomatic influence alone fails to resolve the conflict, persuasion may be required, and the US could enter a more intense environment in which it uses the military to pursue its aim.

NOTE

The Army classifies its activities during peacetime and conflict as OOTW.

- (3) *War*. The most violent and high-risk environment is that of war, with its associated combat operations.

....

1-4. Need for a Health Service Support System

- a. The dynamics of our global responsibilities require a HSS system that is flexible to support the diversity of operations.
- b. Providing comprehensive HSS to Army operations requires continuous planning and synchronization of a fully integrated and cohesive HSS system. The system must be responsive and effective across the full range of possible operations. Medical unit commanders and HSS planners must be proactive in changing situations, applying the medical battlefield rules as the situation requires.

1-5. Medical Battlefield Rules:

- a. The Health Service Support (HSS) planner and operator applies the following rules, in order of precedence, when priorities are in conflict:
 - (1) Maintain medical presence with the soldier.
 - (2) Maintain the health of the command.
 - (3) Save lives.

(Exhibit 13-2 continues)

Exhibit 13-2 *continued*

- (4) Clear the battlefield.
 - (5) Provide state-of-the-art care.
 - (6) Return soldiers to duty as early as possible.
- b. These rules are intended to guide the HSS planner to resolve system conflicts encountered in designing and coordinating HSS operations. Although medical personnel seek always to provide the full scope of HSS in the best manner possible, during every combat operation there are inherent possibilities of conflicting support requirements. The planner or operator applies these rules to ensure that the conflicts of HSS are resolved appropriately.
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- d. By way of illustration, consider a rapid assault of short duration where the composition of the task force precludes deployment of a definitive medical care facility. A medical support conflict now arises between supporting the commander's intent and providing optimal care to the soldiers. The conflict can be resolved appropriately by applying the battlefield rules. Planners must increase the medical presence with the soldiers to resuscitate casualties and maintain stabilization pending evacuation. Greater reliance on forward medical presence compensates for the inability to employ hospitals near the battlefield, supports the commanders' intent, and still provides the patient with state-of-the-art medical care within the limitations imposed by the battlefield. The battlefield rules are thereby used as a means of conflict resolution.

Source: US Department of the Army. *Planning for Health Service Support*. Washington, DC: DA; 9 September 1994. Field Manual 8-55: 1-1-1-3.

in that both strive to return the patient to full health. Patients are involved in their own care decisions and their wishes are typically respected. If a patient decision, however, will prevent the soldier from continuing his military service, he is informed of this. The patient will typically then have the option of deciding what course his medical care will take and if this would preclude further military service, the soldier may be administratively separated from the military.¹⁴ In combat, however, this decision may rest on factors outside the control of the patient or even of the physician. There are policies or procedures that will be enforced over their wishes. This is based on federal statutes, including USC (United States Code) 10,¹⁵ in which the Secretary of the Army has the option to direct medical treatment of soldiers, without their consent if necessary. These statutes were generated by the requirements society legitimately places on those in the military, who are charged with protecting the society and its founding principles as outlined in the US Constitution.

An example of this occurred during the Persian Gulf War when US servicemembers were directed to take pyridostigmine bromide (PB) as a pretreatment against nerve agent exposure. This decision was made based upon intelligence information that the threat of nerve agent use by Iraq was very high and experimental evidence that there was benefit to individuals by reversibly binding the acetylcholinesterase receptors by PB, rather than irreversibly binding by

nerve agent. It was recognized that there could be side effects to PB and that there may be soldiers who would "autonomously" decide to not take PB, but the decision was made both from an individual beneficence position ("The military has a duty to take all available reasonable actions to protect its members.") as well as from a mission accomplishment position ("If this soldier becomes a chemical casualty, he, and potentially other soldiers caring for him, will become ineffective for combat."). A nonmedical analogy is that of ordering soldiers to wear chemical protective overgarments and Kevlar body armor, even in hot environments with the concomitant risk of heat injury, to help protect them from true or perceived harm. The individual soldier does not have autonomy to make decisions about the battle uniform and may not have autonomy in this case (regarding taking PB) as well.

Enforced Treatment for Individual Soldiers

In deciding in favor of enforced treatment for soldiers, it is important to have an ethical basis for one's decision. Factors that have moral weight include beneficence to the individual soldier, duties to the other soldiers in the unit, duties to the command, and duties to society. Arguments against paternalistic treatment of soldiers would include attempts to preserve the autonomy of the soldier, concerns for abuses of the practice, questions of the intent, and potential violations of international law.

Arguments for Enforced Treatment

In examining beneficence, which at least at the surface seems to be in conflict with autonomy, it is important to look carefully at obligations implied to the individual. When an individual enters the military (currently as a volunteer because there is no draft in effect) the military makes an implicit promise to give the soldier the best medical support this country is able to provide. This promise is made with the understanding that it is extremely important for soldiers to feel they are able to risk injury in the course of their duties. Soldiers fear injury and disability much more than they fear death, an outcome toward which they typically have a fatalistic attitude.¹⁶ If the military has made an implicit promise that the best care is available, does this automatically lead to the assumption that this care should universally be applied in all situations to all soldiers? Arguments in favor of this presumption would, of necessity, be based on the paternalistic notion that the military knows what is best for all individuals. This is not a foreign concept to those in the armed forces because there are many examples seen in the daily lives of soldiers (eg, mandatory changes of socks, mandatory canteen checks, and vaccinations prior to deployment). It is a basic tenet among line officers that there are some things that the command must (and will) decide for everyone within the command. This is not only perceived to be necessary for preserving the fighting strength of the personnel within the command to allow for the mission to be accomplished, but is also perceived as the obligation of the command to the well-being of its people. The use of experts in various areas to allow the commander to make decisions for his entire command and the hierarchical structure of the military foster this line of reasoning. It may be necessary for the command to maintain overall control of these decisions and for the physician, as a member of the command structure, to treat soldiers involuntarily.

The military also has a very strong obligation to the other members in the unit. If one individual can refuse treatment, and in so doing increases his chances of becoming a casualty, this has serious implications on the other members within that unit. They would be required to assist in his evacuation, if he is injured or becomes ill, or in the recovery of his body, if he is killed. There is certainly a risk involved in these activities as other soldiers may be injured or killed attempting to assist a fallen comrade. It is also apparent that if the soldier is incapacitated and unable to perform his portion of the

mission, his duties will fall to some other member of the unit. If his role in the operation is not performed, the safety of the individuals on his right or left is compromised. The likelihood of their becoming casualties is increased. This can have a snowballing effect on the well-being of the entire unit. This strongly favors enforced treatment.

There is also a duty to the command, both on the part of the individual soldier as well as on the physician. On the part of the soldier, he has sworn an oath to obey the lawful orders of those in positions over him, as has the physician,¹⁷ and thereby he is required to submit to the decisions of his commander. The physician, as well, through his oath of office¹⁸ and commission¹⁹ has volunteered his art and craft to support those in command. This is not a total acceptance of any and all orders¹⁴ but there are factors involved in the decision to issue the order of which the physician may not be fully aware. (See Chapter 12 for a further discussion of this topic.) These factors may influence the commander in his decision to require treatment for the troops in his units. Because the physician is involved in advising the commander in medical matters, he is more likely to be aware of some of these issues and therefore more likely to understand the decision process. In most cases the commander makes decisions that result in enhancing the overall welfare of his troops. If there is serious concern over the correct medical facts in the order, the physician should attempt to clarify the rationale for the order and discuss the medical facts, as he interprets them, with the commander and attempt to resolve any differences.²⁰ In an extreme situation, the physician may need to request to be relieved of his duties and request court-martial if he firmly believes the course of action chosen by the commander is illegal or morally wrong.²¹ This concept is developed more fully in Chapter 27, *A Proposed Ethic for Military Medicine*.

As a member of the overall society, the physician also has a responsibility. In war, particularly in a war whose outcome is uncertain, a duty to society would support the concept of "preserve the fighting strength" and would allow enforced treatment of soldiers. If the soldier refuses a treatment and thereby potentially is incapable of completing his mission, it may be in society's interest to have the treatment involuntarily given to the soldier. This may cause significant distress in the physician who is told to administer the treatment forcibly to the soldier. Again, it is best to anticipate this tension and examine these issues prior to the actual situation arising.

Arguments Against Enforced Treatment

Alternatively, refusing to administer the treatment may be ethically defended on those grounds previously stated. The vulnerable soldier has already given up so much of his autonomy that it may seem unconscionable to remove this last amount. It is antithetical to respecting his dignity as a person to forcibly treat him. It really doesn't matter what motives the soldier has in refusing—it still is onerous to forcefully administer the treatment. Irrespective of other actions that can be taken against the soldier's permission, it is somehow different when one begins talking about medicine. Once a soldier becomes a patient, his status changes in many ways. Thus he has a different claim upon the system. Most oaths for physicians also note that persons as patients will not be used as means to another's end. In effect most arguments for enforcing treatment are furthering other's goals at the risk to or expense of the patient.

There is also a concern over generalizing this relatively limited use of a policy into one that has great potential for abuse. If it is widely accepted that the commander (or the physician acting for the commander) has the ability to forcibly treat any patient presenting for care, this increases the already *mildly* coercive environment soldiers exist within and could easily lead to the patient being forced to submit to treatment that won't clearly help him (or may in fact harm him). If this is the policy, it is also possible that the patient will expect the physician to order the treatment, no matter what the patient wants. Therefore the perception of the patient is that he really doesn't have any choice anyway. This would clearly lead to a fractured physician-patient relationship and a failure of any possible informed consent in military medical practice.

