

# Physicians at War: Lessons for Archaeologists?<sup>1</sup>

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## BACKGROUND

As an academic philosopher I surely know less about archaeology than anyone else contributing to this book. My research is in various fields of applied ethics, including bioethics and the ethics of war. While these usually occupy separate programmes, they came together during the 2004–5 academic year, when I was on a research fellowship at the Institute for Ethics of the American Medical Association (AMA). Just after I began the fellowship two articles were published in *The Lancet* by Steve Miles in which he discussed alleged violations of military medical ethics that may have transpired through physician involvement in hostile interrogations (Miles 2004a; 2004b). Then, immediately before the holiday break, we received notice that the *New England Journal of Medicine* would be publishing a similar essay by Gregg Bloche and Jonathan Marks in its first issue of 2005. The AMA in general, and the Institute for Ethics in particular, was extremely concerned about Miles' papers and the forthcoming one by Bloche and Marks. Not only were these extremely visible publications, but many thought that the allegations they contained were of grave ethical concern. The AMA, which publishes *The Code of Medical Ethics*, takes very seriously the moral status of the medical profession and therefore was very interested in these articles. (The AMA's Council on Ethical and Judicial Affairs has since published an opinion on physician involvement in interrogation, which represents the culmination of its thinking on these topics (AMA 2006).)

I already had a background in some elements of the ethics of war, and torture in particular (Allhoff 2003; Allhoff 2006a), and my fellowship year quickly evolved to explore physician involvement in interrogations. One element of this project was research into some of the underlying moral issues, while another was to talk to those responsible for military ethics (including military medical ethics) education. This research led me to speak with those teaching military ethics at the US Military Academy at West Point, the US Naval Academy, and the US Air Force Academy, as well as those teaching military medical ethics at the US Army Medical Department Center & School (Fort Sam Houston, Texas) and the University Services University of the Health Sciences (Bethesda, Maryland). After I left the AMA I was also able to spend some time at the Australian Defence Force Academy (Canberra, Australia). In all cases, I was extremely impressed with the professionalism and commitment to ethics that was displayed at each of these training academies.

When starting the research, however, one of the first things that I noticed was how

<sup>1</sup> Part of this chapter was drawn from Allhoff 2008a.

little academic work had been done in military medical ethics. The Borden Institute, an agency of the US Army Medical Department Center & School, had produced two outstanding volumes intended as textbooks for the teaching of military medical ethics (Office of the Surgeon General 2003); Steve Miles (2006) and Michael Gross (2006) have each written books about these topics, though these emerged, at least in part, from the previously mentioned journal articles of 2004; and, finally, a symposium was held in a prestigious bioethics journal, *Cambridge Quarterly of Healthcare Ethics* (2006) (I authored an essay in this symposium; see Allhoff 2006b). The point, though, is that discussions regarding military medical ethics have been rare until the past few years. As a final programmatic note, the topic of physician involvement in interrogations was afforded the plenary session at the largest biomedical ethics conference of 2005, the American Society of Bioethics and the Humanities. This session was somewhat unbalanced, however, insofar as all three speakers argued for exactly the same conclusion (ie there was no conservative or dissenting voice), though a response panel aimed to remediate this shortcoming.

All of these experiences culminated in an edited volume, *Physicians at War: The Dual-Loyalties Challenge*, which explored ethical conflicts attendant to physician participation in war (Allhoff 2008a). The book is wide-ranging, but principally focuses on two questions. First, how are we to conceptualise the moral obligations of physicians during war? It seems straightforward enough that military physicians have *medical* obligations to those in medical need, regardless of the political allegiance that the needy bear.<sup>2</sup> But do military physicians bear *non-medical* obligations elsewhere, such as to the military chain of command, national security, or the greater good? If so, how are these conflicts resolved? If not, are these latter obligations nullified? Trying to answer these questions gives us a broad, theoretical apparatus by which to assess the use of physicians in war. Second, we can apply this thinking to particular issues and, in fact, it is this application that has borne the most popular attention. For example, military physician participation in torture or other hostile measures would seem to contravene the medical value of non-maleficence (for more discussion see Allhoff 2008b, Part II). And the same could be said about military physicians using their medical training to develop chemical or biological weapons (for more discussion see Allhoff 2008b, Part III). But, depending on our stance on the first set of questions, there might be some moral call for such actions. So, in addition to generating the generalised framework, we need to think about how it plays out in some of these particular issues.

