Impartial medical care is one of the most enduring norms of modern warfare. The Geneva Conventions (1949, Article 12) clearly stipulate: ‘only urgent medical reasons will authorize priority in the order of treatment to be administered’. To remove any possible doubts, the commentary to the Conventions (1949, Article 2, para. 2A) makes the following teaching point: Each belligerent must treat his fallen adversaries as he would the wounded of his own army. At first glance, this is an odd sentiment. It would not apply to foreign aid, for example. Nations have no obligation to treat citizens of other countries as they do their own. Nor would it apply to those injured outside war such as refugees who seek medical care in wealthy nations. There is no obvious duty to provide the same care to foreigners that a nation offers its own citizens. On the contrary, the duty to aid foreigners is usually anchored in beneficence and requires states to provide aid only insofar as the cost is reasonable and the needs of compatriots are met first. Because it is difficult to meet compatriot needs entirely, beneficence is at best a weak duty where nations grudgingly set aside the demands of their citizens and tend to the world’s neediest. Given the limits of beneficence, perhaps reciprocity provides the answer: a nation cares for wounded enemy soldiers as their own so their enemy will do the same. The Geneva Conventions apply only to enemy soldiers and during armed conflict medical care is a provision of mutual aid: we will treat your wounded and you will treat ours. That way each side can preserve its fighting force and enhance the morale of its soldiers.

While reciprocity and beneficence capture some of the rationale behind the laws of armed conflict, the imperative to provide need-based medical care impartially transcends both. Medical professionals treat those in need neither to gain treatment for others nor satisfy charitable impulses. Instead, utilitarian concerns often prevail: treating the neediest patient first best enhances the benefits that medicine can provide. As any serious health care debate shows, however, the neediest patient is not necessarily the sickest. Saving lives for some does not necessarily outweigh improving the quality of life for others. This is particularly true when those facing life-threatening illness are very old or very sick and/or in need of very expensive treatment.

However these competing interests are juggled, the choices health care systems make about which illness to treat should remain unaffected by a patient’s personal identity whether enemy, ally or compatriot. This is a fundamental corollary of health care as a human right, and holds regardless of any other attribute a person may possess. Identity based care violates the ‘principle of fair opportunity’ (Beauchamp and Childress 1994: 342) stipulating ‘that no persons should be granted [or denied] social benefits on the basis of undeserved advantageous properties (because no persons are responsible for having these properties)’. A patient’s personal identity or personal relationship to the doctor or nurse is morally arbitrary in this sense; it does not and cannot confer any right to receive prior care because the patient is not in any way responsible for these aspects of his identity. Patients, therefore, expect fair and unbiased treatment solely dictated by their medical condition. Doing otherwise undercuts the trust that patients confer on physicians, impairs the integrity of the
profession and violates the covenant between physicians and the community that requires health care professionals to abjure any personal interest in the patient and use their skills solely for the interests of the sick (Pellegrino and Thomasma 1993: 36–7).

Nevertheless, national identity and national interests can be very important. In general, health care must compete with other social goods such as education, welfare and national security. While medical care for the neediest enhances the benefits that medicine provides society, it may fall short of improving overall social utility if other areas are neglected. Life-saving care may, therefore, be set aside for treatment that improves quality of life but also for more schools or aircraft carriers. National security and military necessity may demand that medical personnel first treat soldiers who can return to duty before treating the critically ill and so relegate severely enemy wounded to the end of the line. The practice of medicine may be blind to national identity but social utility is not. Nations are bound to care for and protect their citizens first. This concern is not merely emotive. Prior care for compatriots preserves the integrity of the political entity, namely the state, best suited to safeguard human security and development. Similar principles prevail in peacetime: while no national health care system may discriminate among its citizens, it may surely exclude foreign nationals who come knocking at the door. As in war, the welfare of one’s own often comes first. The duty to care for compatriots may also upend the covenant solemnizing the relationship between doctors and patients. While this covenant defines the rights and duties of physicians, it coexists with other social covenants, rights and duties. Most vexing are those that stipulate preferential, not impartial, care for family members and friends. It is not always easy for health care professionals to sidestep these conflicting duties.

Reservations about impartial care are particularly salient during armed conflict where at least three circumstances mitigate the force of the Geneva directives: military necessity, two-tiered care in a battle zone and the ethics of comradery. First, military necessity may direct medical workers to triage patients based on their fitness to fight rather than urgent medical need. This radically discriminates against enemy wounded. Second, a state army cannot always provide the same level of care for its compatriots, allies and enemies because medical resources are scarce. In Iraq and Afghanistan, for example, the US Army established a two-tiered medical system that offers significantly superior care to American soldiers and detainees than to Iraqi or Afghan allies. Finally, and regardless of available resources, an ethics of care and comradery reinforce special obligations among compatriot soldiers that may require some medical personnel to treat their own comrades first regardless of medical need. All these circumstances lead us to reconsider the principle of impartial care.

Military Necessity, Medical Care and Return to Duty

Military necessity highlights the means of war that nations must adopt to preserve the welfare of the state, its army and its citizens and offers a cogent exception to treating soldiers based on urgent medical need. All military medical organizations recognize that battlefield circumstances may demand that physicians dedicate scarce medical resources first to those they can return to duty and only then to those whose lives and limbs are at risk. An oft cited case describes ‘penicillin triage’ during WWII when, in 1942, military physicians used scarce penicillin to cure gonorrhoea stricken soldiers and return them to duty before treating those with more extensive battlefield injuries who would never return to battle (Gross 2006: 138–41). More recently, British medical personnel prepared guidelines for conventional triage and mass casualty triage during the Falklands War. Conventional triage emphasizes medical need, caring first for those requiring immediate
resuscitation or surgery and only then for those whose wounds are less severe. Mass casualty triage reverses the order when ‘an overwhelming number of seriously injured … are placed upon locally available medical facilities quite unable to supply normal medical care for them’. Under these conditions, patients who require ‘some form of surgery to save life and limb, short operating time and have good quality survival’ take precedence over those with ‘serious and often multiple injuries’ who need difficult and time consuming treatment (Marsh 1983; Ryan 1984; Ryan, Sibson and Howell 1990).