There could be an unrecognized, or even recognized, desire on the part of the physician to impose

unproved or experimental treatment on the patient. The motive could be a scientific desire to advance medicine while somewhat circumventing the normal controls on scientific experimentation. It could, however, be more sinister and approach the travesties of medical care and experimentation the Nazi physicians forced on their victims.²² The clear concern is that such a policy needs to be carefully examined and reviewed prospectively. Parenthetically, this issue needs to be evaluated for enemy prisoners of war (EPWs). Experimentation upon prisoners is clearly prohibited under Article 13 of the Geneva Conventions regarding prisoners of war, which states that "no prisoner of war may be subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned and carried out in his interest."²³ However, there is a difference between experimentation and treatment. Treatment given to captured soldiers must be able to be differentiated from experiments. It would seem that any treatment involuntarily given to troops should also be able to be given without questions of experimentation to captured soldiers based on the principle of justice. If the treatment is being given to US soldiers to enable them to continue the mission and the EPW refuses this treatment, it is clear that this decision should be respected, but that the treatment should not be withheld from the prisoner if it is requested. If, on the other hand, the treatment is being given for clear medical indications, the refusal by the EPW seems more problematic, but should probably be respected based on autonomy considerations alone. The potential for abuse of captives and memories of German and Japanese experiments on POWs are strong arguments for allowing EPWs to exercise decision making wherever possible, particularly in medical decisions.

BATTLEFIELD TRIAGE

Battlefield triage has been described as "the infamous process" that forces a physician to make decisions *not* to treat patients whom he judges to have little chance of recovery.²⁴ Under certain conditions this may be true, however, the triage concept does not have a totally ignoble past. The word comes from the French verb *trier*, meaning "to sort." Initially it was used to categorize merchandise such as coffee or wool. During Napoleon's campaigns his chief surgeon, Baron Dominique Jean Larrey, sorted the casualties and consistently began treating the most seriously wounded first, "without regard to rank or distinction."²⁵

The Concept of Triage

Triage is defined as the "screening and classification of wounded, sick, or injured patients during war or another disaster to determine priority needs and thereby ensure the most efficient use of medical and surgical manpower, equipment, and facilities"²⁶ or "a system used to allocate a scarce commodity, [such] as food, only to those capable of deriving the greatest benefit from it."²⁶ The *Emergency War Surgery* handbook defines triage as "the evaluation and classification of casualties for purposes of treatment and evacuation. It is based on the principle of accom-

plishing the greatest good for the greatest number of wounded and injured men in the special circumstances of warfare at a particular time....Sorting also involves the establishment of priorities for treatment and evacuation."²⁷(p181)

Triage actually occurs in all aspects of medicine, whether one is operating in a mass casualty situation or not. In practice, one "triages" patients based on the urgency of their complaints, by the number of appointments available, or by the availability of specialty care. In a nonaustere environment, which is seen in most emergency rooms today, there is a triage desk where patients are first checked in. After sorting patients and symptoms, the most critically ill will be cared for first. This patient-centered approach to triage has been the model for many years. However, it is becoming increasingly more common for issues involving allocation of scarce resources to arise in civilian medicine and for triage decisions to be based on limited resources. Although this may not approach the difficulties seen on the battlefield, there are significant moral tensions developing. As resources become more and more scarce (limitations based on financial decisions), these problems will assume a greater role in the future. Mass casualty situations occur in the civilian sector as well and may require institution of some other prioritization procedure during times of limited resources.

On the battlefield, triage based on the most critically injured being treated first holds when there is no overwhelming demand for facilities. This would require full resupply capabilities and the expectation that there would be no likelihood of overwhelming numbers of casualties in the near future. These conditions may be impossible to guarantee on the battlefield and a more austere environment triage scheme may need to be employed.

Establishing and Maintaining Prioritization of Treatment

The sorting of patients, as delineated in *Emergency War Surgery*, assigns them into five groups in decreasing order of medical urgency²⁷(pp184-186):

- (1) urgent: require immediate intervention if death is to be prevented;
- (2) immediate: require procedures of moderately short duration to stabilize severe, life-threatening wounds;
- (3) delayed: require operative intervention but can tolerate delay without compromising successful outcome;
- (4) minimal (or ambulatory): require minimal

surgical attention no more than cleansing, local anesthetic for debridement, and dressings. These are the most common injuries and include minor lacerations, minimal burns, and small soft tissue injuries; and

- (5) expectant: wounds are so extensive that even if this patient were the sole casualty, his survival is still unlikely.

Exhibit 13-3 discusses these five groupings in greater detail.

Models of Triage

I propose that there are actually three basic models of triage used, depending on the situation and circumstances. The previously described model is the one seen in *nonaustere conditions*. When time, personnel, equipment, or supplies are significantly diminished, such that there are true limitations in resources, the second model for more *austere conditions* will need to be implemented. The third model will involve *extreme conditions* and decisions that would be very difficult under normal circumstances; it will rarely need to be implemented.

Under the first, or nonaustere conditions model, the most seriously injured patients would be treated first. No patients would be declared expectant, at least until some significant attempt at resuscitation had occurred. It is clear that some patients may have overwhelming injuries and will die whatever the level of support and resuscitation. Indeed, this could be the case in an American civilian trauma center today. For these patients, once this is evident, efforts could be recognized as futile and care could be withdrawn or withheld, just as is done in civilian situations. 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.

The second model of triage, that seen in austere conditions, could be viewed as an attempt to save as many lives as possible. In so doing, some patients will die who otherwise could have lived had adequate resources been available. This decision would potentially be quite difficult, however, it has certain parallels in the civilian sector and is analogous to allocation decisions that are becoming much more frequent. Under this model, those patients most likely to benefit from treatment would be treated first, even if an individual patient may die who otherwise would have benefited from intervention. Some of these patients who died would have been declared expectant; others may have been too complicated to respond quickly to treatment. This

EXHIBIT 13-3

TRIAGE: ESTABLISHING PRIORITIES OF TREATMENT

Emergency War Surgery, a NATO (North Atlantic Treaty Organization) handbook, offers the following guidance concerning the priorities of treatment for battlefield casualties:

In order to cope effectively and efficiently with large numbers of battle casualties that present almost simultaneously, the principles of triage, or the sorting and assignment of treatment priorities to various categories of wounded, must be understood, universally accepted, and routinely practiced throughout all echelons of collection, evacuation, and definitive treatment....Not uncommonly, the most gravely injured are the first to be evacuated from the collection points. They will also be the first to arrive at the definitive care facility. The receiving surgeon (triage officer) must guard against overcommitting his resources to those first arrivals prior to establishing a perspective of the total number and types of casualties still to be received. It is easier to assign priorities of care to individual casualties if the medical officer has a feel for the usual anatomical distribution of war wounds. Survivors present with a reasonably consistent pattern of wound distribution....With experience, the forward surgeon comes to recognize this recurring pattern and the relatively consistent distribution of wound types and location in groups of battle casualties....Application of the following criteria makes the receipt, triage, and treatment of large numbers of simultaneously arriving casualties more manageable, while at the same time minimizing the confusion and calamity that otherwise could prevail.

Urgent: This group requires urgent intervention if death is to be prevented. This category includes those with asphyxia, respiratory obstruction from mechanical causes, sucking chest wounds, tension pneumothorax, maxillofacial wounds with asphyxia or where asphyxia is likely to develop, exsanguinating internal hemorrhage unresponsive to vigorous volume replacement, most cardiac injuries, and CNS [central nervous system] wounds with deteriorating neurological status.

Therapeutic interventions range from tracheal intubation, placement of chest tubes, and rapid volume replacement to urgent laparotomy, thoracotomy, or craniotomy. Shock caused by major internal hemorrhage will, in these circumstances, require urgent operative intervention to control exsanguinating hemorrhage.

If the initial resuscitative interventions are successful and some degree of stability is achieved, the urgent casualty may occasionally revert to a lower priority. The hopelessly wounded and those with many life-threatening wounds, who require extraordinary efforts, should not be included in this category.

Immediate: Casualties in this category present with severe, life-threatening wounds that require procedures of moderately short duration. Casualties within this group have a high likelihood of survival. They tend to remain temporarily stable while undergoing replacement therapy and methodical evaluation. The key word is temporarily. Examples of the immediate category are: unstable chest and abdominal wounds, inaccessible vascular wounds with limb ischemia, incomplete amputations, open fractures of long bones, white phosphorous burns, and second- or third-degree burns of 15–40% or more of total body surface.

Delayed: Casualties in the delayed category can tolerate delay prior to operative intervention without unduly compromising the likelihood of a successful outcome. When medical resources are overwhelmed, individuals in this category are held until the urgent and immediate cases are cared for. Examples include stable abdominal wounds with probable visceral injury, but without significant hemorrhage. These cases may go unoperated for eight or ten hours, after which there is a direct relationship between the time lapse and the advent of complications. Other examples include soft tissue wounds requiring debridement, maxillofacial wounds without airway compromise, vascular injuries without adequate collateral circulation, genitourinary tract disruption, fractures requiring operative manipulation, debridement and external fixation, and most eye and CNS injuries.

Minimal or Ambulatory: This category is comprised of casualties with wounds that are so superficial that they require no more than cleansing, minimal debridement under local anesthesia, tetanus toxoid, and first-aid-type dressings. They must be rapidly directed away from the triage area to uncongested areas where first aid and non-specialty medical personnel are available. Examples include burns of less than 15% total body surface area, with the exception of those involving the face, hands, or genitalia. Other examples include upper extremity fractures, sprains, abrasions, early phases of symptomatic but unquantified radiation exposure, suspicion of blast injury (perforated tympanic membranes), and behavioral disorders or other obvious psychiatric disturbances.

(Exhibit 13-3 continues)

Exhibit 13-3 *continued*

Expectant: Casualties in the expectant category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival still would be very unlikely. During a mass casualty situation, this sort of casualty would require an unjustifiable expenditure of limited resources, resources that are more wisely applied to several other more salvageable individuals. To categorize a soldier to this category requires a resolve that comes only with prior experience in futile surgery that ties up operating rooms and personnel while other more salvageable casualties wait, deteriorate, or even die. The expectant casualties should be separated from the view of other casualties; however, they should not be abandoned. Above all, one attempts to make them comfortable by whatever means necessary and provides attendance by a minimal but competent staff. Examples: unresponsive patients with penetrating head wounds, high spinal cord injuries, mutilating explosive wounds involving multiple anatomical sites and organs, second- and third-degree burns in excess of 60% total body surface area, convulsions and vomiting within twenty-four hours of radiation exposure, profound shock with multiple injuries, and agonal respiration. Exposure to radiation or biologic and chemical agents when presenting in conjunction with conventional injuries will alter the above categorization. The degree to which such agents compound the prognosis is somewhat variable and difficult to specifically apply to a mass casualty situation. A safe practice is to classify the exposed casualty at the lowest priority in his category. It has been stated that those in the immediate category with radiation exposure estimated to be 400 rads be moved to the delayed group, and those with greater than 400 rads be placed in the expectant category. Those with convulsions or vomiting in the first 24-hours are not likely to survive even in the absence of other injuries. Mass casualty situations are highly probable when troops have been exposed to radiation or chemical or biological agents. There must be areas set aside within the hospital to safely isolate these types of patients, and special procedures must be established to safeguard the attending medical personnel.

