

## **Virtual Mentor**

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### **Clinical Case**

#### **Recruiting for Military Scholarship Programs on Medical School Campuses**

Commentary by Justin M. List, MAR, and by Robert J. Walter, DHCE

Three months of the first year of medical school had passed, and, in addition to the fields of anatomy and histology, Amanda was beginning to learn more about her classmates. She'd been pleased to discover that she had quite a bit in common with many of the students she'd met; like her, they not only had a fascination with human biology and pathophysiology but were also motivated to help others and to prevent or alleviate suffering.

When an e-mail went out to the first-year class announcing an upcoming visit by a military recruiter, Amanda assumed that her friends would agree that the military had no place in an academic institution dedicated to the promotion of health and the safety of individuals and communities. She was shocked to hear her lab partner say, "Actually, I'm in the Health Professions Scholarship Program. My husband and I have a young child, and putting us into debt for my education just wasn't an option. So, I'll do some military service after my residency, and the Army will cover the entire cost of med school. I don't see any conflict in being a military doctor. I'll make a huge difference by giving care to people who are working to keep us all safe and secure."

### **Commentary 1**

by Justin M. List, MAR

This case provides a snapshot of the diverse feelings people attach to the U.S. military and its methods of recruitment. Amanda and her friend undoubtedly have different perceptions of the military, its actions and influence, and its potential impact on the practice of medicine. Amanda might be against a military recruiter presence on campus because she assumes that military demands compromise the ethical behavior of physicians in some way; thus her concern for her classmate. Conversely, Amanda's friend might assume that practicing medicine in the military will allow her the same freedoms in professional conduct that any civilian physician has. Both assumptions contain some truth.

Since the topic of recruitment on campus can provoke heated discussions, let's elucidate what makes concern about military presence at a medical school disconcerting for Amanda. After all, it is less likely she would be so upset if other governmental agencies that provide loan forgiveness in exchange for service, such as the U.S. Public Health Service Corps or the Global Health Fellows Program of the

U.S. Agency for International Development (USAID), were to recruit at her campus. What concerns attached to the military's presence might shape her views?

My comments on the ethical issues raised with military recruitment (i.e., Health Professions Scholarship Program) at medical institutions, posit that it is ethically permissible in theory for the military to recruit medical students as long as baseline military ethical and professional guidelines satisfy universal ethical standards of the medical profession at large. At the same time, I suggest that prudential concerns that have ethical implications might cause specific individuals to justifiably deny, protest, or hesitate in allowing active recruitment on campus.

### **Guidance for Decision Making: Ethical and Prudential Concerns**

There are two baseline ethical guidelines that, I believe, we must consider in evaluating how the military interfaces with medical students and the medical profession. They are: (1) how military medical ethics compares, in general, with universal declarations of medical ethics, and (2) where military ethics stands on specific issues such as physician involvement in interrogation and violations of medical neutrality (e.g., not providing medical care on the basis of need and urgency, which are normative values in medical ethics). To make a case for allowing military recruitment of medical students, it is essential that the core ethical values of medical neutrality in the provision of medical care and adherence to the ethical standards of the practice of medicine be met.

Students for or against active military recruitment on campus, however, may understandably bring *prudential* arguments to bear on the topic, including (1) general attitudes towards the military that stem from widespread opposition to, for example, the current war policy in Iraq and the possibility that a physician might be part of a military unit in which violation of human rights is practiced; (2) the impact of the financial incentives to accept recruitment among an economically vulnerable population of students, given the underfunded state of medical education; and (3) objection to the current administration's influence on the military's behavior on the battle field or at home, as evidenced by labeling prisoners at Guantanamo Bay as unlawful enemy combatants and limiting their human rights; and by the controversial "don't ask, don't tell" policy towards homosexual men and women serving in the military—a policy with human rights implications that has been rejected by other militaries (e.g., the United Kingdom) that allow homosexuals to serve openly [1]. Prudential concerns such as these certainly have ethical implications, but they arguably do not proscribe recruitment or physician involvement in the military on an ethical basis as long as they do not entail physician violation of established human rights and ethical mandates of the profession.