Penicillin triage and related instances of mass casualty triage are instructive because they describe how military necessity may override urgent medical need. In these cases, medical workers treat the less injured first to prevent troop degradation, conserve their forces and bolster the war effort. In all these cases, however, the soldiers in question are compatriots. For them, the principles of mass casualty triage offer a significant benefit: victory in war. For this reason, one may presume that compatriot soldiers and their families also consent to preferential treatment for those less wounded when resources are scarce and military success is on the line. Furthermore, there is a broad presumption that soldiers, upon enlistment, consent to and understand that military needs trump personal interest and well-being (Visser 2003). Utility and consent are two very powerful justifications for preferential care.

But what happens when some of the soldiers are enemy wounded? May their interests be shunted aside in the name of military necessity? During WWII the US government thought so when it allocated 85 per cent of available penicillin stocks to the US military, 15 per cent to civilian hospitals and 0 per cent to treat POWs (Adams 1989). How might this be justified? Preferential treatment for those who can return to battle certainly offers enemy wounded no benefit nor, presumably, would they give their consent.

The claim of enemy wounded to receive medical care is similar to the claim of any moral agent who requires aid from those who can provide it. This claim is not absolute nor does it entail that a rescuer offer aid to others that is equal to what he needs for himself. Fleshing this out is not easy but it seems clear that while the duty of beneficence ‘cannot be so drastic as to require the sacrifice of all a person’s projects [or require] … fundamental changes in the fabric of his life’ (Weinrib 1980: 290). When rescuing agents are states, a similar condition holds: while states may be called upon to aid those in need, no state may be required to relinquish resources at the expense of its well-being, broadly conceived as the material resources necessary to maintain its political and economic institutions. When these institutions are threatened during war, for example, there are grounds to prefer treatment of compatriots who can return to duty. When resources are scarce, impartial, need-based care impinges on a state’s ability to wage war effectively and constitutes an unreasonable burden thereby mitigating obligations to enemy wounded.

Since enemy soldiers do not benefit from an allocation scheme that emphasizes return to duty, there is no reason to think they will consent. Nor is consent required. For a compatriot, preferential treatment for the less wounded infringes on the right of a more seriously wounded soldier to receive medical care from his community. By consenting to allocation scheme that prioritizes return to duty, a wounded soldier waives his right to medical care based on need. For the non-compatriot, however, consent is not necessary to justify preferential treatment for others. A stranger does not have the right to receive the same need-based care as the members of the state that cares for him. He only has a right to receive medical care when sufficient resources are available so that care for strangers does not overly burden the rescuer.

There are several important caveats to this understanding of preferential treatment. First, preferential treatment for compatriots does not mean that enemy wounded cannot complain about abject neglect, mistreatment or abuse. I will return to these points later. Second, the conditions for
mass casualty triage: shortage of medical supplies, overwhelming casualties in a very short period of time and the immediate threat of troop degradation come together only rarely (Beam 2003; Vollmar 2003: 755; Adams 2008). As such, military necessity suggests only a defensible exception to the rule expounded in the Geneva Conventions. Rare exceptions do not invalidate the underlying principle of medical impartiality but merely set it aside in extreme situations. The more morally complex cases are those where resources are sufficient to treat all, but medical personnel choose to treat injured compatriots before enemy wounded regardless of the severity of their wounds. In doing so, they do not appeal to military necessity but to the duties of friendship and comradery. I discuss these cases in the sections that follow.

Finally, it is important to remember that impartial care based on the principle of military necessity is only limited to soldiers who can return to duty. When deciding among compatriot and enemy patients who are all so critically ill that even the compatriots among them cannot return to duty, there are no grounds for preferential treatment based on military necessity. Military necessity only permits preferential treatment for those who, after treatment, can contribute to a war effort. If they cannot, then their status is no different from enemy wounded. For them, medical need alone will determine priority of care, moderated, perhaps, such considerations as compliance and the availability of follow-up care. Within a national health care system where all the sick and injured have access to similar care, post-injury follow-up care will not affect the initial course of treatment. Follow-up care, or more specifically lack thereof, can, however, be an important criterion of initial care in military medicine. This happens when compatriot troops fighting abroad have access to superlative medical care while their local allies, that is ‘host-nation’ wounded, have access only to limited resources and paltry care. This is precisely the state of affairs in Iraq and Afghanistan.

Two-Tiered Medical Care in Iraq and Afghanistan

To support its soldiers, the US Army provides medical care at several echelons. At echelon I combat medics in the field and/or a physician or physician’s assistant in an aid station provide first aid and, when necessary, evacuation to an echelon II facility. At level II, a 20-person Forward Surgical Team offers immediate treatment, surgery and evacuation to an echelon III, Combat Support Hospital (44–248 beds) for orthopaedic, thoracic, oral and maxillofacial surgery, intensive care and psychiatric treatment. However, the number of beds in these facilities is extremely limited. For example, there were only 274 operational beds in Iraq between November 2006 and July 2008 (Richardson 2008: 49). When necessary, therefore, the wounded are referred to a full service trauma centre in Landstuhl Germany (echelon IV) or to Walter Reed Medical Center in the US (echelon V) (Nessen et al. 2008; Office of the Surgeon General 2008: 3–6).

While this system is designed to provide the best possible care for US soldiers, American medical facilities also care for detainees, ‘host-nation’ soldiers and local civilians wounded during American operations. While severe American casualties have access to superior medical facilities, local casualties (with the exception of detainees who remain under American care), must turn to a poorly functioning and under equipped local system. In both Iraq and Afghanistan, repressive regimes and war have decimated the health care system as nurses and doctors fled the country and facilities fell into disrepair (Library of Congress 2006: 8; WHO 2006). Substandard follow-up care compels US military physicians to limit or modify their treatment protocols when treating host-nation soldiers and civilians. This can significantly affect the initial treatment that physicians choose and effectively creates two-tiered system that allocates care based on nationality. Because
advanced reparative surgery, surgical implants, prosthetic devices and facial reconstruction are not available to Iraqi or Afghani wounded, host-nation wounded will undergo amputation, in-theatre plastic surgery or less sophisticated interventions while US soldiers are evacuated for care unavailable to host-nation wounded (Nessen et al. 2008: 65–9, 223–37; Rosenfeld et al. 2006; Filling and Bower 2010; Bridges and Evers 2009).

