U.S. medical schools require a recitation of the Hippocratic Oath at graduation—and those that require it usually use a watered-down version. This is unfortunate, because the oath embodies the highest of medical ideals. These ideals garner trust, and to the extent that doctors still practice the oath, they probably receive more trust from patients than Imber implies. The Judeo-Christian element adds the concept of compassion to the original Hippocratic covenant.

Medicine is complicated, and a health care system increasingly dependent on third-party payers and multi-physician specialty groups makes doctor–patient relationships even more difficult to form and maintain. But these relationships must be restored, not only to renew trust but simply because that relationship is what the essence of medicine is.

In summary, *Trusting Doctors* is well worth buying and reading. The text is only 196 pages, with the remaining pages presenting appendixes, endnotes, and an index. The book's scope is limited, and it offers no remedy, but it does provide a detailed and insightful study of trust in doctors over the last hundred and fifty years.

Medicine must heal itself to restore the trust of its patients and the public. We must look to our roots—the Hippocratic tradition—and must practice that tradition again. Only in this manner can we restore trust in doctors.

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Military Medical Ethics: Issues Involving Dual Loyalties

reported by Neil E. Weisfeld, Victoria D. Weisfeld, and Catharyn T. Liverman for the Institute of Medicine

National Academies Press, 2008, paperback $21.00
74 pages, bibliographic notes, ISBN 978-0-309-12663-2

Military Medical Ethics is the summary of a workshop convened in 2008 by the Institute of Medicine to address the potential conflict of dual loyalties in ethical decision making among health care professionals in the military. Ethical challenges faced by the military at Abu Ghraib and Guantanamo Bay formed a backdrop to the workshop, whose purpose was "to improve military training, policy, and structure to better support ethical decisions by military health professionals" (ix).

In the preface, James Childress, chair of the workshop planning committee and professor of ethics at the University of Virginia, points out that in the exercise of all health care professions there can be conflicts in loyalties. Professionals who are employees have always faced the dilemma of the duty to care within the obligation to authority. This authority may be the employer in the civilian sector, especially in occupational medicine, sports medicine, and prison medicine, or the chain of command in the military sector.

At the outset of the report, however, it should have been stated that the hallmark of a medical professional is the primacy of the duty to the patient. The summary that follows the preface states that "within the military services, primary responsibility to the patient should prevail in *nearly* all circumstances" (3, emphasis added). However, the professional should *always* be a patient advocate in the face of organizational imperatives. There is a single duty in the delivery of professional health care, and that is to the patient. There are obligations to the organization in which that care is delivered, but there are not two loyalties.

The workshop goals were to

- Examine ethical challenges for physicians and other health professionals serving in the military that arise from conflicts between their responsibilities to patients and their duties as military officers;
- Discuss parallels with other fields of health and draw on their efforts to develop ethical guidelines and training models; and
- Discuss effective organizational structures that support and promote a just work culture. (39)

Comparisons among occupational medicine, sports medicine, and military medicine reveal limits to the autonomy of patients and health care professionals in military medicine that are not present in either occupational medicine or sports medicine. However, the fact that a military draft or conscription no longer exists indicates that military patients have consented to receiving health care according to an obedience-to-authority model. This should not, however, translate into an obedience-to-authority model of ethical decision making by military health care professionals.

Two case studies were presented for analysis at the workshop, the first concerning the return to duty of injured military personnel and the second concerning the care of hunger-striking detainees. These studies are excellent representations of the ethical dilemmas that the workshop attempted to address. Each case presentation was followed by a thought-provoking discussion, which is also summarized in the book.

The first case study concerns the return to duty of an injured soldier after six weeks of medical treatment. It is evident that the consequences of a return to duty in military medicine are far more significant and permanent than, for example, a return to work in occupational medicine or a return to the playing field in sports medicine. Perhaps most helpful in this presentation is the recognition of the fact that in the military, as in any community health scenario, there are two patients: the individual and the force (or community).

If the analysis of this case had been consistent with case analyses in other areas of medicine, the conflict of dual loyalties would have been identified as being here, between the health care workers' commitment to individual patients and their commitment to the good of the force or community. By the usual method, various ethical theories, or methods of analytical reasoning, would have been applied to the ethical dilemma—specifically, deontological (objective principled) reasoning versus teleological (subjective) reasoning. Thus, the rights of the individual patient would have been either held sacrosanct through objective reasoning or weighed subjectively in relationship to the greatest good for the greatest number (the force). This was not the framework for ethical reasoning set forth in the workshop, however, where the dilemmas were presented in terms of health care workers' duty to care versus their obligation to authority.

The conflict of duties is elucidated very well in the second case study, which involves the treatment of detainees who have gone on a hunger strike. The case presentation makes clear that directives set forth in standards by the American Medical Association and the World Medical Association prohibit the forced feeding of competent hunger strikers, but these can be contravened under a Department of Defense policy allowing forcible treatment of mentally competent patients if "necessary to prevent death or serious harm." The foundation of such a policy is the preservation of life and health, representing a duty of beneficence to the patient regardless of whether the patient is a member of the U.S. military or a detainee. This same policy states that the relationship of military health care personnel with detainees is "solely to evaluate, protect, or improve [the detainees'] physical and mental health" (17).

The case discussion notes that the obligations of civilian health care providers to report and prevent abuses are the same in military medicine, and in some situations in both civilian and military medicine, access to an ombudsman, who receives anonymous complaints, may be necessary. The report also notes as a concern the fact that the

decision to engage in compulsory treatment of a detainee is made by the joint task force commander on the basis of a physician's medical recommendation that immediate intervention is necessary to prevent serious harm or death. Such a policy could contravene the physician's obligation to exercise independent clinical judgment, as required not only by professional standards but also by the Geneva Conventions. Actual conditions of confinement and interrogation in places like Guantanamo are also noted, and cultural and religious issues pertinent to the treatment of detainees are presented.