The editor of this book asked me to contribute in order that the primary discussion about the ethical use of archaeologists in war could be complemented and contextualised by some other perspectives, such as that of the ethical use of physicians in war. What are the similarities and differences between the use of these professions in war? Can archaeologists learn about the ethical use of archaeological knowledge by considering the ethical use of medical knowledge? And can physicians learn from archaeologists? In the remainder of this chapter, I have two objectives. First, I will discuss in more detail what the dual-loyalties challenge is in military medicine, as well

2 While most people take this to be self-evident, I have argued against it; see Allhoff 2006b.

as various ways in which it may be resolved; this will be done primarily at the theoretical level, but will also incorporate discussion of various issues. Second, I will take this discussion and try to bring it to bear on my (very limited) knowledge of archaeology. In particular, I will focus on similarities and differences between archaeology and medicine as manifest in the use of their practitioners in war.

#### THE DUAL-LOYALTIES CHALLENGE

The motivating premise behind my thinking on military medical ethics is that, in times of armed conflict, physicians are (arguably) subject to dual loyalties. This concept has been explored in greater detail elsewhere (see, for example, Physicians for Human Rights and the School of Public Health and Primary Health Care 2003; see also Allhoff 2008b, Part I), but, for present purposes, we might understand it as the existence of simultaneous obligations which might come into conflict with each other. While dual loyalties can apply across all sorts of contexts, our present concern is with the ones that apply to physicians during armed conflict. In these scenarios, physicians have medical obligations to those in medical need. We could ground such obligations in various ways, but the most straightforward way is to acknowledge the medical duties of beneficence and non-maleficence, both of which have been traditional foundations of medical ethics. According to these duties, physicians are morally bound to render aid insofar as they can and not to (intentionally) make anyone medically worse off.

Such medical duties, however, might come into conflict with non-medical duties, and we can expect such non-medical duties to be expressly manifest during times of war. For example, military physicians are subject to the chain of command and therefore have an obligation to obey their orders. Certainly, it might not *always* be the case that following orders from the chain of command is morally obligatory, but we can presumably suppose that, at least in the cases of ‘just’ war, there is a (defeasible) reason – which we could, for example, cache out in terms of military efficiency – for obeying commands and that, therefore, such commands have some sort of positive moral status. Second, the physician, in virtue of his medical training, might be able to promote national security or the greater good and therefore absorb the associative moral obligations.

Of course, these non-medical obligations could precisely oppose the medical obligations previously mentioned. For example, consider physician participation in weapons development (for more discussion see Allhoff 2008b, Part III). We can easily imagine cases wherein physicians are operating on the just side in a conflict against an evil regime and that their expertise could be applied to the development of chemical or biological weapons; we could further imagine that such weapons would be effective against the enemy and lead to a quicker dissolution of the conflict. With such weapons it could be the case that there would be fewer casualties overall – perhaps by shortening the war – or even that their existence would be psychologically debilitating enough to the enemy that the conflict could rapidly come to an end. If the enemy were a terrorist regime then national security could legitimise the development of the weapons or, regardless, such weapons might serve the greater good – including the

citizenry, present and future, which falls under the dissolved evil regime – and therefore be morally justified. But, despite the moral considerations that would count in favour of the development of such weapons, there are contrary considerations that would inveigh against it. In particular, the development of weapons could violate the physician obligation of non-maleficence since those weapons would be used to harm some individuals.<sup>3</sup> What, then, should physicians do? Are they morally permitted to participate in weapons development?

