

Dual Loyalty Conflict: the Ethical Ramifications of Medical Professionals' Participation in Torture

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Introduction

The act of torture has been a part of our society for hundreds of years. But since the Second World War there has been a major shift in the views of our global society, especially in the Western world, about the unethical and unnecessary use of torture. With the widely accepted concept of universal human rights it has become common to condemn torture by governments and populations across the world. But despite the fact that a majority of countries have shifted their stance to some degree about the unethical nature of torture, its use remains prevalent in our world. There have been many cases of torture by governments and militaries within the past 100 years including: Japanese Imperial Unit 731 during the Second Sino-Japanese War (1932-1945), Nazi Germany during World War II, and the United States prisons Abu Ghraib (2003-2006) and Guantanamo Bay (2002 to present). There are many arguments about the efficacy of torture; some argue that it is effective and necessary to maintain the national security of a country and to be able to stop premeditated attacks from occurring. Others argue that torture is ineffective at collecting accurate data and is a gross violation of personal human rights. I agree with the later, there is no ethical justification for the use of torture under any circumstance. This paper will not be focusing on the ethics of torture as a whole, rather, it will examine the ethical implications of using medical professionals to aid in the design and implementation of torture techniques in military situations, with focus upon the four examples listed above. To analyze these cases, I will be using the dual loyalty conflict, which is an ethical debate that can be tailored to examine where a medical professional's loyalty should lie in the case of torture. The purpose of this paper is three-fold: to analyze the dual-loyalty conflict, to examine the historical involvement of medical professionals in torture, and to offer practical suggestions to improve the future outlook of the conflict.

Torture, which can be defined in various ways, typically displays three characteristics: 1) the act is intentional, 2) it can encompass both mental and physical pain, and 3) it is done either as revenge, to collect information, or to punish. For the purpose of this paper, the definition that will be used comes from the *United Nations Convention Against Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (UNCAT)*. It accurately encompasses the overarching notion of torture, was created by an international body, and includes 157 parties and 81 signatories. The definition states that:

...torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It should not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (United Nations)

As for the term “medical professionals”, this paper uses the term to include anyone, whether a civilian or military member, who is a medical health professional. This means mental and physical practitioners including, “pathologists, primary care physicians, psychiatrists/psychologists, nurses, battlefield clinicians, and advisors to interrogators” (Clark 573).

Dual Loyalty Conflict

The dual-loyalty conflict, within this context, is the ethical question of whether a medical professional’s first loyalty should be to their military or to their medical ethics. A person who

feels that their loyalty lies primarily with the military would argue that it is acceptable and ethical to play a role in torture because their loyalty to their government and military trumps that of their medical code. If a medical professional subscribes to the idea that their first loyalty is to their medical profession then they would argue that it is unethical for them to aid in acts of torture because it damages the role of medical professionals to ‘work in the best interest of their patients’. However, dual loyalty is not limited to military situations. The conflict occurs anytime a medical professional faces a conflict between their medical oath and another interest.

In the public health system it:

Occurs when a managed care plan or hospital exerts financial control over physicians’ choices, when public health regulations require that a physician break patient confidentiality and report someone with a communicable disease, or when a psychiatrist is bound to report that his/her patient may be dangerous to a vulnerable third party. (Solomon)

These examples give some insight into the diversity and frequency of the conflict. It is not confined to the parameters of the military and the question of torture, but rather a more widely encompassing term. Michael Gottlieb explains it as being,

The conflict between their professional duty of loyalty to patients and their concomitant responsibilities to third parties... a physician may have a responsibility to perform a court’s request for a forensic evaluation or to perform actions on behalf of state institutions like prisons, which require specific duties of physicians that conflict with their traditional commitments. (Gottlieb 351-352)

Whatever the context, the dual loyalty conflict can have a damaging effect to both the credibility of the medical profession as well as the second party involved. The conflict is not new, but has become more predominant in scholarly discourse since World War II, when the term ‘dual-loyalty’ became the common way to refer to the conflict. Since the increased use of the term dual-loyalty conflict has grown in the academic and medical fields there have been many scholars who have emerged as major writers in the area. Peter Clark, professor with the Center

for Clinical Ethics at Georgetown Medical School and Jonathan Marks, a professor of bioethics, humanities and law, are two excellent sources on the dual-loyalty conflict in the current era and how the conflict has affected the relationship between medical ethics and international laws and norms.

One reason the conflict is unique in the context of the medical professional versus the military is the complexity of the military relationship and the sense of nationalism that accompanies the military. Gottlieb argues this in his article *Executions and Torture: The Consequences of Overriding Professional Ethics*, stating that,

Military duties are often particularly difficult to reconcile with other personal, professional, or even legal duties. The history of judicial deference to the military in this country [USA], embedded in the Constitution and known as the separate community doctrine, reflects our willingness to cabin military duties as both separate from other duties and, for the most part, unconditional. (Gottlieb 352)

What this does is create an atmosphere where torture can become acceptable, or at least tolerated, because of a blatant or underlying disrespect for human rights by the hierarchical organization. Marks argues that “there is a failure at the highest levels of government to internalize the most fundamental norms of human rights law and laws of war” (Marks 73).

Changing this often requires a shift in ideology and the increase in accountability and standards, none of which are easily implemented. Examples of ways to collectively work against medical professionals participation in torture are discussed later in this article, but will now look at the ethical arguments surrounding dual-loyalty in the context of torture.