Source: Bowen TE, Bellamy RF. *Emergency War Surgery*. Second United States Revision of The Emergency War Surgery NATO Handbook, Washington, DC: US Department of Defense; 1988: 184–186.

model fits in a utilitarian analysis in that the good for the whole is being maximized, but at the expense of individuals. An example of this model in practice occurred during mass casualty situations in Vietnam where resources were not available to treat all patients at one time and with maximal effect.

The third model of triage, that seen in extreme conditions, may arise on the battlefield, in which the battle is going against US troops with a great chance that the line units will not have enough manpower to prevail against the enemy. This may require treating patients with less severe injuries first to preserve a diminishing fighting force. Under this model, patients with non-life-threatening injuries that, if treated, would not prevent the soldier from going back to battle, would be treated first. This has rarely been used in the American military but was the accepted model for triage in the German army during World War II.²⁸ An example from United States history is the use of penicillin in North Africa during World War II.²⁹ The decision was made to treat soldiers with venereal disease with the limited supplies of penicillin available rather than using it in patients with battle wounds, even if the injured patients might die without it. The reasons given were, indeed, the ability to return the soldiers with venereal disease to the

front lines to continue to fight, while those with battle wounds would be unable to return, even if given the penicillin.

Examining the Extreme Conditions Model

The extreme condition model contradicts most decisions medical personnel make, and is a classic example of the conflict in dual agency, or duties to both the patient and the command. Obviously, the command has a great interest in having those minimally wounded soldiers back on the line, and may well support this scheme of triage, but many physicians would find this to be difficult and contrary to what one would do normally.

Respecting the Autonomy of the Soldier

The individual patient who is severely injured may not desire his lower priority of treatment because it will necessitate his waiting for treatment while minimally injured patients are treated (and may significantly increase his chances of dying). Conversely, the minimally injured patient may not want to be treated before his severely injured buddy because the buddy may die if not treated promptly. He may also recognize that the faster he is treated,

the sooner he will return to the front where he may be more seriously injured, or killed. There could be tremendous pressures on the person performing triage to avoid making these decisions. The defense of the decision to treat the minimally wounded first could be made on the basis of a utilitarian approach. Under this analysis, the basic tenet of doing the “greatest good for the greatest number” would allow the decision to be made, not for the benefit of the individual patient, but rather for the good of the unit, the army, or the country. If by not returning the minimally wounded patient to duty, the unit is overrun, there are more casualties generated, the army is defeated, or the war is prolonged (or even lost), thereby causing great suffering in the country, then a strong argument is made for choosing to treat the minimally injured patient.

Conversely, the argument can be made that if these choices are consistently made, the unit will come to know that if one is wounded severely and requires maximum care it would not be given. This can affect the desire to fight or to place oneself at risk. The excellent medical care US troops receive during combat is a “force multiplier.”³⁰ Consistently making triage decisions using the extreme conditions model may well be considered a “force divider,” not only by diminishing the “will to fight” but also by possibly causing “competition” for medical care. One soldier may consider the less injured soldier in the next space as the only thing standing between himself and death. This is likely to destroy unit cohesiveness.

Caring for Noncombatant Casualties

It is also clear that enemy prisoners of war and civilian casualties would not receive priority care

under this triage model. This is in violation of Article 12 of the Geneva Conventions, which states that “[o]nly urgent medical reasons will authorize priority in the order of treatment to be administered.”³ By invoking the extreme conditions model, the healthcare professional may be violating one of the most basic medical premises, which is that once injured and captured, the enemy is no longer a combatant but is instead entitled to the same basic human respect and concern for his medical needs as US military personnel.

Understanding Military Doctrine

US Army doctrine provides guidance for the medical professional facing varying battlefield scenarios. The rules of battlefield medicine as seen in Exhibit 13-2 are ranked in order of precedence. “Return to duty” considerations are the last priority. However, return to duty is still a major ethical dilemma for the medical professional on the battlefield and is difficult, if not impossible, to resolve using generalities. The extreme conditions model of triage has never been encountered in the modern US Army. Even during mass casualty situations in Vietnam triage first selected those most likely to be benefited by rapid treatment rather than selecting those most able to return to the front. Most medical professionals probably would have great difficulty implementing an extreme condition triage model. However, just because it is difficult doesn’t mitigate against preparing for such an implementation. The scenario of overwhelming mass casualties in the face of an advancing enemy force deserves study and analysis by individual medical professionals before they are actually in the unenviable situation of having to decide what to do.

EUTHANASIA ON THE BATTLEFIELD

Physician-assisted dying is a major issue currently being discussed in the civilian sector. Initiatives to legalize physician aid in dying were narrowly defeated in Washington state as well as in California; it passed by a narrow margin in Oregon in 1994. This law survived challenges in court as well as a repeat referendum in 1997 after the Oregon Medical Association withdrew its support for it. Attempts to pass referenda supporting physician aid in dying have since failed in Michigan, Maine, and in other states, leaving Oregon as the only state permitting physician-assisted suicide. Attempts to overturn state laws prohibiting physician-assisted suicide have failed in the US Supreme Court in 1997 and in several state supreme courts, including Alaska, Colorado, and

Florida. Public opinion concerning this issue varies, often apparently depending on the actual wording of the survey, but seems to be pretty evenly divided. The issue remains one of the most hotly debated in all arenas. The issue also exists within military medicine for the same reasons as in the civilian sector, however, the battlefield adds new dimensions and difficulties.

Understanding the Dynamics of the Battlefield: The Swann Scenario

The following scenario, published by Dr. Steve Swann in 1987 in *Military Medicine*,³¹ presents a vivid picture of the ethical dilemmas facing the military physician.

Case Study 13-1: A Hypothetical Scenario. Three weeks ago US Naval forces in the Mediterranean launched air and sea attacks against military installations in Libya in response to increased terrorist activities known to originate from Mu'ammarr Quaddafi's regime. This was followed by the invasion of the 2nd Marine Division near Tripoli. This military action was applauded by Israel but condemned by most NATO [North Atlantic Treaty Organization] allies and, as expected, by the Arab world and communist block nations. US forces suffered few losses and easily secured the country with complete destruction of the Libyan Army. In retaliation, certain Arab countries attacked US forces in Libya and simultaneously invaded Israel. US Naval forces suffered minimal losses from the Soviet-supplied navies and air forces of these nations, and although the Marines have sustained moderate casualties, they still control the battlefield.

One week following the opening of hostilities in North Africa, Warsaw Pact Nations began unscheduled, large-scale "Training Exercises" near the East-West German border. Six days ago these units crossed into the Federal Republic of Germany and attacked NATO units to force a US withdrawal from Libya. The US refused, and combat in both regions has continued to escalate.

As a surgeon in a clearing station in direct support of the 11th Armored Cavalry Regiment defending the Fulda gap [a geographically strategic point for invasion along the border between East and West Germany], I have seen many casualties of all types. I knew that modern warfare would create great numbers of wounded and cause massive destruction, but I had no idea it would be this terrible. Our unit has taken 65% losses. Despite heroic actions, we continue to be forced back 30 to 60 km each day, but short of the Soviet doctrinal 100 km daily advance [Soviet doctrine indicating that to maximize disarray in the enemy's troops, Soviet forces should propel themselves 100 km a day, shocking, overpowering, and demoralizing the enemy with the rapid advance]. The 85th Guards Motorized Rifle Division oppose us, and their lines are 8 km away. They are expected to be at this location in 45 minutes. Intelligence reports that all severely wounded prisoners are being executed [by the Russians as they advance], for the Russians do not want to slow their attack to deal with the problem of caring for or transporting them.

In my clearing station I have no capability to hold patients or transport them with me. I can only triage, initially resuscitate, and then evacuate with higher command assets. At the present time we have 32 wounded, 17 of which are categorized as expectant. They include a German civilian with abdominal evisceration who is pleading to die, two unresponsive soldiers with extensive head wounds, two soldiers with 80-90% total body burns from chemical contamination, eight soldiers who have received a dosimeter-documented 825 rads after unknowingly crossing a nuclear-contaminated area and who continue to vomit and pass diarrheal stools, and a four-man tank crew all of whom received between 60 and 90% body surface area, full thickness burns after the fuel cell of their M60A3 exploded when hit with a Sagger anti-tank missile. The screams of the wounded could easily expose

our position to the attacking Soviet forces or to the Russian commando units known to be operating behind our lines.

The 3rd Armored Division, whom we are screening, will take 3 hours to get land evacuation to me. Air evacuation is not available since the Soviets have air superiority, and besides, we have already lost 80% of our helicopter assets [similar to Figure 13-3]. I lost 40% of my men and equipment, including another physician, a pediatrician, [similar to Figure 13-4] when our convoy was strafed by MiG-27's 2 days ago. I have not been resupplied in 2 days, and I am running short of everything, especially morphine, bandages, and IV fluids. I have just received orders to displace [to another location] in 15 minutes and be ready to accept new casualties from the intensified fighting in 30 more.

Oh, Lord, there is nothing medically I can do to extend the lives of these brave men. They are all doomed to die and suffer immeasurably until they do so. Need I kill these men? Should I take this merciful action so as not to postpone the unalterable?³¹

Comment: Although this scenario is outdated (it predated the demise of the Soviet Union) and the events did not occur, today's battlefield is nonetheless potentially one of massive destruction with weapons that have the potential to generate astronomical numbers of casualties. Thus, although the names of the conflicting forces and locales would be different in a future scenario, the scenario itself remains all too possible and clearly presents lessons to be learned.

Before attempting to answer the extremely difficult question with which this hypothetical scenario ends, a brief study of the history of battlefield euthanasia may be helpful. By examining some documented situations, it is possible that similarities and differences, as well as unifying themes may become more clear.