### **Examining Core Military Medical Ethics**

At the nexus of an ethical examination of military recruitment at a medical school campus lies the question of how well military medical ethics aligns with wider professional mandates in medical ethics—that is, the possibility that physicians' obligations to the military might conflict with their obligations to the medical

profession. This is often called the problem of “dual loyalty,” and it exists in other domains of medicine outside military medicine as well [2]. There are two levels to the dual loyalty inquiry: (1) what official military ethics documents and guidelines dictate and (2) how military physicians and those in charge of them conduct themselves in the field. On core points such as medical neutrality in provision of medical care in conflict situations, official U.S. military medical ethics (according to the *Textbooks of Military Medicine, Military Medical Ethics* [3]) stand largely in line with those of the wider profession, although their guidelines are not always stated as clearly and straightforwardly as they are in nonmilitary professional manuals such as the American Medical Association’s *Code of Medical Ethics*, World Medical Association’s *Medical Ethics Manual*, and the Geneva Conventions of the United Nations.

Physicians for Human Rights (PHR) maintains a library of human rights statements related to medicine practiced in military and humanitarian group settings [4]. PHR monitors the actions of militaries and other groups around the world and government policies pertinent to human rights. A simple query of its search engine displays numerous articles and statements concerning actions that hold negative implications for human rights. Unfortunately, many of these briefs have been created in response to U.S. military, congressional, and executive branch policies. While few military physicians have been implicated in unethical medical behavior, their presence in a military where unethical treatment of people sometimes occurs should be disconcerting to anyone.

In respect to the second aspect of the dual loyalties conflict—what military physicians do in the field—recent years have brought concerns and allegations of physician and health professional participation in interrogation, torture, and prisoner force-feeding in places such as Iraq and Guantanamo Bay. To be clear, if military physicians violate entrenched ethical mandates that proscribe participation in torture and interrogation, either of their own volition or because of orders from military superiors, then medical institutions have a strong case for prohibiting military recruiting on campus. Indeed, their banning of recruiting could be construed a duty imposed by the need for change in the practice of military medicine.

Others have argued elsewhere, as have I, that physicians have a fiduciary duty to practice medical neutrality in all contexts. Conflict situations viewed as public health problems can be likened to an epidemic of disease. Physicians should conceive of conflict situations as destructive, fatal epidemics and respond accordingly [5, 6]. Medical professionalism and the ethical integrity of medicine practiced in its diverse societal domains, including military medicine, should be of the utmost concern to all physicians because the values of the profession are at stake. As Wynia et al. have explained, attitudes of the medical profession reveal much about a society’s well-being and its respect for the rights of its citizens and those of other nations [7]. Given current concerns about certain practices in the U.S. military, Amanda’s reservations are understandable. Medical institutions can play an important role in monitoring and influencing the ethical behavior of other organizations where physicians practice.

Permitting or prohibiting military recruitment on campus might be one way for the profession to make its views known.

### **Concluding Thoughts**

Amanda's opinions about the military's presence and recruitment of medical students might arise in part from a sense of "guilt by association," given accusations of unethical behavior (e.g., force-feeding, unethical interrogation practices, and prisoner abuse) on the part of service members or military health professionals. On this view, if some military personnel violate human rights and health care standards, all military physicians are implicated due to their affiliation—and, one has to suspect, by their failure to speak out about the violations—whether or not they are directly involved. (That physicians should speak out against violations of human rights raises a separate issue that cannot be examined here [5]). The guilt-by-association allegation is, of course, unfair to many outstanding and ethical military physicians. Recently, some physicians abstained from the unethical behavior of force-feeding of prisoners at Guantanamo Bay, while others, unfortunately, reportedly participated [8, 9]. In response to Amanda's hypothetical concern, one can make the counterargument that physicians, especially those knowledgeable in the field of medical ethics, are needed more than ever in today's military and society.

Having looked at statements of military ethics and the conduct of physicians in the military separately, we can return to the question at hand: Is there an ethical argument that justifies a ban on military recruiters at medical school campuses? Based on the criteria I have laid out, the answer appears to be "no," if we are convinced that normative ethical values dictate the military physician's practice, despite any military instruction that he or she receives to the contrary. Given the military's involvement in wars that might not meet the ethical criteria of a "just war" and possible violations of human rights, there are strong prudential arguments—that perhaps gain the status of a duty—for limiting recruitment activities, even if military physicians themselves are not involved in unethical or ethically dubious situations.