A Consequentialist View

Consequentialism is the ethical theory that states that the efficacy of an action is based on the consequences that the action produces. 'It views the moral rightness of acts, holding that an act is morally right only in relation to the consequences of that act or related to that act' (Sinnott-Armstrong). Using consequentialism to examine torture can create arguments both in favour of and against torture. For example, Jeremy Bentham argued that torture was the ethical choice if it would save more people than the amount of harm it would cause:

To say nothing of wisdom, could any pretence be made so much as to the praise of blind and vulgar humanity, by the man who to save one criminal, should determine to abandon a 100 innocent persons to the same fate? (Bentham 347)

The notion here is that torture is acceptable because, if successful, the information received using torture is theoretically able to protect national security and innocent lives. But, while the ethics of torture as a whole is similar to the ethics of dual-loyalty in the context of torture, they are not the same, and the ethical arguments surrounding them have their differences. The core difference is the role of medical professional and their ethical code to work in the best interest of a patient, rather than a military officer's goal to maintain the security of their country. For medical professionals the question is the hypothetical situation in which the act of torture is already being committed by a third party (i.e. the military organization), and the question is whether or not it is then ethical for that medical professional to play a role in the act of torture. It is the question of whether their involvement helps or hinders the situation and whether the consequences to the medical profession outweigh the benefits of their participation. In the case of a dual loyalty conflict, the medical professional's role to work in the best interest of their patient and to 'do no harm' is damaged. This is, in turn, damaging to the credibility of the medical profession as a whole. Jonathan Marks argues that,

If health professionals are to retain our trust, and if they are to maintain the social and cultural status engendered by their perceived humanitarian ethos, their codes of ethics should do more than simply reflect the most fundamental legal prohibitions. (Marks 55)

The argument in favour of medical professionals participating in torture does not produce a strong enough argument that torture is the necessary means to achieving their intended ends, which is usually collecting information to protect national security. The consequences of torture not only reach the medical profession as a whole, but the individual medical professionals involved, the victims, the interrogators, and the country that commits the violations. I have yet to find an example where the use of torture has produced evidence that has positively outweighed the negative ramifications of the actions. In the case of dual loyalty, a medical professional should place their medical oath and promise to their patients above that of their military when placed in situations of dual-loyalty and it is the global community's job to continue to increase pressure on governments to work to protect medical professionals, both civil and military, from being forced into situations of dual-loyalty.

Main Arguments for Medical Professionals' Participation in

Torture

There are a number of arguments in favour of medical professionals participating in torture, as well as different ways that medical professionals can become a part of the conflict. 'These include instances where the torture is being performed according to the law and therefore doctors regard the law as above that of their medical ethics. Medical professionals may also argue that the patient/doctor relationship is not applicable if the doctor is acting on request of the state and not by the patient, therefore removing the victim's ability to invoke the principles of medical ethics' (Vesti and Lavik 4). Arguably in a perfect world there would not be torture. However,

until that time, we must not be naïve and understand that torture does occur and will continue to occur in the foreseeable future. The main argument here entails that torture is inevitable in our society, and in order to give the victim some form of protection, it is ethical to have medical professionals play a role in the design and implementation of those torture techniques. It's the notion that it is "better to have someone on your side than to have no one". A report from the Irish Republican Army (IRA) on 'depth interrogations' argues that "if torture becomes inevitable that it is necessary to humanise it and have an attending physician to moderate it and even stop it if, in his medical opinion, it becomes physically dangerous" (Vesti and Lavik 5). If the reality is that a person is going to be tortured by a military or government organization than is it not better to have a medical professional present to be able to monitor the torture and the techniques used to keep the victim as safe as possible? This could mean that a medical professional would be able to design an interrogation program for a patient that could exploit their fear of the dark rather than have them receive physical pain, or perhaps find a weakness that could make them more compliant without causing severe harm. It could also allow a medical professional to monitor interrogations to ensure the patient remains medically stable and could be theoretically safer for the detainee. Clark discusses this idea, asking;

"once caregivers share information with interrogators, why should they refrain from giving advice about how best to use the data? Won't such advice better protect detainees, while furthering the intelligence-gathering mission? And if so, why not oversee isolation and sleep deprivation or monitor beatings to make sure nothing terrible happens? (Clark 577)

But this leads to a grey area where the best interest of the patient and the best interest of the interrogations success can become unbalanced. The main goal for battling against dual-loyalty is to remove that grey area and create concrete rules and regulations to solidify a medical professional and military organizations expected actions in this situations. Leonard Rubenstein,

executive director of Physicians for Human Rights, explains how this grey area can have negative repercussions.

A doctor approached by a commanding officer for advice on a sleep deprivation program inflicted on a prisoner can reasonably argue that he wants to be sure the program doesn't do lasting harm. Similarly, a medic can advise an interrogator on a patient's physical limitations to avoid serious injury during interrogation. In these situations it may seem reasonable for a doctor to offer advice, but that advice ultimately makes the doctor complicit in torture. In each case, that information can provide interrogators an idea of a subject's weaknesses and allow them to exploit those weaknesses. (Clark 574)

That is a reoccurring theme within this multi-dimensional dilemma. While a medical professional often has pure intentions, in this case to care for their patient and protect their physical well-being, those who are administering the torture techniques may not hold that same mind-frame. This is not to say that those within the military who are involved in torture have purely negative intentions; officers are often working under the consequentialist/utilitarian framework believing that the information they could acquire through torture could help innocent people and their fellow soldiers. Orders are often brought down by higher-level command and officers are given no choice or leeway in their actions. One of the main reasons why this topic is so controversial is because the stakes can have such a monumental impact, and the demand for results leaves little room for interpretation. The use of torture often occurs in high-stress situations in which the need for answers is viewed as the difference between life and death. But this is a naïve approach. If an organization is willing to implement torture techniques, then their first priority is not the safety of their victim; instead they are focusing on the belief that torture produces results that outweigh the potential damages. This means that the medical well-being of the detainee is often overlooked and of lesser importance than the mission's success. Marks argues that in the case of Guantanamo Bay that "psychiatrists and psychologists were brought

into the interrogation process not as gatekeepers or health care advocates for detainees, but as adjuncts to the interrogation mission” (Marks 56). He goes on to say that “after some US Navy physicians refused to force-feed detainees, the Department of Defense began screening doctors assigned to Guantanamo Bay to ensure they would be willing to participate” (Marks 57). But this argument also becomes void when examining the torture and medical practices with the first two cases: Nazi Germany and Japan’s Unit 731. In these cases, the actions of medical professionals showed no desire to collect vital information from detainees and victims were rather used for experimental testing.