Before moving on to a more general discussion of these challenges, let me point out some other specific contexts in which such challenges arise. In particular, we could see the above frameworks also applying to the following: physician involvement in torture and battlefield triage/medical neutrality (for more discussion see Allhoff 2008b, Part IV). It could easily be the case that torturous interrogations serve important military objectives, and that medical knowledge could make the interrogations more expedient, perhaps by conducting them in ways that invoke physical or psychological vulnerabilities of the interrogatee. Again, though, any application of medical knowledge that makes the interrogatee worse off than s/he otherwise would have been could be viewed as problematic when viewed through the lens of medical ethics.<sup>4</sup> Therefore, this is another instance of the dual-loyalties conundrum. On the battlefield itself physicians might face other issues – in particular, battlefield triage and medical neutrality. Here, the scenario is that the demand for medical attention exceeds the supply. Some decision, then, must be made about how medical resources should be allocated. Medical obligations would suggest that these decisions should be made on medical grounds alone: resources should be invested in ways that optimise (medical) outcomes. Just to take an example, imagine that there are two wounded soldiers, one of ours and one of the enemy's, and that there are resources to tend to only one of them. Imagine, further, that the enemy is slightly worse off, though both are very much in need. Medically, it could easily be the case that treatment should be provided to the enemy, since he is less likely to survive without medical care. The other soldier, however, is on *our side*. Should the physician tend to the enemy, despite the fact that this could lead to the death of an allied comrade? Or, more generally, should physicians exercise (political) *neutrality* when making medical decisions? What if the injured enemy were a high-ranking officer who could be an important strategic asset? It could be the case that resuscitating such an officer could, ultimately, lead to the realisation of various military objectives; we could further stipulate that such objectives had moral significance. If the physician chooses to save the enemy officer over our private, is this *fair*? If such an officer were *less* in medical need then, despite the military advantages, it would seem medical virtues would mandate the treatment of the private, though this could have adverse

3 In my own view, this conclusion does not follow since I think that non-maleficence should be understood in an aggregative mode: if physicians harm a few people such that more people are not harmed later – through, let's say, continued military conflict – it seems to me that such an act is not just licensed, but rather required by an appeal to non-maleficence. This is an unpopular view that I will not develop here, but see Allhoff 2006b for related discussion.

4 In fact, this is precisely the view taken by the AMA in its report; see AMA 2006. For a dissent, see Allhoff 2006b.

consequences for key military objectives. These questions can become even murkier when we abstract away from ‘micro’ decisions (eg save this person or that one) and try to achieve some clarity about the general triage practices that should be endorsed; in any case, such situations can clearly manifest the dual-loyalties concern.

#### ADDRESSING THE CHALLENGE

In the previous section I introduced the notion of the dual-loyalties challenge and showed how it could be instantiated in various contexts: weapons development, torture and battlefield triage/medical neutrality. In this section I want to consider various ways to remediate the challenge, and I take it that there are, conceptually, four different options here. First, we could hold that medical and non-medical values are *commensurable* and that, in any given case, we just have to make adjudications about which pull more strongly. Second and third, we could hold that these values are *incommensurable*, but that one or the other set of values does not apply. One option is that non-medical obligations are patently irrelevant to medical decision-making; the other is that medical obligations are inappropriate in these contexts. Fourth, we might say that the values are incommensurable, yet all apply. It is not clear to me how this fourth option is a *solution* to the challenge as it merely posits intractability. And I think, therefore, that it is simply implausible: we all believe that there are right and wrong courses of action in the scenarios mentioned above, and I want to suggest that we all believe this because one of the first three options listed must be correct.