Host-nation causalities also strain US medical facilities. While physicians will evacuate seriously wounded Americans for continued care, they must either discharge host-nation wounded or try to treat them in facilities that were never intended for long-term care. Paix, for example, describes how one combat support hospital provided two weeks of intensive care for 12 ventilator-dependent quadriplegic Iraqi patients ‘who will inevitably die when transferred to a local facility that cannot manage a tracheotomy, or provide tube feeding or pressure area care’. This, in his opinion, ‘subjects patients to futile care, wastes resources … leads to facility overload, puts staff at risk and compromises the medical facility’s ability to provide First World care for Coalition forces’ (Paix 2006: 26). The outcomes are stark: first-world care for coalition forces; third-world care for host-nation wounded.

In one sense, this is not legally or morally problematic because host-nations civilians are not entitled to the same kind of care that occupying armies provide their soldiers. The 4th Geneva Conventions, Articles 55 and 56 require an occupying power to only provide the civilian population with medical supplies and services ‘to the fullest extent of the means available to it’. This makes sense. As an intervening military power, the US cannot afford to provide sophisticated health care to a large Iraqi or Afghani civilian population. Nor is there an obligation to do so. The obligation that comes with occupation draws on the duty of an occupying army to care for those under its control and provide medical services ‘to the fullest extent of the means available to it’. For occupying armies, the means available are most likely those left over after other urgent military and ‘material’ needs have been met (Commentary, 4th Geneva Convention, Article 55: 310). In practice this might demand something similar to what wealthy nations provide poorer countries in humanitarian aid and reflects minimal level of health care that includes preventive medicine, vaccinations, health education, prenatal and maternity care, basic ambulatory and emergency care and treatment for acute and life-threatening diseases, acute non-fatal diseases where treatment restores one to previous health and chronic non-fatal illnesses that require one time treatment (Bobadilla and Peter 1995; Ham 1997; Segall 2010). These are interventions that preserve or restore a reasonable level of functioning for as many as possible at the least cost and are not far from US directives in Iraq and Afghanistan save the ‘life, limb or eyesight’ of host-nation wounded (Richardson 2008; Beitler et al. 2006) while working to improve the level of care across the country for all civilians (Enemark 2008; Zahoor et al. 2011).

Host-nation soldiers, however, are not civilians. They fight alongside American and Coalition troops but receive second tier care that is inadequate to help severely-wounded host-nation soldiers suffering from chronic non-fatal injuries such limb loss and traumatic brain injury. These are the bane of war and there is little in the basic schemes of care outlined above that would ensure their continued care. Detainees and enemy combatants, on the other hand, receive care nearly identical to that provided to Coalition forces. Something is amiss here. Why should enemy soldiers receive better care than allies? Do allies deserve the same care as detainees or, do detainees deserve the same care as occupied civilians and allied soldiers? The answer, I think, is yes to both questions: detainees, allies and occupied civilians all deserve the same level of care but one that is necessarily inferior to the care Coalition soldiers receive.
Equal Care for Detainees and Allies

Complying with the Geneva Conventions, the US extends medical care to detainees and wounded enemy combatants on par with what US and Coalition personnel receive (Sargent 2008; Patton 2009; DOD 2006: 4.1.2). When needed, detainees receive all necessary care at combat support hospitals but are not routinely airlifted to treatment facilities in Germany or the US (Nessen et al. 2008: xxi). Nevertheless, the level of care afforded wounded enemy combatants significantly exceeds that which host-nation soldiers receive.

One is then faced with the stark dissonance that comes when detainees receive better care than allies. Legally, of course, this is the outcome when treaties protect prisoners of war but say nothing about the care due allies, assuming perhaps that allies can work this out on their own while enemy combatants are vulnerable and require protection. Certainly this might have been true in conventional wars between nation states, but modern asymmetric wars are different in two important ways. First, reciprocity is no longer a major incentive for belligerents. In the past, concern for one’s own captives motivated belligerents to take good care of enemy prisoners of war. But today very few Coalition soldiers fall prisoner so there is no reason for a mechanism whose purpose is to ensure quality care for one’s own captured soldiers. Second, many enemy detainees are not innocent in the relevant sense that one usually accords soldiers fighting for state armies. Ordinary soldiers are not criminals. If captured they are not tried or executed but incarcerated and then repatriated when hostilities end. In asymmetric war, on the other hand, some belligerents are terrorists while others may be fighting at the behest of an illegitimate, criminal or genocidal regime. Upon capture many of these combatants are incarcerated to wait for trial. While this does not mean that they forfeit any of their fundamental medical rights to care and protection it does suggest that they do not merit better care than host-nation soldiers fighting alongside Coalition forces.

Treating host-nation soldiers and enemy detainees equally can take one of two forms. One is to offer host-nation soldiers the same care as detainees and Coalition soldiers. This certainly accords with a sense that allies deserve the same level of care as detainees. However, the numbers are daunting. For example, the 62nd Medical Brigade in Iraq describes how it provided care for 170,000 US and Coalition forces, 150,000 contractors, Iraq Army and Iraqi Security Forces, local nationals, and 28,000 detainees in 2008 (Sargent 2008). The US and Coalition forces and detainees received first tier care and the others second care tier. Providing equal care to all nearly doubles the patient base. Whether this is feasible depends upon whether the burden of equal care undermines the standard of care that Coalition forces owe their own soldiers. Moreover, one must ask whether seriously wounded soldiers have a stronger right to health care than seriously wounded civilians. I have argued elsewhere that they do not: absent the prospect of returning to duty there are no grounds prefer seriously wounded soldiers over seriously wounded civilians (Gross 2008). If seriously wounded host-nation soldiers deserve the same care as Coalition forces and detainees, then so do seriously wounded civilians of any stripe. This is not only onerous but beyond the obligation of any occupying army to provide the local population with the health care necessary to preserve or restore a reasonable level of functioning for the greatest number at the most affordable cost.

In these circumstances, an occupying army can only strive to deliver the same minimum standard of healthcare to host-nation civilians, soldiers and detainees alike. These efforts accord with the moral obligation of occupation. Offering equal care to save the life, limb and eyesight of detainees and host-nation soldiers also accords with the moral status of the two. Detainees have no superior right to medical care and, therefore, the three categories of host-nationals – civilians, soldiers and detainees – warrant a similar standard of medical care. Beyond a constant effort to rebuild local health care institutions, equality of care demands that an occupying power transfer
detainee care to the host-nation as the US did when it signed the Status of Forces Agreement (SOFA) with Iraq in 2008 and should do in Afghanistan at the earliest possible date (SOFA 2008, Article 22; Holman 2008; Lieblich 2011: 340–1, 358–9).

