of various sorts? This idea is far from radical: recommendations for discussions between health care providers and patients suggest that some information should be given initially, and additional information should be offered as an option to those who want it (see, for example, R.M. Epstein, B.S. Alper, and T.E. Quill, "Communicating Evidence for Participatory Decision Making," *Journal of the American Medical Association* 291 [2004]: 2359-66). The amazing capabilities of computer-based decision aids may tempt designers to provide too much information up front, and to forget the wisdom of tailoring disclosure to the patient's interest and understanding.

I agree with Neil Manson that the quantitative imperative is part of a larger "informative imperative" in medicine that should be questioned and challenged as Manson, O'Neill, Carl Schneider, and others have done. Considering how to provide the right information, to the right patients, at the right time, by way of a decision aid or personal interaction, raises important ethical and empirical questions, as the article emphasizes.

Doctors and Torture

To the Editor: In "The Tortured Patient: A Medical Dilemma" (May-June 2011), Chiara Lepora and Joseph Millum raise the issue of whether a physician may be justifiably complicit in torture and answer in the affirmative. Their argument is predicated on there being a litany of moral considerations, of which the wrongness of complicity in torture is merely one; this wrongness competes against other values and sometimes is outweighed. While I disagree with some of the authors' assumptions—for instance, that torture is always unethical in the cases that physicians are forced to countenance, or that complicity in an immoral act is prima facie immoral—I agree with their conclusion. Surely those who trumpet deontological constraints would think otherwise, but this conclusion naturally follows from a pluralistic set of moral values.

While they cite a wide range of declamations against physicians' involvement in torture, one that they leave out comes from section 2.067 of the American Medical Association's *Code of Medical Ethics*. What makes section 2.067 interesting is not just what it says, but also the fact that it comes hierarchically nested under section 2.06, which speaks to physician involvement in capital punishment. From the *Code*'s perspective, the issues pertaining to capital punishment and torture are isomorphic: what matters is merely that physician involvement could make the patient worse off. In the case of capital punishment, the upshot is obvious and, in the case of torture, resuscitation in order to facilitate more torture is similarly depraved.

The question to ask is less what would happen if physicians were present, but rather what would happen if they were not.

This argument fails in both cases, and the reason helps elucidate why Lepora and Millum are on the right track. The question to ask is less what would happen if physicians were present, but rather what would happen if they were not. For example, imagine that physicians were disallowed from these settings and a prospective patient experienced complications: the abolitionist would just settle for this person being worse off. A physician's presence ensures that easily remediable situations be remedied, which is precisely what I would advocate. This is not to say that there are no capacities in which physicians could make people worse off, just that there are some in which those people could be made better off; therefore, a wholesale abolition on physician participation misses the mark. (There's also an open question about whether such agents should be conceived of as "physicians" at all—as opposed to medically trained military personnel—but I shall not pursue that discussion here.)

To be sure, those opposing physician involvement in either capital punishment or torture are, almost always, not just opposing physician involvement, but rather those practices themselves. When the *Code* says that physicians must "oppose . . . torture for any reason," it is clearly making a political claim and not one narrowly tied to medical ethics; it is for precisely this reason that I find such statements by the *Code* to be inappropriate. As Lepora and Millum acknowledge, some debate the appropriateness of torture in "narrowly specified, extreme cases." It is a credit to their essay that such a debate is left open, rather than foreclosed by fiat.

From the perspective of medical ethics, the central question is whether physician involvement in torture makes the patient better or worse off. From a more thoroughgoing consequentialism of the sort that I would advocate, this question bears no privileged status. While Lepora and Millum would surely not agree with all of my arguments, they are to be commended for eschewing dogma and reaching a controversial conclusion. More generally, one would also hope that their paper portends increased attention to military medical ethics; this is an important area within medical ethics, and one that has received insufficient attention.

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