Fig. 13-3. This medical evacuation helicopter crashed during Operation Desert Storm in 1991. It is not known whether this was due to hostile fire or accident.



Fig. 13-4. This funeral service for a physician who died in a traffic accident (a) just prior to the ground war phase of Operation Desert Storm was conducted by the chaplain of the 28th Combat Support Hospital (b).

A Brief History of Battlefield Euthanasia

Requests for battlefield euthanasia have, no doubt, occurred on battlefields as long as there have been battlefields. When men have taken up arms against one another, for whatever reason, there have always been those wounded who do not die immediately, but clearly cannot live for long, either because of their wounds or their circumstances. This can generate the desire to hasten their inevitable death, by both the wounded soldier as well as their comrades. These situations have probably occurred throughout history.

For instance, battlefield euthanasia requests are documented in the Bible as far back as the time of Abimelech (around 1100 BC) in the city of Thebes. Abimelech was a Judge of Israel who had captured Thebes but all the inhabitants had locked themselves inside a strong tower inside the city. He attempted to burn the tower and kill those inside, but as he approached it to set it on fire, “a woman dropped an upper millstone on his head and cracked his skull” (Judges 9:53).^{32(p346)} He requested that his armor bearer kill him because he did not want history to record that he was killed by a woman; the armor bearer acceded to his request.

A more famous request occurred in 1010 BC when King Saul was wounded by the Philistines and asked his armor bearer to kill him because Saul was concerned about potential torture if he was captured. The armor bearer refused and Saul “took his own sword and fell on it” (1 Samuel 31:4).^{32(p419)} The armor bearer also committed suicide. An interesting aside is that later in the account, an Amalekite, expecting to be rewarded by Saul’s enemy David, claimed to have been the one who “killed [Saul],

because [he] knew that after he had fallen, he could not survive” (2 Samuel 1:10).^{32(p419)} David put the Amalekite to death for having the temerity to even contemplate harming Saul (the “Lord’s anointed”) much less killing him.

Ambroise Pare describes another case of battlefield euthanasia. Pare was a French barber surgeon who enlisted in the army of Francis I to perfect his training in surgery. In 1537 he was with the forces of Marshal Monte-Jan when they laid siege to Turin in Italy. After the city fell, he recounts an experience in which he came across several enemy soldiers wounded in an explosion. Two of these were still alive. An old French soldier happened by and after asking Pare if there were any hope for them, and learning that there was none, he “gently cut their throates (sic) without choler.”^{33(p22)} Pare was horrified at what he perceived as an act of cruel revenge, and rebuked the soldier. The old man replied that he prayed to God that if he were ever in a similar situation, someone would “doe (sic) as much to him, to the end he might not miserably languish.”^{33(p22)} There are countless other examples throughout history of euthanasia by a comrade on the battlefield.

Physicians’ roles in battlefield euthanasia have also been described. Napoleon’s physician, René-Nicolas Desgenettes, refused to give lethal doses of opium to soldiers dying of the plague.³⁴ During Napoleon’s retreat from Jaffa in 1799, there were several men suffering from bubonic plague who could not survive 24 hours even with the best medical care. The army, however, had to march. Napoleon ordered Desgenettes to give them a lethal dose of laudanum (opium) rather than leaving them to the mercy of the Turks. Desgenettes refused, believing that it was the obligation of the physician to

cure and not to kill. The reports are unclear after this, with some indication that the chief pharmacist, Royer, gave doses of opium to approximately 50 soldiers, but there is no indication that any of them died from receiving the medication.³⁵

A Civilian Example From a "Battlefield" Setting

A contrasting decision, albeit not involving military physicians and combatants, was documented in the book *Schindler's List*³⁶ in which two Jewish physicians were involved in the administration of hydrogen cyanide to four patients who could not be moved from a hospital before a *Sonderkommando Aktion* during the Holocaust. They defended this decision as the most ethical one because of the brutal and inhumane death expected when the Nazis came. The description of this decision is particularly poignant and is recommended for careful reading and reflection. The date is March 13, 1943; the place is the Jewish ghetto in Cracow, Poland.^{36(pp175-180)}

Case Study 13-2: The Ghetto Hospital. [A] doctor of the ghetto's convalescent hospital, Dr. H, sat among his last patients, in darkness, grateful that they were isolated like this on the hospital's top floor, high above the street, alone with their pain and fever.

For at street level everyone knew what had happened at the epidemic hospital near Plac Zgody. An SS detachment under *Oberscharführer* Albert Hujar had entered the hospital to close it down and had found Dr. Rosalia Blau standing among the beds of her scarlet fever and tuberculosis patients....

Hujar himself, acting on the mandate he'd received the week before from Amon Goeth, shot Dr. Blau in the head. The infectious patients, some trying to rise in their beds, some detached in their own delirium, were executed in a rage of automatic fire....

The convalescent hospital[s]...director was a respected physician named Dr. B. By the bleak morning of March 13, Doctors B and H had reduced its population to four, all of them immovable. One was a young workman with galloping consumption; the second, a talented musician with terminal kidney disease. It seemed important to Dr. H that they somehow be spared the final panic of a mad volley of fire. Even more so the blind man afflicted by a stroke, and the old gentleman whose earlier surgery for an intestinal tumor had left him weakened and burdened with a colostomy.

The medical staff here, Dr. H included, were of the highest caliber. From this ill-equipped ghetto hospital would derive the first Polish accounts of Weil's erythroblastic disease, a condition of the bone marrow, and of the Wolff-Parkinson-White syndrome. This morning, though, Dr. H was concerned with the question of cyanide.

With an eye to the option of suicide, H had acquired a supply of cyanic acid solution. He knew that other doc-

tors had too....To know he had access to cyanide had been a comfort for Dr. H on his worst days. By this late stage of the ghetto's history, it was the one pharmaceutical left to him and to the other doctors in quantity. There had rarely been any sulfa. Emetics, ether, and even aspirin were used up. Cyanide was the single sophisticated drug remaining.

This morning before five, Dr. H had been awakened in his room in Wit Stwosz Street by the noise of trucks pulling up beyond the wall. Looking down from his window, he saw the *Sonderkommandos* assembling by the river and knew that they had come to take some decisive action in the ghetto. He rushed to the hospital and found Dr. B and the nursing staff already working there on the same premise, arranging for every patient who could move to be taken downstairs and brought home by relatives or friends. When all except the four had gone, Dr. B told the nurses to leave, and all of them obeyed except for one senior nurse. Now she and Doctors B and H remained with the last four patients in the nearly deserted hospital.

Doctors B and H did not speak much as they waited. They each had access to the cyanide, and soon H would be aware that Dr. B's mind was also sadly preoccupied with it. There was suicide, yes. But there was euthanasia as well. The concept terrified H. He had a sensitive face and a marked delicacy about the eyes. He suffered painfully from a set of ethics as intimate to him as the organs of his own body. He knew that a physician with common sense and a syringe and little else to guide him could add up like a shopping list the values of either course—to inject the cyanide, or to abandon the patients to the *Sonderkommando*. But H knew that these things were never a matter of calculating sums, that ethics was higher and more tortuous than algebra.

Sometimes Dr. B would go to the window, look out to see if the *Aktion* had begun in the streets, and turn back to H with a level, professional calm in his eyes. Dr. B, H could tell, was also running through the options, flicking the faces of the problem like the faces of riffled cards, then starting again. Suicide. Euthanasia. Hydro-cyanic acid....

At dawn the nurse, a calm woman about forty years old, came to Dr. H and made a morning report. The young man was resting well, but the blind man with the stroke-affected speech was in a state of anxiety. The musician and the anal-fistula case had both had a painful night. It was all very quiet in the convalescent hospital now, however; the patients snuffled in the last of their sleep or the intimacy of their pain; and Dr. H went out onto the freezing balcony above the courtyard to smoke a cigarette and once more examine the question.

Last year Dr. H had been at the old epidemic hospital in Rekawka when the SS decided to close that section of the ghetto and relocate the hospital. They had lined the staff up against the wall and dragged the patients downstairs. H had seen old Mrs. Reisman's leg caught between the balusters, and an SS man hauling her by the other leg did not stop and extricate her but pulled until the trapped limb snapped with an audible crack. That was how patients were moved in the ghetto. But last year no one had thought of mercy-killing. Everyone had still hoped

at that stage that things might improve.

Now, even if he and Dr. B made their decision, H didn't know if he had the rigor to feed the cyanide to the ill, or to watch someone else do it and maintain a professional dispassion....

Out there on the balcony he heard the first noise. It began early and came from the eastern end of the ghetto. The *Raus, raus!* of megaphones, the customary lie about baggage which some people still chose to believe....

Then he heard the first volley, loud enough to wake the patients. And a sudden stridency after the firing, a bull megaphone raging at some plangent feminine voice; and then the wailing snapped off by a further burst of fire.... He knew that it all might well have cut through even the precomatose state of the musician with the failed kidneys.

When he returned to the ward, he could see that they were watching him—even the musician. He could sense rather than see the way their bodies stiffened in their beds, and the old man with the colostomy cried out with the muscular exertion. "Doctor, doctor!" someone said. "Please!" answered Dr. H, by which he meant, *I'm here and they're a long way off yet*. He looked at Dr. B, who narrowed his eyes as the noise of evictions broke out again three blocks away. Dr. B nodded at him, walked to the small locked pharmaceutical chest at the end of the ward, and came back with the bottle of hydrocyanic acid. After a pause, H moved to his colleague's side. He could have stood and left it to Dr. B. He guessed that the man had the strength to do it alone, without the approval of colleagues. But it would be shameful, H thought, not to cast his own vote, not to take some of the burden. Dr. H, though younger than Dr. B, had been associated with the Jagiellonian University, was a specialist, a thinker. He wanted to give Dr. B the backing of all that.

"Well," said Dr. B, displaying the bottle briefly to H. The word was nearly obscured by a woman's screaming and ranting official orders from the far end of Józefińska Street. Dr. B called the nurse. "Give each patient forty drops in water." "Forty drops," she repeated. She knew what the medication was. "That's right," said Dr. B. Dr. H also looked at her. Yes, he wanted to say. I'm strong now; I could give it myself. But if I did, it would alarm them. Every patient knows that nurses bring the medicine around.