The Roles of Medical Professionals According to National and International Bodies

Over the last century there has been an increasing amount of international treaties, conventions, and norms with regards to human rights. Medical ethics were developed and improved with new knowledge and insight as well as past ethical teachings. “The Hippocratic oath and the teaching of Moses Maimonides are examples...both of these stated in essence that no considerations except the interests of the patient may enter into the relationship” (Vesti and Lavik 4). This is no surprise given our more globalized and interconnected world combined with the rise of universal human rights. And what this has allowed is for the increased protection, or at least international acknowledgment, against a variety of human rights abuses and the creation of ethical standards that many believe our society should follow. This includes ethical standards for organizations including militaries and governments, as well as professions including doctors, politicians, and even aid workers. The reason these ethical standards are so important is because of the consequences when their standards are broken. “When legal protections for detainees are being

undermined, it is all the more important that professional ethics (in particular, medical ethics) speaks clearly and that codes of ethics do not become subordinate to, or dependent upon, unilateral reinterpretations of legal doctrine” (Marks 55).

The physician in question is a professional who has been enlisted, recruited, hired or seconded like any other professional, to advance the goals of the military. She would seem not to have any discrete medical obligations that might challenge, much less override, those attached to her military duties. Her professional ethics are no more robust, supported, or recognized by the military or government than her personal ethics. Given the current status of medical professional norms and responsibilities in the military, which make them virtually indistinguishable from personal norms and responsibilities, a physician’s complicity and involvement in “legal” but medically unethical activity in Iraq and Afghanistan should be no more surprising than the participation of non-medical military personnel who follow orders that later come under judicial review. (Gottlieb 354)

However there have been great strides in the past 70 years by the international community in creating international legislation against torture, both from multi-national governmental organizations and medical bodies. This shift has come with the widespread implementation of universal human rights codes and was predominantly started by the West after World War II. The purpose of these reports has been to increase awareness of the problem and to attempt to create international norms against the use of torture and make it easier to condemn and deter governments and their militaries from implementing torture within their institutions.

Declaration of Geneva

The Declaration of Geneva, also referred to as the Physician’s Code, was created in 1948. ‘It was accepted into the General Assembly of the World Medical Association and has been a staple oath for medical professionals globally since it’s implementation. The Declaration’s goal is to create an easily read and understood code which remains relevant in the international community, which is why the declaration has seen three amendments (1968, 1983, and 1994) as

well as two editorial revisions in 2005 and 2006. What is different about this Declaration as opposed to other national and international documents is that it is short and concise, comprised of only 11 points. In regards to a medical professionals role in torture, there are six relevant points: “3. I will practice my profession with conscience and dignity, 4. the health of my patient will be my first consideration, 5. I will respect the secrets that are confined in me, even after the patient has died, 6. I will maintain by all means in my power, the honour and the noble traditions of the medical profession, 9. I will maintain the utmost respect for human life, and 10. I will not use my medical knowledge to violate human rights and civil liberties, even under threat” (World Medical Association).

The Geneva Convention also outlines standards in regards to the treatment of non-combatants. The Conventions doctrine, “Relative to the Treatment of Prisoners of War”, was written in 1949 and conclusively condemns the use of torture in all situations no matter the circumstance, which seems to be a reoccurring theme in medical texts.

Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction...The following acts are and shall remain prohibited at any time and in place whatsoever with respect to the above-mentioned persons: violence to life and persons, in particular murder of all kinds, mutilation, cruel treatment and torture; ...Outrages upon personal dignity, in particular, humiliating and degrading treatment...No physical or mental torture, nor any other 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 any unpleasant or disadvantageous treatment of any kind. (Clark 572)

United Nations

The United Nations Convention Against Torture is the most widely known and accepted anti-torture declaration made by the international community. The Treaty has 157 parties and 81

signatories to it, although it is argued that some countries signed to the declaration including the ‘United States, Israel, and Nigeria’ (Amnesty International), leading many to argue that the treaty is not sufficient for the problem at hand. The Treaty, under Article 2(2) states that, “no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture” (United Nations). Continuing on in the Convention is Article 2(3) which argues that this Convention condemns torture as a whole, and that no one can override the Convention: “an order from a superior officer or a public authority may not be invoked as a justification of torture” (United Nations). This section addresses the same area as the dual-loyalty conflict does, arguing that the secondary force against the medical professional does not have the right to engage in torture and place the medical professional in that role as well. The UN Convention Against Torture is furthered by article 5 of the Universal Declaration of Human Rights and article 7 of the International Covenant on Civil and Political Rights, both of which provide that no one may be subject to torture or to cruel, inhumane or degrading treatment or punishment” (United Nations). What the United Nations has succeeded in doing is creating a document that has at least been accepted by a large percentage of world leaders. It was created out of the atrocities of World War II and has been a strong step towards fighting against torture while creating a path that has allowed for more international dialogue against torture, and the protection of medical professionals from complicity in the act of torture.

In 1982 the United Nations introduced the Principles of Medical Ethics. This document sets out the “principles of medical ethics relevant to the role of health personnel, particularly physicians, in protection of prisoners and detainees against torture, and other cruel, inhumane or degrading

treatment or punishment” (United Nations General Assembly). The six principles regard the role that medical professionals have in situations of torture and human rights abuses. The principles include:

1. Health personnel, particularly physicians, charged with the medical care of prisoners and detainees, have a duty to provide them with protection of their physical and mental health and treatment;
2. It is a gross contravention of medical ethics...for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture and other cruel, inhuman or degrading treatment or punishment;
3. It is a contravention of medical ethics for health personnel, especially physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health;
4. It is contravention of medical ethics for health personnel, particularly physicians: to apply their knowledge and skills in order to assist in interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners or detainees; and
6. There may be no derogation from the foregoing principles on any ground whatsoever, including public emergency. (United Nations General Assembly)

The United Nations resolution is a good foundational basis for capturing the overarching issue of medical professional’s roles and actions in cases of torture, but needs to be expended to play a larger role in today’s medical ethics.

World Medical Association

Although it is important to consider reports written by international governing bodies, it is also necessary to consider the legislation on medical professionals’ participation in torture according to international medical bodies. For instance, The World Medical Association created the Declaration of Tokyo in October 1975, officially named the “Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhumane and Degrading Treatment or

Punishment in Relation to Detention and imprisonment”. The Declaration contains seven statutes, all of which specifically regulate a physician’s behaviour in the context of torture. They state that:

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.