The first option is the one that might seem the most straightforward: we acknowledge the existence of conflicting obligations and then have to decide which set carries more weight (while accepting the countervailing force of the contrary). So we could say, for example, that it is *prima facie* bad for physicians to develop weapons while, at the same time, allowing that complicity in weapons programmes could nevertheless be justified if the stakes were high enough. As more lives hung in the balance, as the enemy regime was more evil, or as all other options had been exhausted, we might postulate increasing moral merit in physicians developing these weapons. In the absence of such features, though, perhaps there would be insufficient countervailing moral weight for physician involvement in such a programme, given their medical obligations.

This line of argument is not without problems, both epistemic and metaphysical. Regarding the epistemic ones, we simply do not *know* how many lives might be at stake, or what the consequences will be of us having (or not having) chemical or biological weapons. Metaphysically, we might meaningfully ask how many lives are *worth* a single transgression against non-maleficence, and thence beckons the spectre of incommensurability. The epistemic worries, though, are just that, epistemic: whether or not we *know* the relevant stakes, it hardly follows that there does not *exist* some proper course of action, and we then have to do our best to determine what it is. The commensurability problem is a difficult one as well and people choosing this approach to resolving the challenge will surely owe us an account of their thinking in this regard.

Let me also point out another answer that might present itself here, which is more

empirical than conceptual. In setting up the above challenges I made various suppositions, and people might simply deny that any of these is reasonable. For example, in the torturous interrogation case, I asked that we consider an interrogation that advanced the greater good, despite its transgression of medical virtues. It is certainly an open possibility here to deny that such an interrogation is *possible*, perhaps by denying the plausibility of any sort of utility forecast that would justify the interrogation. In the torture debate more generally this is a common line (Arrigo 2004; Wynia 2005), though I think that there are responses (Allhoff 2006a). This approach, then, admits of the commensurability of the conflicting obligations while, at the same time, denying that there will ever be much pull coming from one of the directions; a quick look at the literature would suggest that the non-medical obligations are more commonly thought to be the impotent ones. However, I think that this is the approach that is most intuitive, though there is some work to be done regarding how the commensurability would be understood.

Second, we could resolve the challenge by saying that one of the two directions (necessarily, as opposed to contingently) exerts no pull. The more common direction that this would take is to deny that extra-medical considerations can have any import on medical considerations. This strategy is one that we might appropriate, in a different context, to Michael Walzer (1983). Walzer has postulated the existence of 'spheres of justice' such that we can make distributions of resources within some sphere only based on considerations internal to it, rather than to some distributive logic that would be motivated from some other sphere. In applying that structure to our context, it would therefore be inappropriate to make decisions regarding *medicine* by appeal to *extra-medical* considerations: medicine occupies its own sphere of justice and, therefore, medical decisions must be based on medical considerations alone. Note, then, that this view is patently one of incommensurability: it does not *matter*, for example, whether there are tremendous extra-medical benefits to be gained through some action that violates tenets of medical justice since the former are inadmissible regarding considerations of the latter. In this view there is no dual-loyalties challenge since there are no *dual* loyalties in the first place: physicians must make medical decisions based *solely* on medical considerations and chains of command; national security and the greater good are impotent against such considerations. While Walzer did not explicitly apply his framework to this present context, such an application is nevertheless fairly straightforward.

This view is not without problems, though many people will nevertheless find it compelling. As far as I can tell, the most pressing objection would have to do with how we individuate different spheres. As I laid it out in the previous paragraph, the medical sphere was conveniently insulated from the non-medical realm, and this insulation provided a solution to the dual-loyalties challenge. However, this structure could receive pressure in either of two directions. First, we might wonder whether this medical sphere is *too small*. In fact, the reason it offers a solution to the dual-loyalties challenge is that it is precisely of the scope that would do so and, therefore, might be thought to be idiosyncratic or *ad hoc*. What is so special about medicine that it gets its own sphere of justice? The postulation of such a sphere almost seems to be