American soldiers will receive superlative treatment when wounded. Host-nation wounded will receive second tier treatment. When multiple health care systems are available to the fighting forces, the duties of care incumbent upon occupying armies permit a two-tiered system as long as the weaker system provides minimally acceptable medical care. Under these conditions, medical personnel in the stronger system may shunt allied and enemy wounded to the weaker and adjust the initial care they provide the wounded to the availability of follow-up care. Nationality, not urgent medical need solely, determines the care that many wounded will receive during war. Within a given system, however, the principle of non-discrimination demands that comparably wounded merit comparable care regardless of nationality. Perhaps this is how the Geneva Convention should be interpreted: critically wounded soldiers treated in the same facility should receive treatment based solely on the extent of their injuries. This seems to be minimal requirement for ethical medical care but faces stiff challenges from the primary duties of care that friends and comrades owe one another.

Special Obligations, the Ethics of Care and Comradery

Consider the following case:

One US soldier and one Iraqi Army [coalition] soldier present with GSW [gunshot wound] to the chest. Both have low O₂ saturations. There is only enough lidocaine for local anaesthesia for one patient, and only one chest tube tray. One will get a chest tube with local anaesthesia, and the other will get needle decompression and be monitored by the flight medic.

Who gets the chest tube and local anaesthesia and why?

In an ordinary medical environment, the national identity of the patient is irrelevant. Deciding whom to treat and how would depend entirely upon medical criteria: which patient was the most severely ill and/or which patient was expected to best benefit from one treatment or another. One might also consider questions of compliance, available follow-up care and other variables that may affect the effectiveness of care. Here, too, the patient expected to most benefit will get the optimal care. Should both patients benefit equally from the chest tube and local anaesthesia one moral solution might be a lottery that would give each patient an equal chance of receiving the best treatment available.

When asked who should get the chest tube, participants in workshops on military medical ethics at Walter Reed did not ask about relative medical need or the availability of follow-up care. Instead, they cut to the chase: Treat the American first. ‘Why?’ we asked the participants. ‘Because he’s our brother’, they replied in near unison. Although little studied, this is not an isolated phenomenon. A small sample pilot study of Israeli medics (n=19) revealed that more than half (10) would treat a moderately wounded compatriot before a more seriously wounded enemy soldier or civilian (Dakar 2009). Carter (1994) found that only two-thirds of 600 US military physicians deployed during Desert Storm agreed that medical need should be the only criterion used for triage.

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1 My thanks to Major Jacob F. Collen, MD, for providing this case for discussion. See also Sessums et al. 2009.
and 22 per cent agreed that POWs, that is wounded enemy soldiers, should only be treated after all allied forces are treated no matter how severe their wounds.

It appears that military medical personnel are of two minds about the Geneva Conventions. On one hand, they acknowledge the principle of non-discrimination and medical impartiality. On the other, they recognize a conflicting and often overriding obligation to provide their compatriots with the best medical care possible. Medical care, in this case, is not only a professional obligation but a duty that health care providers owe friends and comrades-in-arms. These duties do not merely supplement the impartial criteria for allocating medical care but may replace it altogether and offer substantial moral grounds for preferential treatment for compatriots. Morally, the imperative to treat one’s brother first finds strong justification in associative obligations and the ethics of care.

**Associative Obligations and the Ethics of Care**

At one level, offering priority care to friends or family members when others are in greater need violates the principles of impartiality, non-discrimination and opportunity that are central to medical ethics. At another level, however, preferential care for family and friends is a fundamental moral obligation. Parents are not expected to invest much in the care of others before they attend their own children. Friends, likewise, have special obligations toward one another that they do not have toward strangers. In both cases, special obligations to tend to those closest to us replace the principles of justice and utility that usually guide medical care. The question is: which paradigm applies to military medical ethics? On the face of it, it appears that questions of professional duty are paramount. Yet in wartime, exemplified by the case just cited, special obligations of care deserve careful consideration.

Moral philosophy has always taken note of ‘associative obligations’ that reflect the overwhelming moral importance of intense, interpersonal relations among members a small, tightly woven and interdependent family or community that demand preferential care for those who are close (Simmons 1996). Few doubt that friends and family owe duties of aid and assistance to one another that they do not owe to strangers. At one level these duties are grounded in commitments of mutual aid: friends implicitly agree to help one another in times of need. In other instances, there are good social reasons for associative obligations because they preserve such institutions as friendship and family that are essential for well-being and survival. At another level, however, is an ‘ethics of care’ that transcends mutual aid and social utility and invokes unconditional duties that certain individuals owe one another by virtue of a special relationship between those who can provide life sustaining care to those who need it. The ethics of care invokes an emotive rather than contractual bond that calls for ‘personal concern, loyalty, interest, passion and responsiveness to the uniqueness of loved ones, to their specific needs, interests [and] history’ (Held 2006: 95).

Guided by preferential and discriminatory principles, special obligations toward friends, family and compatriots inevitably raise questions of distributive justice: what if others are in greater need of care and attention? In all but the most extreme cases, however, this question does not arise. Special duties of care reflect moral principles that operate independently of universal principles of justice. As such, expected utility is not always a relevant moral principle. Friends and family should aid one without expectation of reciprocity, often at great personal cost and when knowing that the same aid might benefit a stranger more (Mason 1997). This is a common intuition. To think too hard about aiding a stranger when the life of one’s family or friends is in danger is, as Bernard Williams famously put it, ‘one thought too many’. Is medical care for enemy wounded also one thought too many?
Answering this question requires some understanding of the personal relationships among soldiers. Military sociologists often distinguish between primary and secondary bonding. Primary bonding reflects the close and constant personal ties between primary group members and their immediate leaders at the platoon level (40–50 soldiers). Secondary bonding binds group members to the larger military organization to which their small unit belongs and is characterized by institutionalized, impersonal and formal ties (Siebold 2007; Kirke 2010). Primary groups are an essential feature of an effective military organization and engender the loyalty, assistance, self-sacrifice and commitment needed to create successful fighting units. Primary groups are not merely a collection of well-coordinated, self-interested individuals, but a cohesive band knitted together by ‘mutual affection, interdependence, trust, loyalty … peer bonding and teamwork’ (Siebold 1999: 15). Although ad hoc when compared to ethnic or religious communities, primary military groups serve similar functions by helping to ensure individual and collective survival and by providing an important dimension of personal identity (Siebold 2006). For these reasons, primary groups generate ‘particularistic’ or special obligations to members of one’s community that are not extended to everyone (Etzioni 2002: 577). For a medic in a small military unit, these obligations might require preferential care for compatriots.