The workshop summary correctly states that adherence to ethical principles in the delivery of health care is strongly influenced by organizational values and behavior. Nothing substitutes for leaders who hold the same commitment to ethics as to other goals. A "just organization" is defined as one that "communicates openly about decisions after the fact to effect improvements, and it commends rather than punishes individuals for bringing ethical issues to light" (29). The workshop identified four characteristics of a just organization: ethical awareness, judgment, motivation, and the implementation of ethical standards. Also presented were structural mechanisms for promoting medical ethics within a health care organization, including peer review, advisory boards, institutional review boards, systems engineering for continuous learning and improvement, and the involvement of various professionals (e.g., clergy, educators, and social workers). Lieutenant General Eric Schoomaker, U.S. Army Surgeon General, correctly noted that, organizationally, ethical issues in military medicine reflect those faced by the larger medical community, and further initiatives are needed to continue the examination of competing ethical principles and assure the highest level of transparency while maintaining national security.

In military medicine, just as in civilian medicine, there are limits to confidentiality. Because these limits are greater in the military, health care providers must communicate them to patients at the outset. Furthermore, three ethical precepts were identified as applicable to the treatment of both prisoners and military personnel: equality or parity in treating patients, elasticity or flexibility in implementing policies, and the historical principle of "First, do no harm" (*primum non nocere*). *Parity* was defined as "equality in treating patients" (4), but in reality, when ethicists determine the ethics of resource allocation, a more precise term is *equity*, which is based on a patient's need and ability to benefit from the resource.

To prepare professionals to address conflicts, the report summary advocates a core curriculum in medical ethics for health care professionals, including a variety of teaching methods, multi-professional conversations, case studies, role playing, exposure to invited speakers with real-world experiences, and community and field practice exercises. However, the examples given for such learning experiences do not relate to war-time realities: while principles involved in palliative care and geriatrics may be transferable to other populations, these clinical scenarios are not the ones that arise in military medicine. Scenarios presented in field practice exercises on board a humanitarian ship are also mentioned, but they comprise case discussions without even simulated clinical experiences. Such scenarios do reflect the realities of military medicine, however, including conflicts between opinions of health professionals and force-protection rules, impact on host nations, questions pertaining to what constitutes a standard of care outside the United States, resource allocation when there are more patients than can be treated, and respect for the culture of the host country (27).

The workshop closed with concluding remarks by Childress and Joseph Kelley, Deputy Assistant Secretary of Defense for Clinical and Program Policy. Childress noted that circumstances of dual loyalties compromise patient trust, and Kelley pointed out that provisions for military health professionals to exercise their right of conscience do exist. But the emphasis in the concluding remarks was on the need for communication, transparency in policies, and structures that do not require individuals to act heroically to ensure that ethically proper decisions are made.

Only four of thirteen workshop presenters are identified as military personnel, which may account for the absence of specific recommendations. Perhaps greater experiential military emphasis could have been achieved if more of the presenters had military experience. An even greater disparity was apparent among members of the planning committee, most of whom were affiliated with universities rather than the military. It is also notable that no nurse presented at the workshop, and only one nurse sat on the planning committee. This is an important omission, because in many medical military scenarios a nurse implements the orders of a physician, which may escalate the conflict in a military obedience-to-authority model.

The U.S. military comprises highly educated professionals; they include health care professionals with doctoral degrees as well as individuals with expertise in bioethics, philosophy, law, sociology, and even religious studies. There is a wealth of expertise among military personnel who are familiar with the realities of ethical decision making in a military milieu. It is this reviewer's hope that future initiatives will capitalize on these resources.

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Galileo Goes to Jail and Other Myths about Science and Religion

edited by Ronald L. Numbers

Harvard University Press, 2009, hardcover, $27.95
313 pages, bibliographic notes and index, ISBN 978-0-674-03327-6

I was once astonished to hear the academic dean of a medical school state without any hint of irony that the history of U.S. medicine—from the founding of the nation's first hospitals through the advances in surgery during the Civil War to the miracles of MRI—could be taught to students in one (not two or three) forty-five minute class.

To such academics—and this highly-trained physician-*cum*-dean was not a rare exception—history is largely a record of error and mistake: Henry Ford called it "more or less bunk," and satirist Ambrose Bierce famously described it as "an account mostly false, of events mostly unimportant, which are brought about by rulers mostly knaves, and soldiers mostly fools." Like the study of fiction (inherently "non-truth"), time spent on humanity's past is simply time spent away from the proper focus of education—the present and future.

Fortunately, there are millions of physicians, biochemists, and cancer researchers who respect the humanities. Such will welcome—and enjoy—the essays gathered here by Ronald L. Numbers, Hilldale Professor of the History of Science and Medicine at the University of Wisconsin–Madison.

First, however, a short quiz. Where do you stand on the following propositions? "Christianity's rise brought about the stifling of ancient science." "The medieval church was a stumbling block to Europe's intellectual advancement for more than a thousand years." "Columbus proved that the world was round." "The medieval church banned human dissection." "Religious beliefs unique to Christianity explain why science was born in Christian Europe." "The Scientific Revolution liberated science from religion." "Evolution destroyed Charles Darwin's faith in Christianity." And last, "Science causes secularization."

If you support any of these positions, then you should enjoy this attractive book. Written by major scholars who have no "obvious scientific or theological axes to grind" (twelve of the authors self-identify as