question-begging against ‘greater good’ considerations, since it eliminates those considerations out of hand (eg by asserting a sphere which they cannot penetrate). We could certainly carve up the spheres differently, and perhaps ‘greater good’ could be a sphere of which medicine were a proper part. Regardless, it would seem that the postulation of spheres needs to be *motivated* in some way, and it is not clear to me what the motivation for a medical sphere would be.<sup>5</sup> Conversely, perhaps the medical sphere is *too big* (as opposed to too small). If there is a medical sphere, there could very well be sub-medical spheres: just as some features set off the medical sphere from others, features within it might be used to set off facets of it from itself. The problem would then be that this conception of spheres could lead to a sufficiently high number of them that they would not be useful in particular cases. Regardless, the proponents of spheres will have to say something about *why* there is a sphere of medicine and why it does not either get subsumed under a bigger sphere or fracture into multiple smaller ones; only a compelling story here would preserve the merits of this answer.

Finally, we could resolve the dual-loyalties challenge in the third way, which is again to deny that there are dual loyalties at all. While the spheres of justice approach negates the relevance of extra-medical obligations, a converse approach holds that *only* extra-medical obligations are admissible and that medical obligations do not apply. Again, this line would deny that there is a dual-loyalties *challenge* since there would not be competing obligations at all. This is undoubtedly the least popular of all the options and, as far as I can tell, I am the only person who defends it (Allhoff 2006b, 395–400). The idea here is that medical obligations apply only to *physicians* and that there is conceptual space for medically trained military functionaries who are *not* physicians.<sup>6</sup> Physicians are members of the medical *profession*, and this carries with it various moral features. For example, they have taken an oath to abide by various aspects of that profession, including providing care for those in need. But we could easily imagine medically trained personnel who are not members of this profession: they may never have taken the oath nor ever planned to provide positive medical services. Rather, they could use their medical training in an adversarial way, such as through the development of weapons or through participation in hostile interrogations.

I want to suggest that medical obligations do not apply to these people, whom I take to be something other than physicians. The contrary view would have to hold that, *regardless* of these people’s non-participation in the medical profession, the obligations nevertheless attach to them. I think that this line is problematic for various reasons and have argued against it elsewhere (Allhoff 2006b, 395–400). A second critique of this position is that the people that I would otherwise exempt from medical obligations are, in fact, physicians: they *have* taken the associative oaths and *are* members of the medical profession. I do not disagree with this claim, but it does nothing to erode the conceptual space that I aim to delimit. Rather, it seems completely possible to me that military physicians could *opt out* of the profession, and

<sup>5</sup> In the book (and in subsequent literature), this topic is explored, though I take it to continue to be one that assails the position.

<sup>6</sup> I acknowledge that, despite this contention, the title of this chapter nevertheless invokes ‘physicians’. I do this most proximately for ease of use, but also in recognition of the consensus view on this issue.

that some of their obligations would thereafter dissolve. (Some, however, would not, such as the obligation to preserve confidences obtained through participation in the profession.) Furthermore, there is no reason that these personnel had to take whatever oaths would ground medical obligations: we could easily imagine a medically-trained force that completely rejects these values altogether.

#### APPLICATIONS TO ARCHAEOLOGY

Having now developed a conceptual framework for thinking about the ethical foundations of military medicine, let us now turn to archaeology, the principal topic of this book. In particular, what does the aforementioned discussion have to do with archaeology? Is it at all relevant? Much of this assessment will have to be carried out by those who know more about the discipline, although there are a few comments worth making; let me identify and focus on two. First, there is the issue of whether participation in a military campaign is tantamount to (tacit) endorsement of that campaign. And, second, there is the issue of voluntariness. I will take these in turn.