The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.

4. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.
5. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.
7. The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

There is clearly an increased momentum on an international scale against the use of torture as a whole, as well as the prohibition of medical professionals, especially physicians, playing a role in acts of torture and human rights abuses.

Historical Context

A historical context is necessary for any practical analysis of an ethical question, and the dual-loyalty conflict is no exception. ‘Medical knowledge became the province of a new kind of scientifically trained doctor during the 15th and 16th centuries. During this time doctors participated in healing the sick as well as judicial interrogation under torture and executions in both secular and ecclesiastical law. This was one of the first instances of a medical professional’s codes of ethics and standards. Doctors would oversee and participate in the physical wellbeing of the accused and condemned, as well as being an authoritative figure legitimizing the torture and executions ordered by the state’ (Vesti and Lavik 4). Since the 16th century there have been major shifts within medical ethics and standards for medical professionals. The 20th and 21st century, since World War I, has been a time for rethinking and improving the amount of international standards for the military and medical community along with the emergence of universal human rights. ‘Cases of torture began to emerge on a large-scale in the international community during World War II when doctors and surgeons participated in torture and genocide both in Europe and the Far East’ (Vesti and Lavik 4). This paper will focus on four examples from three countries over the past one hundred years. The reason for choosing examples within the past one hundred years is to give a more recent context while still including examples from around the world; three countries on four different continents. The historical examples are: the Second Sino-Japanese War (Unit 731), Nazi

Doctors during the Second World War, and the United States both in Abu Ghraib (2003-2006) and Guantanamo Bay (2002 to present). The examples are not only instances where the governments and militaries have implemented torture techniques but have incorporated medical professionals in the design and implementation of the techniques or have had medical professionals perform the torture and medical experiments exclusively. The examples will provide a more complete understanding of the different situations of dual-loyalty. All of the examples have been gross human rights abuses as condemned by the international community and seems to paint a picture that we have made improvements as a global society to fight the dual-loyalty conflict although we have quite a ways to go before we have sufficiently solved the conflict.

Second Sino-Japanese war: Unit 731

Unit 731 was a unit of the Imperial Japanese Army, led by Shiro Ishii, during the Second Sino-Japanese War between 1932 and 1945 which conducted thousands of human medical experiments. ‘The Unit’s experiments argued to have surpassed in scale, extent, and duration that of Nazi doctors in German-occupied Europe. It took place in a series of camps in Manchukuo and included testing on civilians and prisoners of war, including Chinese, Koreans, Russians, Mongolians, Americans, and other prisoners of war (POW’s). In this circumstance, Unit 731 followed the ideology of Nazi Germany claiming that acts were acceptable because victims were ‘less than human’. “Symbolic of their disdain for human life, the Japanese referred to these testing subjects as “Maruta” or “logs” (The World Future Fund). This “moral disengagement” occurs when subordinates of labelling group regard the interests of the labelled group as less relevant because of the political culture under which they live” (J. A. Singh 11).

This is not specific to this case either as it is seen in the ideology of all four case studies. ‘To prevent dual-loyalty society as a whole must work to protect physicians from being placed in a role where this disengagement can occur. This is also true with the mental adoption of “victim-blaming” which is seen in the cases of the United States and Germany where physicians knowingly or unknowingly hold the victims responsible for their own fate’ (J. A. Singh 11).

In the case of Unit 731, testing on victims focused on physical rather than mental pain. They included: the testing of grenades, flame throwers, and bombs on human beings; the removal of entire bodily organs which were purposely infected with various diseases in order to see the effects of the disease on the organ; amputations of limbs to study the impact of blood loss; frostbite experiments; operations on subjects in which parts of organs would be removed and limbs would be moved around on the body; healthy organs would be removed to study the reaction of the body; food and water deprivation to study the effect and duration before death; air pressure experiments in which subjects died; burning experiments to determine the physiological effect of fire on the human body; x-ray radiation experiments; a combination of animal and human blood experiments; and simulated stroke experiments using air bubbles. The justification for many of these experiments is that it helped Japanese doctors and military understand the damage of war wounds on soldiers so they would better be able to heal their injured soldiers during the war.

These atrocities were carried out by doctors and surgeons for the argued benefit of the Japanese military. Ken Yuasa, a wartime surgeon with Unit 731 in 1942 was interviewed in 2007 about his experience and actions within the unit. He explained that, “his fervor, and the nationalist indoctrination of his schooling, quickly subordinated any sense of conscience. By his second

month at Luan's army hospital, Yuasa was aggressively performing vivisections [experimental surgeries] on live Chinese prisoners, and diverting dysentery and typhoid bacillus to Japanese troops for use in biological warfare" (Yuasa). This is one of the major areas for reform and protection against dual-loyalty. Stressful situations and instances in war tend to create blurred lines of loyalty and past cases have lacked the international standards to protect doctors from swaying loyalties. Yuasa goes on to state that he, "was in denial of the things I did in Luan until the war was over. It was because I had no sense of remorse while I was doing it...we believed that the orders from the top were absolute. We performed the vivisections as ordered. We erased any sense of culpability by doing so, even though what we did was horrendous" (Yuasa). And these are not isolated occurrences. The use of authority to make medical professionals turn against their oath and commit human rights abuses is more common than we would like to admit. One of the most sinister and infamous cases occurred during the same time as Unit 731, and that was the case of the Nazi doctor during the Second World War.

World War II Germany: Nazi doctors

In Germany during the Second World War there was a large amount of human experimenting and testing done by the government and medical professionals.

During the Nazi era, medical ethics no longer applied to individuals. They changed concepts legitimised torture and the annihilation of the infirm, the mentally retarded, and the healthy alike. The methods were developed partly by the medical profession and they were frequently carried out with the direct participation of medical doctors. Furthermore, doctors directly conducted pseudoscientific experimentation in the form of medical torture, and this was freely reported in the medical press. (Vesti and Lavik 5)

While there were many crimes against humanity and genocides occurring under Nazi rule, the area that will be focused on for the argument of the dual-loyalty conflict are the infamous cases

of the Nazi Doctors. ‘These doctors did human experiments on many of the victims being held in the holocaust death camps in Eastern Europe. Four of the most infamous doctors were Dr. Joseph Mengele, Dr. Carl Clauberg, Dr. Herta Oberheuser, and Dr. Karl Brant. Most worked in Auschwitz, and all specialized in different forms of torture and experiments based on their medical specialties and medical positions at the time of their crimes. Their crimes included testing on twins, sewing children together in an attempt to create conjoined twins, sterilization of women, mustard gas experiments, freezing, radiating patients, experimenting with poison, removing vital organs while patients were conscious, and recreating battle wounds on victims’ (Bulow).