As the nurse prepared the mixture, H wandered down the ward and laid his hand on the old man's. "I have something to help you, Roman," he told him....

"Please, Roman," said the doctor, meaning that the old man should unclench his body. He believed the *Sonderkommando* was coming within the hour. Dr. H felt, but resisted, a temptation to let him in on the secret. Dr. B had been liberal with the dosage. A few seconds of breathlessness and a minor amazement would be no new or intolerable sensation to old Roman.

When the nurse came with four medicine glasses, none of them even asked her what she was bringing them. Dr. H would never know if any of them understood. He turned away and looked at his watch. He feared that when they drank it, some noise would begin, something worse than the normal hospital gasps and gaggings. He heard the nurse murmuring, "Here's something for you." He heard

an intake of breath. He didn't know if it was patient or nurse. *The woman is the hero of this*, he thought.

When he looked again, the nurse was waking the kidney patient, the sleepy musician, and offering him the glass. From the far end of the ward, Dr. B looked on in a clean white coat. Dr. H moved to old Roman and took his pulse. There was none. In a bed at the far end of the ward, the musician forced the almond-smelling mixture down.

It was all as gentle as H had hoped. He looked at them—their mouths agape, but not obscenely so, their eyes glazed and immune, their heads back, their chins pointed at the ceiling—with the envy any ghetto dweller would feel for escapees.

Comment: This case perhaps best illustrates the agonizing decision faced by the physician in the Swann scenario (Case 13-1). In this example, the physicians consider killing their patients out of compassion preferable to allowing them to fall into the hands of the Nazi soldiers and suffering a violent and painful death.

Thus far this discussion has presented scenarios that involve a military physician pondering euthanasia, soldiers euthanizing other soldiers, a physician refusing to euthanize soldiers, and a physician who knew of a decision for euthanasia, but was not directly involved in being the agent of death. (In the *Schindler's List* account, the person who prepared and administered the solution was a senior nurse.)

As these examples have shown, the agent actually administering the act of killing can vary from a fellow soldier to a physician. This discussion will now focus in on the role of the military health professional. The case presented by Swann is very difficult in that the patients are directly under medical care. As commander of a clearing station, the military physician has mixed duties to his patients and to the command. The patients certainly expect him to continue to provide care for them, but the command also expects him to be ready for more patients in the new location (and on time). He cannot take the patients with him and he also cannot "hide" by allowing a line commander to give the order for euthanasia because the patients are his responsibility.

Available Courses of Action: The Swann Scenario

The scenario published by Swann was presented in abstracted form to the battlefield medical ethics conference at Brooke Army Medical Center in San Antonio in May of 1990, approximately 3 years after it had first been published in *Military Medicine*.³¹

There were three basic courses of action identified at the conference, but there are almost infinite variations of these. The first course of action is to obey the order to retreat, and to euthanize all patients that cannot be moved. The second is to obey

the order to retreat, but to leave the patients behind with a minimum amount of support from healthcare professionals and chaplains. A third possibility is to refuse to relocate the unit and to remain with the patients and provide all care possible to patients in the present position. Any of these courses of action could be chosen, and there may be some defensible argument for each. The general aspects of ethical decision making will be examined as applied to this case. These courses of action illustrate problems with each option.

Ethical Analysis of Options

The three possible options for the physician in the Swann case will be addressed using several different ethical approaches. There are many other approaches as well, as a review of Chapter 2 in the first volume of this text clearly demonstrates. I have selected these three—principle-based ethical analysis, utilitarian analysis, and military specific analysis—as being the approaches most likely to offer assistance to the military medical professional in this particularly difficult situation.

Principle-Based Ethical Analysis

In analyzing a case, it is usually helpful to use a systematic and standardized approach. In ethical decision making, a way of doing this is using the four principles discussed earlier in Chapter 2, *Theories of Medical Ethics: The Philosophical Structure*, in Volume I of this textbook. Briefly stated, the principles are:

- (1) Autonomy: the respect for a person's right to make his or her own decisions, having been given all necessary information to understand the probable outcomes of the decision;
- (2) Beneficence: doing good for the patient; involves acting in the patient's own best interest, without concern for outside interests;
- (3) Nonmaleficence: avoiding "doing harm" to the patient; *primum non nocere*; and
- (4) Justice: "giving to each his due"; distributing resources to patients based on the balancing of competing claims among all needy patients.

Because these principles have different agents and interests at stake, they can conflict with each other. The resolution of this tension is much of what ethical decision making is all about. For example,

in a situation where a patient may desire no treatment, including treatment that would clearly improve chances of survival, there is a clear tension between the patient's *autonomy* and the principle of *beneficence*. This was an obvious difficulty in the transition from a paternalistic healthcare system, where the "doctor knew best," to the system seen today where patient autonomy is the criterion for most decisions.

Another obvious area of conflict is between autonomy and distributive *justice* when there are limited resources. The decision as to who will live when not all can live, seen in the early rationing of dialysis, for example, is another very difficult issue (Exhibit 13-4). This is clearly a topical issue in today's environment of expensive, high-technology medical care. It will likely have even greater weight as the United States proceeds with healthcare reform.³⁷

Using these four principles—autonomy, beneficence, nonmaleficence, and justice—the following analysis of this particular case, the Swann scenario, can be made.

Autonomy. Using the first principle, that of autonomy, one would want to examine the underlying issue of whether or not a soldier has true autonomy, or whether he has voluntarily or involuntarily given this up to some degree. It may well not be the autonomous choice of a soldier to attack a hill from which a machine gun is firing, but in the military this action is performed routinely. As discussed before, the soldier doesn't receive "informed consent" before his charge up the hill.

By analogy, a soldier who is injured probably doesn't have the autonomous choice as to what treatment he would receive and when he would receive it. There is considerable intrinsic loss of autonomy upon joining the military. There also may be overriding considerations (as seen in the scenario) preventing a patient from receiving all the care he might desire or request. Should patients be fully informed of the situation and their prognosis? It might be possible to discuss the situation with some of the "expectant" patients and allow, as much as possible, the patient to enter into the decision making process. However, this might just cause more suffering and anxiety when the patient learns of the true situation. If his wishes cannot be respected, this could be even more unnerving.

However, what if the patient requests active euthanasia after learning about the situation? It may well be the autonomous, expressed wish of the patient to be killed, both due to current suffering, as well as concern for greatly increased suffering caused by being captured (and presumably tortured or killed by the enemy). The latter is certainly a fac-

EXHIBIT 13-4

A DOCTOR REFLECTS ON LIFE AND DEATH DECISIONS

In the early 1970s when renal dialysis and kidney transplantation were being developed, a team at Walter Reed Army Hospital was involved in helping to determine who would receive these extraordinary, life-saving methods of treatment. I was a member of that team. The number of patients in chronic end-stage renal disease far exceeded the number of dialysis machines. The team's job was to evaluate the patients and their living related donors, for their psychological ability to go through these revolutionary new techniques. A separate committee of physicians and laymen determined who should be selected for dialysis. Collectively these two groups decided who would live and who would die. It was the ultimate conflict of interest. Some individuals tried to avoid this duty, but were told that they were the best and most qualified to do it.

Most of these patients wanted to start dialysis, and tried in every way to make a favorable impression, so that they would be selected. If they were not selected, or developed complications, many wanted help to let them die quickly and painlessly. Sometimes they killed themselves. This was particularly difficult for the nursing staff because the patients often asked to be euthanized. After a few months, the medical staff could usually tell who had the will to go on, and who didn't. A few nurses admitted to me that they had thought of granting the patient's wish [for euthanasia]. The only thing that kept us honest and faithful was to remind each other of our oath to do them no harm.

Fortunately, this dilemma lasted for only a few years. The federal government began to pay for renal dialysis, and the biomedical industry ensured that supply met the demand. Renal dialysis was soon available to almost everyone who needed it.

Source: James Collins, Colonel (Retired), Medical Corps, US Army

tor that is not likely to be experienced within the civilian sector and might have enough moral weight to sway the decision in favor of euthanasia. Should this request be considered a request for "medical treatment"? In his article, Dr. Swann asserts that "in war, euthanasia is a justifiable method of treatment available to the physician."^{31(p546)} If it is morally permissible to euthanize a patient, it may only be a small step to requiring this to be performed as part of normal medical practice and it would be much more difficult to refuse to provide this "treatment" when requested. And then the question arises as to whether a physician has a moral responsibility to provide all treatment a patient requests. This is particularly true on the battlefield when it is impossible to refer the patient to another physician and withdraw from caring for the patient. However, even on the battlefield, the physician continues to be a moral agent, responsible for his actions.

The next question is "Who should be the one who actually performs the mercy killing if that is the choice?" There could be an argument for having the physician removed from the process because society does not expect a physician to be involved with killing patients. However, the physician is already deeply involved and any attempt to separate himself in this situation is just a vain attempt to estab-

lish some moral distancing. The method of euthanasia chosen may be important here as well. Using a scarce resource (morphine or other medication) in the face of expected large numbers of patients in the future may be inappropriate. It may be necessary to use a weapon instead. If this is the case, this may also mitigate against the physician being personally involved.

Another issue revolves around what should be done for patients who are unable to participate in the decision-making process because they are sedated or have shock or head injury causing altered consciousness. They do not lose their "right" to the same merciful dying just because they can no longer express their wishes. One would prefer to provide the same level of comfort and dignity to all patients, not just to those who are fortunate (or unfortunate) enough to be conscious. Therefore, one would think that all patients would receive the same benefit from mercy killing and to deny it to an unconscious patient would be unjust. However, by opening it up to patients who cannot request it, one is clearly not making the decision on the basis of autonomy, but by judging what would be in their "best interests." Deciding in the "best interests" of patients, however, allows the physician to determine just what those best interests are. This is a position of great

power—power that can be abused. It could be inhumane to discuss the real situation with those patients unable to be moved but who can understand the gravity of the situation. It may cause more harm for them to know that they are about to be euthanized. Conversely, even if they had requested that they not be euthanized, it may still be in their best interests to be killed painlessly and not abandoned to the enemy. This is a slippery slope through nonvoluntary euthanasia (where the patient can't request it) into involuntary euthanasia (where the patient can request it but is not consulted or the patient requests that euthanasia not be done).