It might be useful to have some context, so let us recognise the participation that archaeologists played in the recent Iraq war. Other contributors to this volume will discuss the facts in greater detail,<sup>7</sup> but suffice it to say that archaeologists collaborated with American and allied forces to develop a list of thousands of sites that should be spared during the then-imminent bombings; estimates include up to 5000 named sites (Hamilakis 2003, 105) including ‘historic mosques, churches, forts, khans, and treasures housed in museums’ (Stone 2005, 1). It has been acknowledged that this initiative led to the protection of sites that might have otherwise been lost during conflict (Hamilakis 2003, 106). After the invasion, many archaeologists drew attention to the significance of much of the looting that was taking place and offered their services in attempts to assess and to rectify the damage that had already been done (Hamilakis 2003, 105–6; also see numerous chapters in Stone and Farchakh Bajjaly 2008).

Yannis Hamilakis has argued against the involvement of archaeologists in this capacity, saying that it shows a failure of ‘responsibility’ and evinces a stewardship over artefacts rather than over people. He wonders (2003, 107) why ‘archaeologists ... agree to act as advisors to the invading armies, oblivious to the fact that their role provided academic and cultural legitimacy to the invasion?’ But, of course, playing an advisory role does no such thing. Imagine, for example, that the invasion will happen with or without archaeological feedback, as it almost surely would have. The professional archaeologist is therefore placed in the (unfortunate) position of either telling the attacking forces what not to destroy or not telling them this. Any professional archaeologist with special knowledge of important sites in the to-be-invaded region clearly has an ethical obligation to advise in a way such as to minimise those damages.

This fails to be true only in a very small subset of cases, such as when the archaeologist knows – or is culpably ignorant for not knowing – that the information

<sup>7</sup> In addition to the contents of this volume and for the specifics of the UK response, see Stone 2005.

would be used nefariously in order to actively target the archaeological sites. So, for example, imagine that the attacking force wants to effectuate some blow to the morale of the enemy by destroying culturally important sites. In this case, imagine that the archaeologist is brought in and told to identify such sites precisely so that they can be destroyed. Still, it is not obvious that such disclosures cannot be justified. For example, the invaded population might surrender more quickly if its morale were destroyed, thus saving more lives overall, effecting less economic and cultural damage, and so on. If the destruction of one museum helped bring this resolution about – and further assume, if you think it matters, that the museum would otherwise be at high risk during a drawn-out conflict – then there cannot be anything wrong with the archaeologist providing the corresponding assessment. After all, as Hamilakis would have us believe, what ultimately matters is the people and not the artefacts.

But this gives rise to a further point, which is that archaeologists (and physicians) are neither tasked nor qualified to render commentary on ‘the criminality of the whole campaign ... [or] ... the illegal colonization of [some] country’ (Hamilakis 2003). This is simply empty rhetoric, unsubstantiated by any serious assessment of the legal merits of the Iraq invasion. That it portends a more general call to politicise archaeology is even more troubling. Politicians and lawyers should decide whether wars are legal or not and should wage them accordingly; this is where their expertise lies and is the reason that we elect and hire them. The American Philosophical Association (APA), for example, provided a resolution against the war in Iraq (APA 2005), but it is hard to discern what this is supposed to amount to other than a group of philosophers saying that they do not like the war. Given the left-leaning orientation of academic philosophy, such a result is hardly surprising, though it hardly seems relevant, either. Nor, again, do philosophers have the appropriate training or expertise to render such commentary; there seem here to be a lot of similarities to a grade school class ‘opposing’ climate change. A similar statement was issued by the 5th World Archaeological Congress (WAC), which I assess similarly (Hamilakis 2003, 109).

Suffice it to say, then, that I oppose the politicisation of archaeology and medicine. The AMA, for example, has issued an opinion saying that ‘[p]hysicians must oppose and must not participate in torture for any reason’ (AMA 2004, 2.067); similar things are said about capital punishment in a related opinion (AMA, 2.06). But these are political issues and not ones directly relevant to medicine. For example, the medical value of non-maleficence goes, at best, to physicians not participating in torture and says nothing about whether physicians must actively oppose it in all its instances. And, given that torture (or executions) is likely to happen regardless, the physician only makes the recipients worse off by not participating, thus violating the value of beneficence. Regardless, I do not think that the AMA should issue these statements any more than the WAC should issue their analogues.