These examples are unique because they are of individuals who willingly gave up their medical responsibilities and oath of protecting their patient. But that was of course not the case for most doctors placed in those situations. Those specific cases were the most publicized doctors who were charged with war crimes during the Nuremberg trials. Most of the doctors were not viewed as cold-blooded killers. Most were average, normal doctors living under the Nazi regime with no choice but to abide by the rules handed down to them. As Clark explains,

An extreme case in recent history occurred in Nazi death camps, where doctors supervised killings and selected which people went into the camps and which were killed. Physicians who interviewed Nazi doctors said most were normal people who went home on weekends to be fathers and husbands. They weren’t killers before serving in the death camps and didn’t continue killing afterwards. Those who interviewed US soldiers about atrocities in Vietnam, said there’s an internalization of the ethos of the organization that then prompts actions the person wouldn’t ordinarily perform. (Clark 570)

This was topped with the threat of repercussions to one’s self and one’s family for not following the rules of the regime. This is one of the tragic circumstances that proved to the world the need for a strong international body to counter these atrocities and create safeguards for the future.

Hannah Arendt's work, *Eichmann in Jerusalem: A report on the Banality of Evil*, examines the trial of Adolf Eichmann, a German Nazi who claimed that "he did his *duty*...; he not only obeyed his orders, he also obeyed the law" (Arendt 135), though Arendt is very critical of this legalist defence. Eichmann argued that "I never did anything, great or small, without obtaining in advance express instruction from Adolf Hitler or any of my superiors" (Baumeister and Bushman 7). Fritz Allhoff argues that, "in the crucible of war, physicians serving in the military can end up compromising 'ordinary' ethical standards in pursuit of the extraordinary political objective to which their superiors have committed" (Allhoff 320).

This issue was explored by psychologist Stanley Milgram in the United States during the 1960's. The experiments, referred to as the Milgram experiments, were a series of social psychology tests looking at individuals responses to obey orders given by an authority figure. The experiments began during the time of Eichmann's trials and Milgram sought to answer the questions: "Could it be that Eichmann and his accomplices in the Holocaust were just following orders? Could we call them accomplices?" (Baumeister and Bushman 13). "The results of Milgram's experiment showed that, despite the moral lessons thought to have been learned from the case of Nazi Germany, 62.5% of participants would deliver severe shocks at the highest level even after the shock victims (who were actors) were screaming in pain, and a staggering 85% still continued after the shock victims complained of pain and pleaded to be let out of the experiment" (Baumeister and Bushman 316). But while these examples show the negative effects of obedience, there is much literature, especially on this experiment, about the necessity for mass obedience in our society. Our world would not be able to function if citizens did not follow the majority of rules put on us including laws forbidding stealing, murdering, or even

following traffic laws. Baumeister and Bushman argue that our willingness to obey authority figures is a positive aspect of human psychology because it enables us to live in large cultural groups. But Milgram's experiments, as well as real life historical actions, have proven that blind-obedience for following orders can lead to immoral actions and conflicting internal beliefs. Hence, another form of dual loyalty comes into play, the conflict between following the orders given by an authority figure/authoritative body and questioning obedience when it conflicts with your moral compass. This is often the case with medical professionals as well as military personnel in cases of torture. And often in historical cases, while someone may be aware that the ordered actions are immoral, there would be severe consequences for the individual if they refused to perform the immoral acts.

Others who committed crimes as part of the 'Nazi Doctors' argued that their actions were justified because of the benefits and outcomes of experiments. They argued in line with consequentialism, that the consequences of their experiments were actually more beneficial to their society and therefore necessary. Dr. Karl Gebhard writes:

A doctor high in the Nazi medical hierarchy accused of torturous and murderous experiments on prisoners of war and civilians, claimed, *inter alia* [among other things], that it is a state's right to experiment on persons in order to combat diseases and alleviate human suffering, which would justify experiments on condemned prisoners...Another doctor, Adolf Pokorny, had proposed to Himmler that injections of caladium seginum be tested on 'criminals' as a means of sterilization in lieu of castration. He claimed that he had acted out of a 'lesser evil', damage-minimizing motive. (Ginbar 328)

But in both of these cases the arguments were not accepted as justification for the actions of medical professionals who were not working under a coercive atmosphere. Without a coercive atmosphere doctors are less likely to have been placed in the dual-loyalty and more likely to be acting by their own accord. Another example was Dr. Herta Oberheuser, whose majority of

experiments were on prisoners at Auschwitz and Ravensbruck by recreating battle wounds to improve medical treatment for Nazi soldiers injured in war. But those working freely in these instances were unable to claim that these actions were justifiable and acceptable uses of their roles as medical professionals. This question of responsibility and duty can hopefully be answered by international doctrines and norms and will be discussed further in this paper.

The United States: Guantanamo Bay and Abu Ghraib

In the case of the United States, the two most publicized uses of torture in the 21st century are Abu Ghraib and Guantanamo Bay. Both situations are post WWII examples of the military superseding international doctrines and having medical professionals participate in torture.