Banning military recruiting from campus does not prevent students from seeking out HPSP opportunities if they choose to do so, again, on the proviso that the military satisfies universal medical ethics guidelines. There are many ways to serve U.S. citizens and others around the globe; a career of medical service to the men and women of the armed forces and civilians in combat settings is one example. Amanda, like many who are concerned with the actions of military, possibly recognizes the need to provide exceptional medical ethics education and uphold the rigorous ethical standards of professionalism. Her friend in the vignette holds the same values. In order to continue strengthening and protecting the ethical integrity of the medical profession, medical students, physicians, and the public should settle for nothing less in the military's relationship with physicians. In raising concerns and civil discussions on these issues, the values of transparency and accountability in the medical profession are more important than ever.

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## Commentary 2

by Robert J. Walter, DHCE

When an individual has more than one professional role, the potential or possibility for strain among role obligations exists. In the case of military medicine, a physician is placed at a nexus of the profession of arms and the profession of medicine. Each of these professions has an ultimate end, or *telos*, with corresponding responsibilities and obligations. In the case scenario, Amanda asserts that the ends or goals of medicine and those of the military are incompatible. To oppose that view, one must look to the theoretical constructs and practical realities of both the professions.

The *telos* of a profession provides insight into the theoretical construct that shapes and influences the practical application of its values by its members. Should a conflict between the *teloi* of two professions exist, it might be said to create an inherent or intrinsic incompatibility. Such a situation would mean that anyone who attempted to negotiate the two at any given time would be necessarily in violation of at least one set of professional obligations. On the other hand, if it could be established that the *teloi* of the two professions were, at the very least, commensurate, then theoretically an individual could practice both without necessarily violating the professional obligations of either.

Are the ends (*teloi*) of the profession of arms and the profession of medicine compatible? As described by Edmund Pellegrino, the *telos* of medicine may be broadly interpreted as “the right and good healing action taken in the interests of a particular patient” [1]. Extrapolating from the goal to its social obligations, physicians are charged with the promotion of health within society. The goal of the profession of arms, that is the profession that exists among soldiers who represent a legitimate government authority, is broadly the protection and safety of the society it serves. Both professions claim service to society as a *telos*, and both place self-sacrifice and the promotion of certain common values above personal gain and the pursuit of personal values and goals by practitioners.

Often what is called a conflict between professions is instead a conflict between professional demand and career demand within one profession rather than between professions. The prototypic professions (medicine, law, clergy, and academia) are dedicated to certain common goods and values that benefit society (i.e., health, justice, faith, and knowledge, respectively) and require that their members subordinate the pursuit of personal ends and values and adhere to certain objective standards and values. Careers, by contrast, are not necessarily governed by a set of unifying principles, values, or standards, but allow individual practitioners to pursue individual ends as long as they are within the bounds of respect for the rights of others; that is, one may not pursue personal gain indiscriminately at the expense of other individuals.

It is the pursuit of personal ends or goods versus the pursuit of a common good and the subordination of certain personal ends that distinguish professions from careers. At a theoretical level, both the profession of medicine and the military profession require members to subordinate certain personal ends and adhere to a certain set of objective standards contained within their professional code. Understood broadly, both professions’ goals—the health, safety, and protection of society—are compatible.

While an inherent conflict does not exist when the professions are considered theoretically, the reality of practice may at times present overwhelming and potentially insurmountable obstacles and frustrations that necessitate the practical divorce of two professions. Two cases illustrate this point. In the first, the role obligations of the professions may become blurred to the point that the agent is

unable to discern effectively which acts are proscribed by each profession. A physician in a noncombatant role in asymmetric warfare, for example, may not be able to tell whether it is more important to observe the immunity of an ambulance carrying opponent victims or to protect his or her troops from possible ambush by a weapon- or bomb-carrying guerilla fighter hiding in the ambulance. In the second case, role conflict may arise from the manner in which one or both of the profession is employed or embodied within specific circumstances. Many of these conflicts-of-circumstance are shared by military physicians and their civilian counterparts, e.g., whom to treat, allocation of scarce resources, complicity with actions that conflict with personal morality.