At the most primary level of military medical care, a combat medic or aidman provides immediate first aid and life-saving treatment to members of his platoon, a primary group linked together by strong personal ties of friendship, comradery and loyalty. This is particularly true of an infantry platoon where the medic trains with and forms an integral part of a small fighting unit (Hurtado and Montoya 2009). Within this unit, bonds of friendship dominate moral relationships and generate duties of care that may dictate preferential treatment and trump considerations of impartial justice. There are two reasons for this. First, the survival and effectiveness of the group depend upon preferential treatment for group members when resources are scarce. Second, and perhaps more important, is the moral primacy the special obligations of care among friends and comrades irrespective of the instrumental value of the group. These two arguments are often difficult to disentangle even when the unit is a family. Here, too, one can describe the instrumental value of the family as a vehicle that nurtures human development and which will suffer if members don’t care for one another, and the intrinsic force of strong and overwhelming duties among family members. Medics are no different from their comrades in this regard. Each is but another primary group member that brings a special skill to their group and each remains duty bound to use that skill, first and foremost, to assure the well-being of the other.

In the institutionalized settings that characterize the higher echelons of military medical care, on the other hand, the duties of friendship and comradery weaken. In the process, preferential treatment for primary group members falls to impartial standards of care typically demanded of the medical profession. The ethical demands on caregivers, in other words, should vary according to the strength of primary bonding. As primary bonds weaken and secondary bonds strengthen, the universal duties of justice replace the parochial ethics of care. This might be particularly true of physicians rather than medics. Physicians train first in medicine and only then receive rudimentary military instruction before working in an institutional setting. In contrast, medics train first as soldiers and only then receive medical instruction before (re)joining a small military unit.

Transposed to the battlefield, the associative obligations and the ethics of care can have important ramifications. Consider three different scenarios.

1. Equality of Injury: In the chest wound case described above, resources are scarce and compatriots and non-compatriots suffer similar life-threatening or disabling injuries. Criteria dictating the order of care include the patient’s chance of recovery, available follow-up care
and the likelihood of returning to duty. Absent any utilitarian criteria to decide between the cases, a lottery might determine the order of care. A lottery may accord with impartiality but ignores the moral significance of the duties imposed by primary group membership. These duties are not negligible but, in this case, only serve as a tie-breaker after all other impartial criteria of distributive justice are exhausted.

2. Gross Inequality of Injury: When compatriots are lightly wounded and non-compatriots suffer life-threatening or severe disabling injuries, far more good will come from aiding non-compatriots than compatriots. Here, special obligations of care are overruled by a different concern, namely the duty of beneficence, that is, the obligation to aid others when the cost is reasonable and the danger to strangers is very great (Blum 1980). On the battlefield, however, and without sophisticated diagnostic equipment or expertise, the relative severity of soldiers’ wounds may not be readily apparent. This will often lead caregivers to treat on the basis of the category I, wounds of equal severity, or on the basis of category III, wounds of only moderate levels of disparity. Either case leads to preferential treatment for compatriots.

3. Moderately Inequality of Injury. These are the hardest cases. Consider the following:
   a. There are sufficient medical resources to save the life of one compatriot or two (or more) non-compatriots.
   b. Compatriots face disfigurement or loss of limb while non-compatriots face loss of life.

Impartial need-based care demands treating the non-compatriots first. Associative obligations and the ethics of care, on the other hand, emphasize the prior and superior moral duty to treat compatriots first. Among compatriots, saving lives is usually more important than saving limbs. If forced to choose between saving the life of one soldier or the limb of another, the former is morally preferable. When faced with saving the life of a non-compatriot or the limb of a compatriot, limb may easily trump life. Similarly, it may be morally permissible to save the life of one compatriot rather than the lives of two or more strangers.

The moral reasoning is directly analogous to that of a parent who, acting on the compelling demands of the ethics of care will prefer the welfare of her child at the cost of many other lives. Beneficence, the duty to aid others, weakens considerably when the costs to the rescuer are onerous. At the same time, associative duties direct a caregiver to give preferential aid to those with whom the primary bonds of friendship or kinship are strongest. When lives are at stake our duties to friends and family are clearest and it is easy to imagine that almost any number of other children’s lives will outweigh a parent’s duty to save his own child from harm. When limbs are at stake, one must ask whether a national health care system would sacrifice salvageable limbs of compatriots to save the lives of foreigners. Here the answer is more difficult. While one might commend an allocation scheme that saves lives for some while costing others their limbs (while perhaps providing them with prosthetic devices) one might also reasonably object to a level of foreign aid that saves the lives of foreign nationals at the expense of medical care that might save the limbs of compatriots who expect a reasonable level of national health care.

Nevertheless, associative duties and an ethics of care requires attention to the plight of strangers and reflect concern for what Held (2006: 71) calls ‘moral minimums’ of care and respect for human rights (also Miller 2005: 72). Medical personnel, for example, may recognize this when medics report a readiness to stabilize or sedate severely-wounded enemy soldiers while they first attend to the less serious wounds of their comrades (Dakar 2009). It also explains why medical personnel might treat seriously wounded compatriots before seriously wounded enemy soldiers but refrain
from treating compatriots once they have already begun to care for non-compatriots. Apart from a justified concern that withdrawing care is akin to murder, it is also clear that medical personnel enter into special relationship once they begin treating any wounded soldier. This new relationship carries strong obligations of care of its own that cannot be readily abandoned.

As this last remark indicates, professional obligations exist alongside associative obligations at all levels of care. At the level of primary, battlefield care professional obligation to provide impartial care attenuate and fall to obligations of friendship and comradery but become increasingly compelling at the higher echelons of care where medical personnel operate in an institutionalized setting. Here, the duty of care to comrades-in-arms recedes in face of the immediate relationship between a health care professional and her patient. As such, the prevailing model of care reverts to one of strict, impersonal professionalism that demands that physicians treat impartially according to need. This does not mean that obligations of comradery are not present, but only that one would expect them to weaken as the relationship between health care professionals and the patients become less personal.