Abu Ghraib is a prison located outside of Baghdad in Iraq, which was used by the US military as a prison to hold convicted terrorists during the 2002 war in Iraq. ‘The prison was used between 2003 and 2006 before it was transferred back to the control of the Iraqi government. During the height of its use it housed approximately 7,490 prisoners’ (LTG Mikolashek 23). This included “107 detainees under the age of eighteen...some detainees as young as eight years of age who had been subjected to the same mistreatment as adults” (Clark 575). The prison has been exposed as having frequently practiced torture during its use, including the use of medical professionals to aid in torture. Crimes at Abu Ghraib and within Iraq and Afghanistan,

“included beatings, burns, shocks, bodily suspensions, asphyxia, threats against detainees and their relatives, sexual humiliation, isolation, prolonged hooding and shackling, and exposure to heat, cold and loud noise. Other abuses include deprivation of sleep, food, clothing, and material for personal hygiene, and the denigration of Islam and forced violation of its Rites. Detainees were forced to work in areas that were determined not to be safe and were seriously injured. Abuses of women detainees were less well documented but included credible allegations of sexual humiliation and rape (Clark 571).

These crimes become crueler when used against children. ‘A Pentagon investigations by Major General George Fay reported in January 2004 that “a leashed unmuzzled military guard dog was allowed into a cell holding two children” with the intention to scare the children. Amnesty International also reported that a fourteen year old boy was bitten by a guard dog and that children held at Abu Ghraib were denied the right to see their parents or a lawyer. “The military medical personnel allegedly were aware of these actions and...Not to report such action as torture, cruel, inhumane and degrading treatment of punishment defies comprehension militarily, legally, ethically, and from a humanitarian perspective” (Clark 575).

This is also true for Guantanamo Bay, the United States military prison located in Guantanamo Bay, Cuba. Guantanamo Bay was established in 2002 after the attacks of September 11th, 2001. The detention center was initially referred to as being a temporary prison used to hold those who posed a dangerous threat to national security until a more permanent prison could be made where prisoners would be tried for war crimes. ‘President Obama called for Guantanamo Bay to be closed within one year in 2009, but Guantanamo seems to have become a permanent detention center, having held over 780 people, with 122 currently still residing there’ (Scheinkman, Williams and McLean).

At Guantanamo Bay, interrogators with the assistance of military medical personnel have been accused of using aggressive counter-resistance measures in systemic fashion to pressure detainees to cooperate. These measures include: sleep deprivation, prolonged isolation, feigned suffocation, and beatings. Other stress-induced tactics have allegedly included sexual provocation and displays of contempt for Islamic symbols. (Clark 571)

The dual-loyalty conflict is apparent in both prisons. And the fact that both situations have occurred within the past 15 years is cause for concern and cause to look deeper at how these

ethical violations have occurred. In these two situations, military discipline has trumped the ethics of the medical professional, in large part because of the desperate times in which both violations occurred. In the cases of Guantanamo Bay, medical professionals were actually chosen based on their willingness to violate their medical obligations in favour of their perceived military duties. Marks explains that, “after some US Navy physicians refused to force-feed detainees, the Department of Defense began screening doctors assigned to Guantanamo Bay to ensure they would be willing to participate” (Marks 57). ‘This occurred after a large number of hunger strikes, which also included 28 suicide attempts by 18 prisoners’ (J. A. Singh 573).

The Effects of Dual Loyalty on the Medical Profession

The dual loyalty conflict puts a strain on the relationship between the military and medical communities placing both parties in situations where they have to violate their moral and ethical boundaries. Medical professionals often play an ethical and vital role in the military and during war. Many doctors and surgeons are on the front lines of war working honourably to save the lives not only of their fellow soldiers and allies, but those on the enemy side as well. The use of medical professionals in torture is therefore also damaging the work that military doctors are doing and have been doing for over a hundred years. Medical professionals:

...should be given greater deference in pursuit of their ethical obligations than other professionals by virtue of the nature of their work and its effects. The work of the physician involves particular vulnerabilities on the part of the patients and carries the potential to elicit powerful and conflicting psychological and emotional impulses on the parts of both physicians and patients. (Gottlieb 355-356)

As we have seen in the examples above, the impact of dual-loyalty conflict on the medical profession and its practitioners involves negative consequences far surpassing the argued

benefits of allowing torture. The role of the medical professional is unique because they deal with our health and wellbeing and are entrusted to maintain confidentiality and work in the best interest of their patients. They are entrusted to maintain a high level of respect and dignity based on their role as mental and physical caregivers in our society. When a doctor or psychiatrist participates in the design or implementation of torture techniques they not only bear consequences to their own medical oath and responsibility but also create detrimental consequences to the reputation of their profession.

When a military health professional provides advice to interrogators on how to obtain information from an interrogatee during a rapport-building interrogation, he is performing a non-therapeutic function. He is trying to advance the military intelligence mission rather than the welfare or interests of the interrogatee. (Marks 64)

For example,

at Abu Ghraib, a physician and a psychiatrist helped design, approve, and monitor interrogations. At Guantanamo Bay interrogators were given access to medical records and psychiatrists and psychologists were part of the strategy that employed extreme stress, combined with behaviour-shaping rewards, to extract actionable intelligence from resistant captives. (Clark 573)

In all of the four cases the medical professional has received a blow to their credibility because they have shifted their loyalty from their medical oath to their military. This can occur intentionally or unintentionally and with both positive and negative intentions.

For prisoners and detainees to see their primary care physicians also in the role of assisting those who tortured and abused them, or to see them remain silent in the face of such human rights violations, undermines the credibility of the medical profession and is irreconcilable with the physician's role as healer. (Clark 576).

It also hinders the efficacy and international standing of the government or military allowing not only the torture, but the medical professional's participation within it. A government in our international society is judged and trusted based on their national and international actions. If a

military is found to be violating international norms, even if the country is not a signatory to the declarations prohibiting torture and medical professional's involvement, it will bode negatively for that nation. Fortunately, since World War II, torture has continued to become a less accepted form of violence, and the international community will hopefully continue press for action against countries implementing torture.

The fundamental question raised by many Americans is how could military medical personnel have been directly involved or complicit with these human rights violations? One reason, according to Amnesty International's Report, *Capturing Torture: A Manual for Action*, is that since September 11 attacks, terrorism has been linked inextricably to the public mind. (Clark 570)

And this acceptance on a nationalist level is where the use of international doctrines and standards becomes important, as argued in the case of Nazi Germany.

What Can We Do?