The difference for the military physician is that these conflicts take place within the context of combat and war. While few would object to the social good and necessity of a standing military for civil and national defense, there are those who might object to the means employed toward that end in particular instances. The military's means and activities might conflict with personal beliefs or moral standards. When this conflict occurs, it raises the question of how complicit that individual may be by his or her association with the military profession.

In the case of a military physician, the role is that of a noncombatant whose primary responsibility is the treatment and evacuation of wounded soldiers. The military physician plays no direct part in the aggression, though returning former patients to the fight is an indirect contribution to the war. This is an important distinction, since the intention of an agent (physician) imparts a moral character to his or her actions. The physician's intention is the restoration of health and the prevention of disease; it is not necessarily the intent of the physician that the aggression persists.

A parallel example can be found within the domain of civilian medicine. Individuals enter the profession of medicine with the intention of serving its proper goods and ends, desiring to help others and to act as instruments of health in society. Yet, for many, entry into the civilian medical profession is entry into a broken U.S. health care system that permits death and disabilities due to poor access to care. We do not, however, claim that physicians are therefore complicit with this often unethical distribution of health care simply by virtue of their participation in the profession of medicine. This example shows that material cooperation within a system—even one that conflicts with personal morality or the *telos* of the profession that it incorporates—does not necessarily invalidate or implicate the actions of individuals whose intentions are true to their profession.

### **Prioritizing the Conflicting Goals of Two Professions**

So far I have argued that the ends of medicine and the military are not inherently incompatible, and that the practices of these professions are not necessarily incommensurate. When an individual (or group of individuals) works toward two distinct *teloi*, even commensurate *teloi*, the potential that their intermediate ends and goals will come into conflict is real. One can point to a number of conflicting intermediate examples, such as who is treated first, allied soldiers or injured hostile

combatants? What means of triage should be employed? What is the extent to which a physician is a noncombatant? Is there a role for the physician within the realm of prisoner-detainee interrogation? How might one negotiate these conflicts?

One approach to resolving the conflicts requires a hierarchical structuring of goods that may be referenced when conflict occurs among them. Simply put, is the individual a soldier first or a physician first? This is, in part, a personal consideration that must be reflected upon by all military physicians. At the same time, the axiological structuring of values is too important to be limited solely to the realm of personal reflection. It requires a broader discussion among all those who participate within this group; it should be discussed at the organizational level within the medical corps.

Another instance of conflicting intermediate goals may be useful in illustrating the point. Within the profession of medicine, we often speak of intermediate ends or goals, such as palliation of pain and suffering and the prolongation of life. These intermediary ends or goods are sought by the profession in the service of its *telos* (the right and good healing action taken in the benefit of a particular patient as the ultimate goal of the practice of medicine). There are times, however, within clinical care situations that the intermediate goals conflict, as in the case of an individual with multi-organ system failure. Here, it is possible to envision a point at which it is no longer medically feasible or personally preferable to pursue both intermediary goods, and thus the focus should be placed upon one or the other of them. Hospice might represent an example of such a transition point.

Within contemporary medical practice in the United States, the negotiation of these divergent goods is achieved by reference to the hierarchical structuring of values by the patient; that is, the patient, by reference to the values he or she holds to be important (and how they are hierarchically ranked), decides which intermediary end is to be sought. So, too, is the military physician called upon to rank hierarchically the intermediary goods of the profession of medicine and the profession of arms to resolve scenarios in which those goals conflict.

### **Amanda and the Military Recruiters**

In the case we are presented, Amanda believes that military recruiters have no place in an academic institution devoted to healing and public safety. Her claim is most likely based in a belief that the profession of medicine and the profession of arms are either intrinsically or practically incompatible in their goals. While this may be a view of a significant minority in society, I have attempted to illustrate some of the main considerations that must be investigated in order to determine whether *teloi* and practical realities of the profession of medicine and the profession of arms are incommensurate. It has been my argument that indeed there appear to be no theoretical incompatibilities between the two professions and, while the potential exists for practical incompatibilities that necessitate reflection on the part of the individual physician and medical corps, these are not so insurmountable as to render the professions incommensurate. Rather, while the role the military physician

embodies many unique challenges that require reflection and discernment, it presents the unique opportunity to practice medicine in the important capacity of caring for individuals who willingly and selflessly place their lives in harm's way in service to their country and its ideals.

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