**Conclusion: The Limits of Impartial Care during Armed Conflict**

Despite the clear directives of the Geneva Convention, impartial treatment of soldiers wounded is not always morally defensible. Military necessity, the demands of compatriots and the special obligations of care often mitigate demands for impartial need-based medical care during war. Defending preferential treatment in the name of military necessity and social utility invokes what Brian Barry (1995) has called ‘second-order’ impartiality. Recognizing the occasional need and desirability of relationships anchored in privileged concern for others, moral philosophers are prepared to reject first-order or universal impartiality as long as preferential care is justified by impartial second-order principles such as utility or contract. Impartiality, in other words, anchors favouritism. In this way, military necessity may allow military medical personnel to treat wounded compatriots to return them to duty while deferring care of more seriously injured enemy soldiers. Utilitarianism will, to some extent, also justify rules that restrict access to a national health care system to compatriots or permit occupying forces to provide second tier care to host-nation nationals. To do otherwise would rapidly deplete military resources and threaten the well-being of all.

Some defenders of special obligations, however, reject Barry’s argument as incomplete (Held 2006). While impartial principles sometimes offer grounds for preferential care, there are other cases where implementing impartial principles of justice will significantly harm family and friends thereby forcing one to choose between justice and care. When relations are close and fundamental and friends, family or comrades-in-arms in need of aid, the special obligations of care are not merely a tie-breaker but often command priority.

In military medicine too, there are the conflicting imperatives of justice, community and friendship. Justice is a fundamental feature of good medical care while friendship, loyalty and devotion are the foundation stones of an effective military environment. Each carries significant moral weight. At the higher echelons of care the two might conflict and leave physicians to carefully navigate between impartial treatment and priority care for compatriots. At the most basic level of care provided by combat medics and physicians, however, there should be little conflict. Here the special, associative duties of care largely replace the demands of impartial justice.

The tension between the demands of impartiality, the imperatives of military necessity and the duties of care and comradery is just one facet of the dual agency dilemma that bedevils health
care providers in the military. In most cases, this dilemma sets the demands of the mission, that is, military necessity, against the demands of disinterested medical care and the patient’s best interest. Dual agency dilemmas arise when medical personnel must give prior care to those who can return to duty, return moderately ill soldiers to duty or withhold information about the effectiveness of vaccines so soldiers will not suffer anxiety (Howe 2003). Dual agency dilemmas also arise when medical personnel must choose between the duties of comradery and the obligations of impartial treatment, particularly at the most basic echelons of military medical care. Recognizing the severity of this dilemma, Sidel and Levy (2003: 302–3) conclude that ‘military physicians cannot, as members of the armed forces, live up to the expectations and responsibilities of the Geneva Conventions’. Their solution is to take medical care from the hands of military personnel and create an independent civilian medical organization to provide care during war.

This solution is problematic because it is often impractical to call on civilians when only trained military personnel can provide medical care on the battlefield. More importantly, civilian doctors, nurses and medics do not address the underlying causes of preferential care. Military necessity sanctions prior care for the lightly wounded at the expense the seriously wounded regardless of who provides the treatment. Scarce resources permit less sophisticated care for host-nation nationals. Finally, there seems little to prevent civilian medical staff from forming the same close relationships if hired to replace medics and care for compatriots in small military units. In these cases, the associative duties combined with the imperative of military necessity and limited medical resources will frequently dictate preferential treatment for compatriots during armed conflict.

Bibliography


*Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field*. Geneva, 12 August 1949, Article 12.


Chapter 5
Medical Neutrality and the Dilemmas of War
Paul Gilbert

The Dilemma

A surgeon at a small hospital is about to perform an operation to treat a minor injury incurred by a patient. If the injury is treated promptly the patient will soon be able to return to work; if not, recovery will be delayed. But just then a casualty is wheeled in requiring immediate surgery to save his life. This will necessitate the use of drugs and devices originally set aside for the first patient’s operation. However, it seems evident that the surgeon will have to prioritize the casualty and leave his patient to wait, with the delay in recovery time that this implies. Few, not even the unfortunate patient, would question the decision to do this which the surgeon makes or represent the situation as one in which he has confronted a difficult decision.

Now let us paint in a different background to that which has probably been assumed. Instead of a civilian hospital in peace time we have a field hospital in time of war. The lightly injured patient is a soldier of the army in which the surgeon is employed as a member of the medical corps. The casualty is an enemy combatant, a victim of the army’s offensive. Now, many people would maintain, the surgeon does face a dilemma – a dilemma expressed in terms of his apparent dual loyalties: on the one hand to his profession as a doctor and to his patients, with the usual priorities which this implies, on the other to the state in whose army he serves and to its fighting forces (for example Allhoff 2008).

The purpose of this chapter is to question the characterization of this sort of situation as one of dual loyalties. It is also to suggest that the military background should normally make no difference to the surgeon’s decision about the proper priorities for treatment, and this claim will be defended against an alternative. I shall propose a way of conceptualizing the military doctor’s position which should go some way both to relieve the tension he may feel and to deflect possible pressures upon him to decide differently. Needless to say, I believe that my conclusions have implications beyond this particular example.

Loyalties

Loyalty in its primary sense consists in standing by some individual, some group or some institution into which people are organized. A classic case of dual loyalties is provided by the novelist E.M. Forster’s declaration: ‘if I had to choose between betraying my country and betraying my friend, I hope I should have the guts to betray my country … Love and loyalty to an individual can run counter to the claims of the State’ (Forster 1965: 76–7). Here talk of dual, or as we sometimes say ‘divided’, loyalties and of the possibility of a conflict between them is clearly in place. But it is harder to discern this pattern in the army surgeon’s case. We cannot as easily construe it as a clash between loyalty to the state and loyalty to his profession as my initial formulation might suggest. Loyalty to the state involves acting in a way that furthers its interests, not letting it down...
by acting in a way that runs counter to them. In our example such loyalty would supposedly be demonstrated by treating one’s own wounded first so that they could return to battle. But it is not in this sense of loyalty that this might be described as being disloyal to one’s profession. It is not the interests of the medical profession that would, except perhaps very indirectly, be damaged by it; it is the profession’s standards that are arguably violated. This is not a case, then, where the army surgeon might display loyalty to his profession in the way he would if, for instance, he defended the conduct of doctors against adverse criticism. We would be better to say that the surgeon who opts to treat the enemy combatant because of his attachment to his professional standards is true to his profession, true, as we say, to his calling. This may arguably be a source of conflict, but not of a conflict of loyalties in the sense that I originally outlined. Nor is this just a verbal quibble. Someone can be loyal to his profession but not true to his calling in demonstrating his loyalty, as a philosopher would be if, when defending fellow philosophers against accusations of irrelevance to real life problems, he mounted arguments which he knew to be unsound.