The dual-loyalty conflict is not an easy fix and will require systematic and ideological changes in our governmental and military systems. There are many aspects within the conflict that require improvement for there to be long-term effective change. After examining the main regulatory documents and scholarly reports there appears to be three aspects necessary to create an effective plan to counter dual-loyalty in the context of the role of medical professionals in torture and human rights abuses: 1. It needs to create national level, ideological change, 2. It must include a strong, interdisciplinary community consisting of governments, militaries and the medical community, and 3. It must be effective and enforceable to be taken seriously by countries that have previously gone against international norms and conventions.

National Ideological Change

The first area necessary for improvement is within the governments and militaries who are committing the crimes. It is the military and governmental structure that has accepted the use of torture and in-turn accepted the medical professional's role within it. As Vesti and Lavik point out, "national law...reflects the surrounding society, and with a totalitarian governmental system the law may even be an instrument to impede progress in medical ethics" (Vesti and Lavik 5). This occurred in the case of Nazi Germany and may continue to occur if governments render sections of laws invalid, create new laws allowing crimes and human rights violations, dissolve national medical associations, and silence medical professionals attempting to speak out against abuses' (Vesti and Lavik 5). As in the cases in the United States, there is an internal view that the "war on terror" should receive top priority therefore lowering the perceived necessity of medical ethics in situations pertaining to terrorism. Michael Gottlieb argues that the "disempowerment of medicine's professional role" has been a steady decline in the courts and national agenda for the past thirty years.

The physician's involvement in Abu Ghraib typifies a broader situation in which American physicians increasingly allow other duties or perceived duties to trump their ethical obligations to patients and to the profession. (Gottlieb 356)

This follows with the common argument that many doctors acting in situations are not evil or unethical but rather put in situations that leave them no option but to act as they have. "It is also possible that doctors are involved simply because they are at the place of torture, as conceptualised in the phrase 'Doctors at Risk', pointing to the higher likelihood for doctors to become involved in torture when employed by various authorities that condone torture" (Vesti and Lavik 6). The abilities for internal governments to change the climate of their culture and society into allowing or tolerating abuses that wouldn't normally be tolerated is why I have listed

it as one of the three most important areas for change. History has showed us how much power and how many atrocities can occur when disregard for human rights is tolerated within a society, and this makes national level ideological change so important and also one of the most difficult tasks.

International Interdisciplinary Collaboration

As will be shown in the examples below, there is a majority of scholars in consensus that to create lasting change on an international scale there needs to be the collaboration from both political and medical bodies.

Regardless of the ethical principles and scholarship that may be applied in individual countries or health systems, there is a great need for international humanitarian law, which serves both to protect vulnerable prisoners and to shield health professionals who treat prisoners with respect and dignity from abuse and penalty.
(Benatar and Upshur 2165)

This collaboration must be seen at all levels of government and organizations and should include medical associations, conventions on medicine and human rights, politicians, political rights groups, human rights NGO's, and ethical standard boards. The more widely encompassing the group is who is creating these regulations the more effective they will be and the better chance they will have at being an enforceable power. Our society over the last 100 years has taken a major step towards the notion of collaboration between fields and specialties. The discourse between medical communities, government entities, human rights groups, etc., means that new perspectives can be introduced and created. Our global community is too interconnected in all facets of our daily lives for us to expect change on a powerful topic like torture without putting that interconnectivity into play. The reason for the collaboration specifically between medical and governmental bodies is because governmental entities have the ability to impose the

sanctions and repercussions on a scale that the medical community is so far unable to do; and the medical community has the knowledge and experience working with dual-loyalty and other human rights issues and can help build the relevant actions necessary for effective change.

Effective and Enforceable Implementation

Having a plan of action that combines the first and second points are integral for creating change, but they are not applicable unless they can be effectively implemented. International conventions and declarations are built to create an international understanding about the views on a particular subject but are often ineffective in enforcing them when countries, both signatory and non-signatory members, violate the conventions. ‘In the case of the doctors role in torture, there have been many international standards already outlined including the Tokyo Declaration by the World Medical Association in 1975 and the United Nations’ Principles of Medical Ethics created in 1982. These declarations specifically outline that medical professional’s participation in torture is unethical and adoption of these Declarations were unanimous. However, they,

Carry no obligation for the adopting governments and, in fact, some of the governments were totalitarian at the time of adoption and others later became completely out of touch with democratic traditions. (Vesti and Lavik 5)

This includes the difference between the doctor’s oath in the USSR at the time of the UN Principles of Medical Ethics, the abuses of human rights on a large scale in Uruguay and Chile “despite both countries having signed a large number of international declarations that condemn such infractions, including doctor participation in torture”, and Arab states practicing Sharia law which had also adopted the UN Principles of Medical Ethics, despite contradictory laws on acceptable punishment (Vesti and Lavik 5). But imposing sanctions against violators is often

easier said than done. And the best way to impose repercussions is often vastly different depending on the country causing the violation because of the vastly different government, economic, and cultural differences between countries. For example, a country with a substantial national economy and little international trade may not be deterred by imposing international trade sanctions. In other circumstances a country with a large or forceful military may not feel deterred if they believe that the country imposing the sanctions cannot or would choose to not take forceful action against them (as in the case of North Korea). The best chance for change in the case of dual loyalty would be strength in numbers. The shift by a majority of countries to condemn torture has created an environment conducive to even greater change. What the international community has to do is continue the work that has been done and maintain solidarity. The more countries, organizations, and individuals that can come together in this cause, the greater the force will be for any change proposed by the community and the greater the chance of it creating realistic and lasting change.