In this sense, I see a similarity between archaeology and medicine: archaeologists should do archaeology and physicians should practise medicine. Archaeologists and physicians should not make claims about what is legal or illegal, but rather should leave those queries to those with legal expertise. This is not to say that neither archaeologists nor physicians will get it right or wrong in any given case – after all, we might assume they have a 50% chance either way – but rather that their

professional training and expertise are inappropriate to take those sorts of stances. I further think that, were such proclamations to come from professional societies – as they did from the APA and WAC – that would be dramatically unfair to the rest of the membership, most of which will not have signed up in order to be wielded as some sort of partisan bullhorn.

While I take that to be a similarity between archaeology and medicine, there is also a principal difference: military physicians do not have a say in whether they participate in a conflict, and archaeologists do. For reasons given above I do not take participation to be tantamount to any sort of tacit approval and I further think that, regardless of the morality of the conflict, the participation might be morally required in order to reduce overall harms. Nevertheless, I do think that the notion of volition is relevant. To wit, imagine that a military physician participates in an immoral war – or else performs an immoral yet commanded act within a moral one. Perhaps the physician enlists under one administration and the next goes off to this unjust war, yet his period of service has not yet ended. It seems to me that his blameworthiness is mitigated by his lack of volition. Perhaps some sort of disobedience would be required in some situations, though it is hard to see how, for example, a physician might justifiably not elect to treat a wounded soldier such that the soldier could not be returned for battle.

Archaeologists, as far as I can tell, are playing only advisory roles in military campaigns rather than (otherwise) actively contributing to them. If some archaeologist were to contribute to that effort in such a way that the situation were ultimately made worse off, there would be blameworthiness not appropriate for the physician. As argued above, this is not to say that archaeologists should not participate in unjust wars: in order to minimise overall harms, it is quite possible that they should. Rather, the thought is that they enter at their own risk insofar as they do so voluntarily. Note that this proviso might, at some level, apply to military physicians as well insofar as they should think before enlisting about what moral quandaries they might find themselves in. However, with the archaeologists the links are presumably more proximate and the ethical burden is therefore correspondingly greater.

Because archaeologists are advisers I do not see them as straightforwardly subject to the dual-loyalties framework that I developed for physicians. What would the dual loyalties be? As I said above, I think that archaeologists should, as they can, provide military support that would lead to the protection of important sites. I take it, though, that Hamilakis need not disagree: presumably he would acknowledge that this is one value, of which there are others, to which archaeologists should be attendant. And what is the value against which this value can come into conflict, thus effectuating the *dual* loyalties? Hamilakis thinks that the competing value has to be one such as to be derived from being an outspoken critic – as opposed to tacit endorser – of unpopular (or putatively illegal or unjust) wars, though I reject this completely.

What I would not reject bears a stronger similarity to the medical case, which is that archaeologists owe some consideration to the greater good. If physicians can violate apparent strictures of medical ethics to use their expertise in the development of weapons (cf non-maleficence), then that justification would presumably have to be made by citing just and important moral value (eg self-defence, deposition of an

aggressive and evil regime, and so on). So imagine that the compromise of archaeological values would somehow bring about an improved state of affairs in the world. For example, an important museum could be classified as non-important, thus allowing for its destruction. And, furthermore, that destruction could catalyse a negative response throughout the world, by bringing attention (and corrective action) to an unjust war, an exposed population, or whatever. In this case, should the archaeologist sacrifice the museum? Maybe, though the epistemological challenges are myriad. Nevertheless, I do think that it is possible for archaeological value – which I take it is the archaeologist's to defend – to come into conflict with other values. And therein, perhaps, lies the archaeologist's own dual-loyalties challenge.

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