Trying a different tack to exhibit a conflict between loyalties in the same sense of the term, we might be inclined to detect a clash between the surgeon’s loyalty to the state or to his comrades and his loyalty to his patients. One problem here for our particular example is that loyalty is possible only in an established relationship. Such a relationship already exists between the surgeon and both the state and his colleagues, but not between him and his patients in the sense in which this term covers prospective patients as well as existing ones. The enemy casualty is as yet only a prospective patient, and one way of putting the question that confronts the surgeon is whether to accept him as a patient. Only then could he consider what loyalty to him required. Let us leave this aside, however, since we can imagine modifying our imaginary scenario so that the wounded of both sides are already patients. Is there a conflict between loyalties to different patients here, since some are comrades and others are not? Or a conflict between loyalty to the state and to some patients?

In fact, I do not find the characterization of the army surgeon’s situation as either kind of conflict of loyalties a felicitous one. It is not clear to me that the surgeon would be demonstrating either loyalty to the state or to comrades if he treated the slightly wounded soldier on his own side first. Perhaps we could say that he is expressing his patriotic feelings, or that he is showing solidarity with his comrades. But talk of loyalty seems to me to be out of place, and this may be because we expect loyalty to come at a price, while none seems to be being paid by the performance of this demonstrative act. I am even less happy to say that the surgeon would be manifesting loyalty to his patients if he decided instead to save the enemy casualty’s life. A description in terms of his being true to what he takes to be his professional standards strikes me as a happier characterization. There is room for talk of loyalty to patients, in staying with them if the field hospital is overrun, say. But I do not see that, without further background, merely treating them as seems fit is a case of being loyal to them. Rather, it is a case of demonstrating the concern which a doctor is expected to show his patients.

Loyalty is expected of those in certain sorts of relationship, but the relationships involved in carrying out one’s profession make a wide variety of behavioural and attitudinal demands upon one. Just as the doctor should have a concern for his patients, the lawyer should have hopes for his clients, the teacher should have expectations of his students, and so on. These demands arise from the responsibilities that professionals have for others. If I fail to fulfil these responsibilities I will be letting people down. But letting them down in this sort of way does not automatically count as disloyalty. Broadly speaking, loyalty kicks in at a stage beyond the discharge of responsibilities, when a relationship has been established through their discharge. Loyalty is, in this case, an expression not of professional obligations, but of more personal ones, which carrying out a
profession will typically generate, given normal human proclivities to form attachments of various strengths and with varying degrees of imperatival force for one’s behaviour (for example Sklar 1993: 184).

These remarks count against the elucidation of dual loyalties which is given by those who employ the notion to describe our kind of scenario. They spell out the idea in such terms as ‘the existence of simultaneous obligations which might come into conflict with each other’ (Allhoff 2008: 5), or, in our specific sort of example, as a ‘tension between two, distinct professional obligations: the military and the medical’, since an army surgeon ‘is a soldier and a doctor … with obligations and duties that may clash in ways that seem irreconcilable’ (Gross 2010: 458). This conflict of obligations account is intended to unpack what it is to have dual loyalties, namely that one is under two sets of obligations that may collide. To be loyal is both to have certain obligations and to fulfil them. Someone who breaches an obligation that loyalty to one party imposes is thereby disloyal. Thus in the conflict situation he cannot be loyal to both.

However, I am inclined to think that acts of loyalty are seldom strictly speaking obligatory in the way that the discharge of professional responsibilities is. They fulfil looser requirements which stem from the expectations people have of caring professionals. The loyalty which the soldier should have to the state for which he fights is a different matter. This doubtless does impose actual obligations, not least because it is the product of an oath of loyalty or some analogous commitment. But again we need to distinguish the requirements of loyalty from obligations arising from the orders the soldier is given, bearing in mind that in entering the service he has put himself under a general obligation to obey. In most cases his putting himself under that obligation will reflect his loyalty to the state, but it does not follow that fulfilling this obligation in particular cases demonstrates loyalty nor that disobedience always constitutes disloyalty.

The Army Doctor’s Role

Whether or not it would be loyalty proper that gave rise to conflict, is there, nevertheless, a conflict of obligations facing the army surgeon? We need to return to our example to see why a conflict seemingly requiring resolution is postulated. It is because the surgeon is also an army officer. He occupies two distinct roles. Roles are social positions of whose holders various requirements and expectations are made with varying degrees of precision and explicitness. The etymology of the term – the roll of parchment on which an actor’s script was written – provides a good picture of the relation between the role and its holder. He or she has to conform to the script to a high degree in order to count as performing the role. An agent who is playing more than one role runs the risk that in a particular situation his scripts may prescribe different actions so that he cannot conform to the requirements of each role. He may then cease to count as occupying one of the roles. This, I take it, is what a conflict of roles comes to. Is this the situation of the army surgeon in our example?

A full answer would necessitate a deeper investigation of the roles of doctor and of army officer than I can undertake here. It also needs to be said at the outset that, in view of the indefiniteness and implicitness of the expectations associated with these sorts of role, we should not anticipate an answer that is uncontroversial. One reason for this is that the expectations associated with a role are those of a variety of people affected by role performance in different ways, so that there may well be some divergence of views among them. Nonetheless, we can begin to sketch out some relevant features of the roles of doctor and army officer in order to test out whether a conflict exists between them in our example. The expectations upon doctors are set primarily, I suggest, by other doctors and by patients, actual and prospective. Employers play a significantly lesser part
in this, and that for two reasons. First, a doctor’s role is *pervasive* (see Parker et al. 1967: 145) in the sense that performance is expected at any time and place, and therefore outside working hours. In a medical emergency a doctor is expected to help whether or not he is specifically employed to do so. Second, a doctor’s role is *autonomous*, in the sense that he is solely responsible for the medical judgements on which he acts. He cannot be ordered to act on an employer’s judgement about what treatment should be given and to whom. If he is so ordered and obeys then he is, one might suggest, acting not as a doctor but as a medical technician of some kind, employing medical skills but not professional judgements the capacity for which is what qualifies him as a doctor. A recent example in the English National Health Service illustrates this point. In order to reduce waiting lists, hospital managers assigned surgeons to perform easy operations first, while patients in greater need of treatment – treatment which was more time consuming – were made to wait. This created considerable resentment among surgeons, who felt that their professional autonomy was being violated.