Plans for Action

In June of 2005 the American Psychological Association produced their *Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security*. The purpose of the report was to re-examine the Ethics Code in place by the Association and whether or not there is sufficient ethical guidance for medical professionals, specifically psychologists and mental health professionals, to deal with investigations, interrogation, and cases of torture related to national security. The Task Force found twelve areas for improvement, many of which address the serious issues that I believe are necessary for improvement in dual-loyalty situations. ‘The task force’s key findings include: that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other

cruel, inhumane, or degrading treatment; medical professionals have the ethical responsibility to report these acts to the proper authority channels; they cannot use medical weakness against their patients; and they have the right to refuse unethical orders. Statement six particularly pertains to Guantanamo Bay and Abu Ghraib prisons, when it states that,

special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities.
(American Psychological Association Presidential Task Force 6)

These ethical standards include ‘understanding aspects of individuals culture and ethnicity to ensure no misunderstandings and to receive proper training and teaching in these areas to maintain competency (American Psychological Association Presidential Task Force 4-9). The report also discusses how psychologists should be sensitive to, aware of, and trained for situations where they could be placed in mixed roles during interrogation. But where the report fails is in its acceptance of the participation of medical professionals in interrogation and national-security roles. It argues that, “psychologists can serve in consultative roles to interrogation and information-gathering processes for national security-related purposes as psychologists have a long-standing tradition of doing in other law enforcement contexts” and goes on to argue that “psychologists have a valuable and ethical role to assist in protecting our nation, other nations, and innocent civilians from harm, which will at times entail gathering information that can be used in our nation and other nations defence” (American Psychological Association Presidential Task Force 2). This leaves room for interpretation, which often leads to human rights violations. What the dual loyalty conflict needs is clear guidelines for medical professionals to follow without interpretation and to be able to lean back on in cases where the conflict arises. Most of the conflicts would be solved if there were a consensus that medical professionals cannot play any role in the design and implementation of torture. Creating

safeguards for the beginning stages where the conflict would occur can better protect the medical professionals and the medical community as a whole.

Peter Clark builds off the APA report in his article *Medical Ethics at Guantanamo Bay and Abu Ghraib: The Problem of Dual Loyalty*. Clark, a professor of Theology and Health

Administration as well as the Director of the Institute of Catholic Bioethics at Saint Joseph's University offers recommendations as to how the national and global community can do their part to protect medical professionals from being placed in a situation of dual-loyalty. He does so by offering five points, which include action by international medical bodies as well as global governments and militaries. His recommendations are to:

- Create an independent board of inquiry to investigate military medical personnel in regards to human rights abuses. This should include military medical representatives, human rights groups, legal and medical academics, ethicists, and health professional associations;
- Implement a military training program: to allow medical personnel to recognize situations of dual-loyalty and how to confront these situations;
- Create a military ethics committee: help medical staff understand "dual-loyalty" and provide an independent and confidential outlet for reporting these abuses;
- Have an American Psychological Association task force to examine ethics policies;
- And condemning of actions and sanctions for violators' (Clark 578)

These recommendations were to enhance global responsibility and awareness, and to create a more rigorous discourse condemning the actions of militaries and medical professionals in the position of dual-loyalty. Clark's recommendations are comprehensive because they follow the three requirements I believe will optimistically create effective change, as well as creating an encompassing plan with realistic recommendations.

Another suggestion was put-forward by Peter Vesti and Neils Lavik, in their article on torture and the medical profession in the Journal of Medical Ethics. They propose a three-tiered system of prophylactic responses in an attempt to safeguard the multiple levels of the conflict. The first is *primary*, with the goal of making torture and medical professional's participation universally illegal using international standards and conventions including the United Nations Convention Against Torture. In the *secondary* level Vesti and Lavik propose the need for strong international ethical medical standards to work in tandem with international political standards found in the first response. The *tertiary* level consists of the prosecution of the perpetrators by the international community (Vesti and Lavik 6-7). Vesti and Lavik's proposal contains the main theme's found in Clark's argument and follows in line with the main points which seem to be overarching in the responses by the political and medical communities which are the call for international sanctions and repercussions, the ideological shift within militaries and governments towards views on torture, and the combined force of international governmental and medical organizations.

The dual-loyalty conflict presents a reoccurring issue of how to protect medical professionals from being placed in the situation of having to decide whether or not to participate in torture. In most cases, medical professionals are not given a choice, especially in the cases of Unit 731 and Nazi Germany, where your refusal to participate would often lead to your incarceration or death. We have seen from the international declarations and conventions above that there has been great improvement in our understanding of the problems of the participation of medical professionals in torture. This understanding has created a movement to strengthen the medical professional's ability to be removed from the equation. And that is what must be continued. There needs to be

“stronger support of medicine’s autonomy, as well as a more formal structure of accountability for those who would violate the profession’s core values. A history of medical involvement in immoral activity, state sanctioned or otherwise, demonstrates that abuse flourished when physicians become morally detached from the interests of their patients” (Gottlieb 356). There needs to be strong international sanctions which are decided by and agreed upon by both the medical community and governmental bodies. For example, in the case of Guantanamo Bay, “the main recommendation from the assessment team was to establish clear Standard Operating Procedures for the Behavioural Science Consultation Team (BSCT) members, many of whom felt conflicted in their role supporting interrogation operations and being medical professionals” (Qureshi). This is because we see countries like the United States who are signed to conventions against torture but still allow it to occur, therefore the penalties must be sufficient to cause maximum deterrence. As Clark’s article argues, these situations of medically assisted torture can serve as an “eleventh-hour wakeup-call for the western world to rediscover and live by the values enshrined in its international treaties and democratic constitutions” (Editor).

Conclusion

The dual-loyalty conflict has been a struggle between national autonomy and international norms and standards. The international community has witnessed atrocities at the hands of medical professionals and governments and has worked for the past 100 years towards creating international legislation and standards that will a) protect people from becoming victims of torture, and b) protect those within the military from being placed in this position in the future. While the conflict is still a problem in our current international society, there have been great strides between the international political and medical community to create guidelines and

sanctions to fight torture and the dual loyalty conflict. Many scholars have offered propositions to best create the change necessary and many have created frameworks that are a step in the right direction. The important thing to remember is that the dual-loyalty conflict is still a current topic, it has been an issue for doctors in the past and continues to plague doctors in the future, whether that is within the military context or not. The key is dialogue and discourse. Our global society has weighed the benefits and consequences of torture and the medical professional's role within it and the majority have responded that the medical professional's loyalty should lie first with their medical profession. This is corroborated by international legislation and medical standards. Next, we must continue the work of our international organizations, remembering that we need medical and political dialogue, and that there needs to be harsher repercussions for state's allowing medical professionals to be placed in this dilemma. If our global society continues on the path it has since the Second World War, than perhaps the next few generations of medical professionals will be cautious of, but safe from, the dual-loyalty conflict.

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