Looking at autonomy issues from the perspective of the medical team raises the question, "If the decision is to leave some personnel behind, how is that decision made?" This could be an autonomous decision by the members of the healthcare team who could volunteer. Or it could be by the commander ordering certain people to stay (possibly the least crucial to the mission). It could even be by random selection. There is no clearly correct answer.

Beneficence. The second principle, that of beneficence, examines what would do the most good for the patient. Using this principle, one would look only at what directly affects the individual patient. Is it ever in his own best interest for the patient to die? Is life such an overriding "good" that nothing that shortens it could ever be in the patient's best interest? If the patient is imminently dying, could the slight hastening of his death be considered in his best interests? This is somewhat beyond most constructions of beneficence in that it is counter-intuitive to suggest that dying is better than living, but in very unusual situations this may well be true. Could psychological suffering by the patient waiting for the enemy to capture him, perhaps torture him, then kill him cause more harm than his dying? It may be that in these extreme situations this harm could occur and a very real suffering may be removed by mercy killing. On the other hand, it may be appropriate to question just how certain it is that the enemy will indeed kill or torture the patients. If one is responding to data based on conjecture and not facts, it would be possible to make a decision that would be at the very least erroneous and at the worst morally suspect. The problem with reacting unquestioningly to "intelligence" (or rumors) is illustrated by the following case/example.

Case Study 13-3: The Terrified Wounded POW. During the Persian Gulf War, a 13-year-old Iraqi soldier, who had been told that the Americans would torture and kill any prisoners they captured, suffered a traumatic ampu-

tation of his foot from a land mine. He hid himself among some corpses to attempt to evade capture. He wasn't found for over 24 hours and was pleading to die when he arrived at the 28th Combat Support Hospital. Fortunately, the mess officer spoke Arabic and by talking with this young man ("You are in a hospital. You are being treated kindly, are you not? Has anyone tried to hurt you?") he was able to convince the patient that he was going to be helped and not tortured.

Comment: This case demonstrates the need for translators in the hospitals. It also demonstrates the misinformation that can circulate during a war. The American forces had likewise heard tales about how the Iraqis treated captives and in general these were also greatly exaggerated.

Nonmaleficence. The third principle, that of nonmaleficence, involves avoiding doing harm to the patient. Is it harmful to kill the patient? One of the earliest statements of the principle of nonmaleficence occurs in the Hippocratic Oath where it states "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone."³⁸ There are at least two interpretations of how the Hippocratic Oath can be applied in this situation. One would hold that the proscription against killing is supreme. It is clear in the oath that one is swearing to not kill a patient, or to advise a patient to kill himself ("To please no one will I prescribe a deadly drug, nor give advice which may cause his death"³⁸). This proscribes any form of physician-assisted dying and is the dominant interpretation of the Oath. The other view would see the withholding of a comfortable death as a cruel travesty of the principle of nonmaleficence in that it is "doing harm" to the patient to allow him to continue suffering (or to face increased suffering when captured) and that this violates the potentially conflicting goal of acting "for the good of my patient," if it is indeed good for him to stop his suffering. It could also be harmful to allow continued suffering without adequate pain control.

Distributive Justice. The fourth principle, that of distributive justice, balances competing claims on limited resources. Obviously, if resources were not limited, all patients would receive excellent pain control, would be evacuated prior to any expected enemy contact, and would be provided with excellent medical care. However, in the Swann scenario there are competing demands on the resources available. There are other patients requiring care, patients who will survive if they receive proper care. The expectant patients have already been prioritized into a lower category based on patients already in the system. The situation clearly can only

get worse, with the unit retreating and being required to set up to receive more casualties from an expected escalation in combat. Who has a greater demand on the resources—current patients or potential future patients who may be more likely to survive? This is a classic conflict in duties. A physician treating his patient is usually unwilling to make decisions limiting his patient's care and he does feel a greater obligation to the "patient with a face." However, in this scenario, the duty to the command and to the other soldiers in the supported unit may require the physician to allow these patients to die in the hopes of treating future patients and overall doing more good. Even the possible course of action in which the expectant patients are left behind with some care providers may be problematic due to the decreased ability of the unit providing care to future patients. Any decrement in the unit's ability to provide care for future patients in the new location is a violation of the orders to retreat as well as a violation of the commander's intent in those orders.

In summary, then, the principle-based ethical analysis looks at the overall situation of these patients in terms of autonomy, beneficence, nonmaleficence, and distributive justice. Ultimately, however, it is how the individual physician weighs these components against the facts as they appear at the moment that will assist in making what may be the most difficult decision any physician ever has to make.

I cannot offer a cookbook "solution" to the Swann scenario based on this analysis, or the following two, for that matter, other than to note that the first step in understanding the dynamics of such a decision must come long before the physician is confronted by such a horror. Only by thinking about these issues now, before the need arises, can a physician guard against being overwhelmed by the reality of the task at hand should events, like those in the Swann scenario, occur. To not begin to consider the situation of these patients and their needs in a hypothetical manner when there is no crisis is to risk being unable to quickly evaluate their situation and respond accordingly in an actual crisis. A failure to be prepared for such a situation is, indeed, a failure to provide care for patients when they are most vulnerable.

In beginning this discussion of the ethical analysis of options, I noted that several approaches would be presented. Each of these has bearing on evaluating the scenario and coming to an ethically justifiable resolution of the patients' needs. The utilitarian analysis that follows is the second of these approaches to understanding the difficult decision that the physician faces.

Utilitarian Analysis

One could defend euthanasia in the Swann scenario by the utilitarian maxim, "the greatest good for the greatest number," because by euthanizing the patients who cannot be transported (in this case due to constraints on time and transportation assets) and displacing the entire functioning unit to a new location to receive more casualties, one could maximize the good done for the line units and other, potentially salvageable, casualties. This could even contribute to winning the war and protecting society, an apparent good that presumably would have some moral weight. If any members of the healthcare team were left behind with the casualties, this would diminish the effective strength of the unit, thereby decreasing the good that could be done for the expected casualties in the future. By analogy, using any of the limited medical supplies or medications to provide further care for those left behind would also diminish the good to be done for future casualties. Using this model, the method of euthanasia must be examined. It would be inappropriate to use the limited morphine to assist in the death of the expectant patients, but rather it may be appropriate to use a weapon or other method of ensuring their death. The patients who are not expectant will also present a problem. They can not be transported either and they may need to be left with only limited ammunition and possibly no medical supplies or personnel. This may be such an unusual situation that extreme solutions are necessary. Using this line of reasoning, the utilitarian analysis would seem to require euthanasia of (or simply abandoning) all patients and retreating with an intact unit and supplies.

Conversely, however, should this become policy, the utilitarian analysis might reach the opposite conclusion. This concept was introduced previously in the section on triage. As stated before, the excellent medical care traditionally provided to US troops is listed as a "force multiplier." US soldiers are more willing to expose themselves to danger because they believe that they will receive superb medical care if they are wounded. However, if soldiers perceive that wounded comrades may be killed within this medical system, particularly if the general perception is that the wounded are not requesting this, it could diminish the "will to fight" and possibly affect the outcome of the battle.

Once again, it is clear that the conclusion depends on the interpretation of the facts, an analysis of their probability, and their weighting (or prioritization). There truly is no simple, consistent, "book answer."

Ethical analysis is often unable to identify a single, proper course of action.

Military Specific Analysis

There are several problems with euthanasia on the battlefield, some of which can be generalized from civilian experiences and others that may be unique within the military. In the discussion that follows, several of these problems will be explored using the experience from the Netherlands, which has recently legalized euthanasia. Euthanasia has been practiced openly since at least 1973, and, although technically illegal, it had not been prosecuted since 1981, when guidelines under which physicians could practice assisted suicide and euthanasia and report these deaths as such were established. In 2001, the Dutch parliament legalized this practice.³⁹

Attempts to Control the Euthanasia Process. In the Netherlands, where there is a growing experience with euthanasia and physician-assisted dying, there are very stringent controls on the actions, including ensuring that the patient is competent, that there is a well-informed and well-considered request, that there is durability of the request over time, that at least two physicians certify that the request is apparently the autonomous decision of the patient, and that all other options have been explored.⁴⁰ On the battlefield, however, it will be very difficult to have decisions such as these be durable because this is both a volatile and an emergency situation. If there were enough time to develop durability of the request, it would be likely that transportation assets could be arranged. The urgency of the situation requires that these decisions be made within moments and the effects of the decisions will likely be permanent. It may be possible for consultation with other physicians to occur and presumably this would be necessary, if there were more than one physician in the unit. The physician should also utilize the "chain of command" to benefit from the experience of more senior medical officers. Clearly, there would be "strength in numbers" and a difficult decision would be somewhat easier, if one could talk it out with peers. Unfortunately, if the elements of the decision have not been examined before the situation arises, it will be very difficult to quickly work through all the ramifications as the enemy approaches.

"Slippery Slope" Issues. Another concern with following the Netherlands model is that of potential abuses.⁴¹ Various reports show significant underreporting of euthanasia cases in the Nether-

lands and document that many of those reported are actually not in compliance with the standards accepted by the community. Even with these carefully crafted controls, there are many reports of violations of the controls, relaxation of the reporting, and other abuses.⁴² For example, the Rummelink report⁴³ estimated the reporting rate to be 18% and about 2,700 deaths due to euthanasia and assisted suicide. It also documented more than 1,000 cases of patients being euthanized without their consent as well as 8,100 patients being given an overdose of pain medicine, not to relieve pain, but to cause their death. For 4,941 (61% of these patients), this was performed without their consent. There are also reports of infanticide, which are clearly not covered by the legal guidelines. A study similar to the Rummelink Commission's was performed in 1995 with similar results.^{41,44} The reporting rate of cases of euthanasia had improved to 41%, but this still means that the majority of cases were not reported.⁴¹ This report also documented an increase in euthanasia and assisted-suicide deaths to 3,600 while involuntary euthanasia cases were down to about 950.⁴⁴ Reports continue of depressed patients and infants being euthanized. There are reports of older citizens who are afraid to enter Dutch hospitals for fear of being killed.⁴⁵ These data give credence to the slippery slope argument. The battlefield is an arena that is less subject to careful and critical review and thus there is a real concern for controlling euthanasia here.

Moral Issues. There is still a problem from a moral viewpoint with active euthanasia for many professionals. It is difficult to envision a healthcare professional allowing a patient to be tortured or killed in a brutal fashion when overrun by the enemy. This, however, does not mandate that the healthcare professional participate in or encourage the practice of euthanasia. The physician is a moral agent and as such has an obligation to uphold his oath. A physician may find it impossible to participate in the killing of his patients. He, as a moral agent, may feel his duty to his patients and the Hippocratic Oath and Oslerian doctrine of "firstly, do no harm" would prevent his involvement in killing or in abandoning his patients. The Judeo-Christian view of the sanctity of life and the Hippocratic tradition of not killing a patient carry the force of 2,500 to 3,000 years of learning, literature, and culture. It is difficult to overlook this powerful determinant of action, and it is not necessarily appropriate to propose this. Deeply held values may indeed be properly held values and there may be excellent reasons to hold to them.

This rather lengthy discussion of the Swann scenario, including the ethical analysis of options and the impact of those options, can only conclude with the observation that should it ever come time to make such a decision, any physician making that decision must have thought long and hard about the issues beforehand. The physician should also seek counsel from more senior military physicians as he develops his decision-making ability for situations such as these. There simply is no “cookbook” approach, or formulaic solution, that draws the line and states that under these circumstances one should euthanize and under those one should not. The fluidity and chaos of the battlefield are such that it is simply not possible to reduce these decisions to simple approaches.

Military Policy vs. Practicality

Although it may be wrong to propose policy to support battlefield euthanasia, I personally have difficulty in saying that under no circumstances would I

ever request such an action for myself, and therefore I cannot categorically state that I would never even consider this action. I believe that almost any course of action would be preferable to euthanasia and would recommend that fellow physicians examine their convictions as well. It is true that in the rare “supreme emergency” situation, basic moral convictions and moral laws might be violated. However, there is a very real danger in generalizing these situations and making the indication for violating moral laws anything other than such an extreme and supreme emergency that the consequences of not violating the moral law are so unthinkable that they cannot occur. It is possible that the consequences of leaving patients behind to be tortured and killed would constitute such a case and may prescribe euthanasia, but such cases should be extremely rare and the consequences should be carefully examined. The potential negative consequences of adopting euthanasia as official policy are so great that it should remain proscribed and decisions to violate policy should remain extremely rare and subject to review.

PARTICIPATION IN INTERROGATION OF PRISONERS OF WAR

Another issue that may arise on the battlefield is that of physician participation in the interrogation of enemy prisoners of war (EPWs). The most likely scenario would occur when the prisoner is already injured when captured, and he has been presented for medical care. It is also possible that physicians might be asked to use their medical expertise and knowledge to attempt to extract information from an EPW who is not already injured. These courses of action lie on a continuum from ones that are clearly extremely morally objectionable and constitute torture to those that may be morally acceptable. Some cases will be analyzed to attempt to identify some of these issues. It is important to clearly identify factors in the decisions and to carefully weigh the criteria used in deciding.

Restrictions Imposed by the Geneva Conventions

Physician participation in interrogation of EPWs, at least where such participation is able to be classified as torture, is clearly proscribed by Article 12 of the Geneva Conventions concerning wounded and sick in the armed forces: “[they]...shall not be...subjected to torture or to biological experiments....”³ All wounded EPWs are considered non-combatants and as such are afforded protections in general under that status. They are to be cared for without discrimination and to be triaged equally with US troops as well as those troops of allied nations.

“Moral Distancing”

The medical profession has traditionally attempted to remove itself from being identified with some actions not considered to be within its charter by establishing some “moral distance” between itself and the action. An example is the official position of the American Medical Association (AMA) on physician participation in capital punishment.^{47(pp9–12)} In this document, the AMA states that physicians should not be involved in capital punishment. It describes activities that are considered to be participation, including, “but not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.”^{47(p10)} Actions considered permissible by the AMA include testifying at a trial, certifying competence to stand trial, “certifying death, provided that the condemned has been declared dead by another person,”^{47(p10)} and treating acute suffering in the condemned person awaiting execution. The issue seen here is that the medical profession does not desire to be associated with certain actions and therefore attempts to separate itself from even peripheral involvement in the process. This attempt for separation exists even

though a case could be made for physician participation to prevent cruelty or unnecessary suffering. Andre Guillotine was a physician who was concerned with the suffering of prisoners as they were being executed.⁴⁸ He was instrumental in establishing a law requiring execution to be carried out painlessly and efficiently by means of a machine because other less efficient and less rapid methods of execution led to unnecessary suffering of the condemned. His invention therefore would be more merciful. His name became synonymous with execution and his device became a standard method of execution, even being used by the Nazi physicians to obtain the freshest “specimens” for their dissection work by having the guillotine attached to the dissecting table and beginning the dissection just after the victim was killed.⁴⁹ (See Chapter 14, *Nazi Medical Ethics: Ordinary Doctors?*, for a further discussion of science and medicine during the Nazi era.) Much of the concern over physician participation in capital punishment or interrogation is that this moral distancing is violated. There is justifiable concern that the active involvement of a physician in interrogation will lead to a “misuse” of medical knowledge and possibly even participation in actual torture.

Developing and Participating in Torture

There is something particularly repugnant in the image of a physician inflicting harm on a helpless person. Unfortunately, however, physicians have been involved in torture—both in developing methods of torture as well as actually participating in the torture process—for generations.^{50,51} The possible areas of involvement will be explored and an attempt will be made to answer why physicians would do so and which physicians could be most at risk for this.

Participation in torture can occur at any point along the process but will be divided into development of methods of torture; examinations and treatment prior to torture; presence, examination or treatment during torture; examination or treatment after torture; and concealing facts after torture.

Physicians have assisted in developing technology and perfecting techniques used in torture. An example of the former is the “Tucker Telephone” (Figure 13-5) reportedly designed by a prison doctor, Dr. A.E. Rollins.⁵² This device used an electrical generator taken from a ring type telephone and wired in sequence with two dry cell batteries. The wires were attached to the victim’s great toe and penis and the crank was turned, generating a high-voltage electrical charge. The process was repeated several times with the duration of charge being

designed to stop just short of the victim “passing out.”⁵² It is clear as well that this method of torture was made more efficient by medical involvement during the use of the device.

Involvement of the medical profession in certifying that prisoners are physically capable of being tortured is the next area of involvement. An example of this reportedly occurred in Israel, in which a physician was required to examine a prisoner and determine if there was any physical limitation to using coercive means (including an isolation cell, restraints, blindfolds, and subjecting him to prolonged standing) in interrogation. This practice has been estimated to involve at least 5,000 Palestinians



Fig. 13-5. The “Tucker Telephone,” so named because it was used at the Tucker State Prison Farm in Tucker, Arkansas. This device was used to deliver electrical shock to an individual. It was developed by the prison physician; its use was perfected by Mr. Jim Bruton, the prison superintendent. The device was last used in the 1970s. Reproduced with permission from the Arkansas Department of Correction. Available at <http://www.state.ar.us/doc/images/gal28.jpg>.

a year during the early 1990s. After this practice was exposed, the Israeli Medical Association directed its members not to fill in the fitness form because the physician by doing so becomes an accomplice in torture.⁵³⁻⁵⁵

The presence of a physician during torture and even using medical means to contribute to the torture is documented in Brazil. Physicians and nurses assisted by reviving victims who had lost consciousness, or even had cardiorespiratory arrests. They also examined patients during the torture sessions and used medications to enhance the effects of torture.⁵⁶ Another example is that seen in the involvement of the psychiatric profession in the use of psychoactive drugs in the former Soviet Union. Patients who were determined to be enemies of the state were also diagnosed as being insane. Psychoactive drugs were administered to these patients, partly in order to make them more susceptible to interrogation.⁵⁷

One of the more infamous cases of physician involvement after torture when the victim was brought to him for treatment is that of Steve Biko, who died on 12 September 1977 of head injuries probably received during a torture session. The physicians involved were disciplined for their negligence in adequately diagnosing and treating this patient.⁵⁸ There are other examples reported in Chile, Kuwait, Mauritania, and Turkey. There are also reports of medical reports being falsified in order to conceal evidence of torture in these same countries.

Physicians in the military may be particularly susceptible to helping in torture methods. There are several reasons for this, including the predisposition of military members to obey orders, the closed and hierarchical structure within the military, and an identification of physicians with the military unit to which he belongs. This identification with the unit is a very powerful force in determining behavior. The means of developing torturers has been studied by Mika Haritos-Fatouros with findings that are disturbing for those in the military.⁵⁹ In Greece, soldiers were selected to become interrogators using guidelines developed during the military junta in power from 1967 to 1974. Potential torturers were selected on the basis of their having political views (as well as coming from a family with those political views) in agreement with those of the junta as well as their strong anti-Communist behavior. They also underwent a second selection process during their training based on their "(a) ability to endure beating of all kinds and exercises to exhaustion; (b) obedience to the demands of au-

thority, even of the most illogical and degrading kind; [and] (c) free selection of the part of the recruit to go through the 3-month hard training of KESA [the Center for Military Police Training]."^{59(p1114)} They had been, and continued to be, subjected to initiation rites that included withdrawing all basic human privileges (food, water, and toilet facilities) designed to induce severe stress. This served to destroy any ability to resist as well as promoting a group identity, fostering an "us versus them" mentality, developing a group mentality that all actions done by the group are appropriate, and that group members are totally dependent upon and faithful to each other. There were group nicknames for each other as well as for the trainers and methods of torture. The recruits were subjected to many of the methods of torture they would ultimately use on others. Haritos-Fatouros, a psychologist, identifies four principles of behavior change used by the trainers. These were (1) overlearning (learning to obey without questioning), (2) desensitization (enduring pain themselves and starting to experience it as a part of everyday life), (3) role modeling (older recruits flogged and degraded the newer ones), and (4) reinforcement (both negative and positive). This whole process has chilling similarities to that received by members of US elite forces, including physicians associated with those units, and they appear to be very effective. Military physicians must be extremely careful to avoid this overidentification with their unit and becoming participants in illegal or unethical actions.

Battlefield Cases of Physician Participation in Torture

A continuum of cases will be presented, with possible explanations for participation or nonparticipation for each. These cases are fictional but are based on situations that have occurred on the battlefield.

Case Study 13-4: Administering Drugs to Assist Interrogation. A captured enemy soldier is brought to a military physician by troops who are specialists in interrogation, including medical facilitation of the process. They tell the physician that this captured soldier knows vital information that could prevent the destruction of an entire unit. The interrogators want the physician to give this soldier succinylcholine to transiently paralyze his respiratory muscles so that he will remain alert but unable to breathe. The terror this produces should induce him to talk after the effects of the paralyzing agent have worn off. If a single administration isn't effective, the dosage could be repeated as often as necessary.⁶⁰

Comment: In this case, the requested medical intervention is clear. The physician is asked to be directly involved in the interrogation. This medical intervention is clearly torture. Succinylcholine is a depolarizing neuromuscular blocker that will cause total paralysis of all skeletal muscles, including those required for breathing. The patient is fully awake and alert, but unable to breathe and would need artificial ventilation to survive. The effects wear off in approximately 5 minutes.

As was discussed earlier, this degree of involvement is clearly proscribed by Article 17 of the Geneva Conventions concerning treatment of prisoners of war²³ and would generally be condemned by the medical profession. Thus, the superficial answer to this request is that this amount of involvement is well beyond the comfort level of most physicians. However, there may be factors that would cause the physician to reach a different decision. The size of the unit in danger, or its importance, may have some moral weight for the physician in deciding about participation. If the unit is a major command, and its being destroyed would cause the war to be lost, this might be considered the supreme emergency addressed earlier. Another possible situation could be one similar to the terrorist attacks on September 11, 2001 on the World Trade Center towers in New York and the Pentagon. If one of the terrorists had been captured before the others were able to execute their missions, it could become more attractive to use all means available to save the lives of thousands of American citizens. But in the absence of a supreme emergency, it is difficult to justify physician participation in this interrogation, both legally and morally.

Another form of chemical interrogation that these specialists might suggest uses Sodium Amytal®, the so-called “truth serum.” This agent is a barbiturate with an intermediate onset and duration of effect that may assist in a hypnotic state or decrease resistance to questioning. This differs slightly from succinylcholine in that this method of extracting information is less terrifying and thus less likely to be considered torture. Sodium Amytal® “just” loosens the EPW’s inhibitions and makes him more likely to talk. (This effect is questionable and its effectiveness is probably much less than is commonly believed, but the ethical issues remain the same.) In this situation, the intervention is possibly less clearly forbidden under Article 17 of the Geneva Conventions, as well as Article 13 (“no prisoner of war may be subjected to...medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the pris-

oner concerned and carried out in his interest”²³), but ethical issues persist. One issue in both variations of this case is the use of medical knowledge and expertise in the interrogation. There is no moral distancing here. The physician is deeply involved in using his unique abilities for purposes other than the best medical interests of the EPW. This is at the very least a violation of the EPW’s autonomy and would be very difficult to justify ethically. The extreme emergency issue discussed before could be applied to using Sodium Amytal® in this case. Once again, this would seem to be the only potential justification for such an action. This extreme emergency situation should be invoked very rarely, if at all, because grave violations of human rights could be condoned using this argument. Even with very stringent controls, a true slippery slope would likely occur and it is probably appropriate to forbid any use of these techniques. Department of Defense doctrine prohibits the “use of any form of physical or mental torture or any coercion to compel prisoners to provide information”^{61(p4)} and this is appropriate.

Another reason mitigating against the use of medical methods of interrogation is that there is the likelihood that even if these methods were to be employed, the EPW would not give information or that the information given would be false. It is felt that torture is extremely unlikely to give valuable information⁶² and therefore the lack of likelihood of success should mitigate against using torture as an interrogation technique. This may remove even the extreme situation justification for the action.

Case Study 13-5: Withholding or Delaying Treatment to Facilitate Interrogation. During intense combat, a captured enemy soldier is brought to the military physician. The EPW’s arm is hanging limply by his side, injured by a missile. He appears to be in mild pain. Before the physician can assess the damage he is told that this captured soldier has information that could save the lives of several of the units’ soldiers. The soldiers want to question the EPW immediately because any delay in obtaining information could lead to the loss of the soldiers. They add that if they offer him treatment only on the condition that he gives them this information, this might make the difference between his talking or not talking and thus saving several soldiers’ lives.⁶⁰

Comment: The issue in this case is whether it is appropriate to withhold medical care, or to predicate medical care on cooperation by the wounded EPW.

Withholding or delaying of treatment as a tactical approach to gaining information from an interrogation is clearly forbidden under Article 12 of the Geneva Conventions, which notes that individuals

“not willfully (sic) be left without medical assistance and care....Only urgent medical reasons will authorize priority in the order of treatment to be administered.”³ However, it is important to look at the ethical issues involved here as well and to make a decision based not only on the legality or illegality of the action. In these circumstances, this action would be difficult to justify ethically. The EPW’s autonomy would be clearly violated if needed medical care were to be withheld or predicated upon his disclosing information. Beneficence would dictate appropriate medical care when triage and medical indications are met. Nonmaleficence would also mitigate against refusing care. An argument might be made that the EPW is still acting as a combatant if he refuses to disclose the information, but this is an extremely weak argument and would not hold up under examination to determine if it could be generalized to all situations, which is a basic tenet of ethical decision making. If friendly soldiers should not give this information if they were wounded and captured, this shouldn’t be expected from enemy soldiers either. Geneva Conventions (Article 17) are clear in what information is required from prisoners of war (“bound to give only his surname, first names and rank, date of birth, and army, regimental, personal or serial number, or failing this, equivalent information”²³), and information critical to the war would clearly be protected. It would also seem to be a form of torture under Article 17 to withhold pain medication or to refuse to treat a person unless he would disclose information (“No...form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to unpleasant or disadvantageous treatment of any kind.”²³) This is a very short “slippery slope” distance from even more active participation in torture.

Case Study 13-6: “Looking the Other Way”: Participation by Silence. The military physician is treating his own and enemy soldiers during intense combat and has heard stories that on occasion captured soldiers who have vital information and will not talk are taken up in helicopters. If they continue to be silent, they are thrown off. The physician is now treating an injured enemy soldier for a superficial flesh wound. The paramedic comes to the physician and states that interrogators waiting in another room were overheard to say that the enemy patient now being treated has vital information. After he is finished treatment, they are considering threatening to take him up in a helicopter and to throw him out if he won’t talk.^{63(p453)}

Comment: Conflicts are more likely in this case, because there is some moral distance for the physician. The reports are more hearsay than actual fact and it is thus

possible that the interrogators are not really considering such an action. It is also possible that the stories of such actions are exaggerated and that the discussion between the interrogators is just for “show.”

However, if the facts are true, that is, EPWs are being treated in this way, this would be a clear violation of Article 13 of the Geneva Conventions (“prisoners of war must at all times be protected, particularly against acts of violence or intimidation”²³). If the interrogators in this case are likely to treat the EPW in this manner, then the physician may have an obligation to his patient to attempt to protect him from this action and may attempt to prevent such treatment. Intervening in this way could be justified under the Geneva Conventions treatment for EPWs and as a beneficent action for the patient. A criterion possibly mitigating against this attempt would be that by “blowing the whistle” in this case, future EPWs requiring medical care might not be brought to the medical treatment facility and wounded EPWs may suffer more overall harm than good derived from this current action.

It may also be possible that devoting the necessary time to investigate the allegations, discuss the Geneva Conventions with the interrogators, and follow the appropriate notification procedures may hinder the care of other patients for which the physician is responsible. However, it seems likely that ignoring the possibility that this patient would be tortured would be difficult, if not impossible, for the physician. It would also make the physician a moral accomplice to the torture.

Geneva Conventions require (in Article 129) that signatories search for and prosecute persons who commit grave breaches such as torture of EPWs.^{20,23} The physician who does not attempt to stop such actions would be culpable under this Article and could be prosecuted himself.

The easy and glib answer to the question about physician involvement in interrogation (or even torture) of EPWs is that it is contrary to every tenet of medical practice. However, in battle there are many factors that make this easy answer less satisfactory and will certainly cause some moral distress to those making the decision. It may be impossible for the physician to separate his fear, anger, and hatred for the enemy who may have killed or injured friends or colleagues (or at the very least has caused severe destruction and death to friendly troops) and this may influence his decision. Decisions made under these conditions of duress may not be ethically defensible, or even legal. It is important for all physicians to have thought through such possibilities and to have preliminarily determined some basis for deciding.

CONCLUSION

There are many situations that can lead to stressful decisions, both in peacetime and in war. Caring for patients on a daily basis in peacetime is tremendously challenging with many ethical dilemmas experienced. The cases in this chapter demonstrate how much more challenging it is to care for patients on the battlefield. There are added factors encountered on the battlefield that simply have no civilian counterpart—there usually isn't an "enemy" threatening the civilian healthcare team and civilian patients aren't usually needed immediately for a greater mission. On the battlefield, decisions must be made immediately and often without all the data one would like. One may be stressed, tired, or even wounded at the instant these decisions need to be made. Most likely, one will not have time for deliberation and reflection on these consequences and models. A major way to increase one's ability to make a decision that must be made "in an instant"

but "lived with for the rest of your life" is to approach these issues now and at least have some preliminary internal guides for decision making. The difficulty experienced in making these decisions is perhaps summed up in the following modification of a quote concerning combat surgery often used by Colonel Basil Pruitt,⁶⁴ Medical Corps, US Army—"The certainty of [ethical] opinion is directly proportional to the square of the distance from the site of combat." It is my hope that this discussion has stimulated some questions and some discomfort, for then there may be continued growth in ethical decision making for the battlefield.

The following chapters in this volume will continue to explore the issues unique to military medical ethics, examining the situation as it exists currently. They will also attempt to clarify future directions for study and propose an initial military medical ethic.

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