For the most part, doctors are employed (or employ themselves) as doctors, not in some other role for which their medical knowledge and skill equips them. And doctors can occupy the role of doctor even when not so employed.¹ In this respect they are like philosophers and not like university professors. Roles of this sort we can describe as *self-standing*, in that pursuing them is not necessarily operating as part of the regular workings of an institution. When it is, this is because the institution recognizes the role as ready-made, so to speak, and employs people in their roles, as universities employ philosophers. The institution plays no part in the shaping of the role, though its demands may, of course, produce tensions for those who hold the role and participate in the institution’s workings primarily to perform it. I shall say that roles of this kind are *embedded* in the institution.

It is immediately obvious that the role of army officer is categorically different from a doctor’s. It is not self-standing, since its holder is necessarily operating as part of the workings of an institution – the army. Nor is the officer’s role, as such, fully autonomous, for he is obliged to follow the orders of his superiors; and it is not pervasive, since the role involves no expectation that he will exercise command outside a military context. An army officer is, we may say, a soldier, in the sense that any member of the army is a soldier. But in the sense in which a soldier is a fighter, not all members of the army count as soldiers. This is not just because there are many who do not serve on the front line, but act as engineers, caterers and so on. Occupants of such positions count as soldiers in the more restricted sense for two reasons. First, because their occupations are clearly ancillary to the task of fighting. Second, and consequentially, because if occasion demands their holders can be required to take up arms and fight themselves. But army chaplains, for instance, are members of the army, yet there is only a very indirect connection between their role and that of fighters. An army marches on its stomach, but while spiritual sustenance may boost morale it is not inevitably necessary to keep the fighting going. For this reason chaplains can play no part in it themselves, and the same goes, I shall argue, for army doctors.

I want to distinguish, then, between the war machine, with its numerous cogs which make up by far the greater part of an army, and the army structure as a whole, with its various chains of command and relationships of comradeship. For simplicity we can assume that all members of the army are citizens of the state whose army it is. Like any other citizens they put faith in the army to defend the citizen body, and as members of the army they accept responsibility to play their parts in this, if they are cogs in the war machine by fighting or expediting the fighting others do. But what if

¹ There may then be little call on them to practise as doctors, at least in developed western countries, though elsewhere they may have ample opportunities so to do.
they are chaplains or doctors? Are they confronted with a conflict of roles? If they were part of the war machine then we can see that they might well be. But I have suggested that they are not, though in the army doctor’s case this may seem counter-intuitive. For what is the difference between, say, mending a broken down tank to keep the fighting going and patching up a wounded soldier so that he can return to battle? Let us make the simplifying assumption that his wounds are sufficiently serious to prevent the soldier from fighting. Then he differs from the tank in that, while it remains a legitimate target, he does not. He is hors de combat, no longer able to act as a fighter and therefore not vulnerable as one. It is not, then, as a cog in the war machine that he is patched up, but simply, we may say, as a man. The army doctor treats men, not fighters, just as the army chaplain provides for the cure of souls, not primarily for the morale of soldiers.

Now it is irrelevant to the plausibility of the picture I am painting here that doctors might be employed by armies precisely to patch up their wounded soldiers, or chaplains to boost morale, so that what they did for enemy casualties or prisoners was just a spin off. But the motive with which an employer hires staff is irrelevant to the role that they perform unless the employer’s expectations contribute to the constitution of that role. Consider the case of a chef, taken on by a public house that previously served only microwaved meals. He is hired to raise the pub’s status but his role remains that of producing nutritious and appetizing food. While his cooking does raise the pub’s status it is no part of his role as a chef to aim to do this directly, by, say, writing out his menus in French. Similarly the army doctor is employed in his medical role. The role is embedded in the army structure. Thus, though the army’s task is to maintain and deploy its war machine, the army doctor’s role is not ancillary to that, even if the army employs him primarily for this purpose, as might be suggested by, for example, the US Medical Corps motto, ‘To conserve the fighting strength’.

Medical Neutrality in War

It will now be clear why I believe that there is no potential conflict between being an army officer and a doctor, and why, acting as a doctor, our imaginary surgeon should exercise his medical judgement alone in the prioritizing of cases, presumably in the same way as he would do outside the military context. There is an expectation that the army doctor will continue to act as a doctor, with the medical priorities which this implies. For it as a doctor that he has the position in the army that he has. Since his role is embedded in this way there is no reason to think that his military commission imposes any obligations which run counter to the carrying out of the role, as they would if he were part of the war machine. He does, of course, occupy other, less clearly defined roles, that of a comrade to his fellow soldiers and that of a citizen of the state in whose army he serves. Here I shall only observe that the role of doctor precludes giving special treatment on the grounds of occupancy of such other roles. This is characteristic of a range of professional roles, and the epithet ‘unprofessional’ attaches to those deviations from role requirements which arise from the intrusion of interpersonal loyalties or analogous concerns.

There are, however, several objections that could be made to this position. First, it could be argued that roles do not fall into the neat divisions that my story suggests, so that the army doctor is not rightly described as occupying a doctor’s role embedded in a military structure. Rather,
it is, so to speak, a hybrid role combining elements of the medical and the military in a distinct configuration which imposes requirements different from those of either taken separately. In certain situations those requirements seem to clash, but the conflict can be resolved, with military necessity sometimes overriding medical need. Second, it may be maintained, the picture of roles I have presented does nothing to resolve the surgeon’s dilemma, which is essentially a moral one. With which, if any, of his various role requirements he should comply in our imaginary scenario is a question over and above that of which takes precedence in a conventional structure of roles, for this yields no moral insights. Both these objections raise difficult issues, so I shall merely sketch possible replies before moving on to a third, namely that my account does not capture the feelings of conflict which the army surgeon may experience in our example.

As far as the first objection is concerned I shall say only two things. Firstly, the hybrid role characterization does not seem to me to be a plausible description of an army doctor who, qua doctor, does not cease to attract the expectations of doctors generally. Even if he were employed by the army only to patch up its own wounded the pervasiveness of this role would lead people to expect him to treat others too, and to do so in accordance with the usual priorities. And other doctors, to whom he is answerable, would also have an interest in preventing the hybridization of the role. An example of an actual hybrid role might be that of a commercial artist, who arguably ceases to be an artist proper, with the internal standards which that role implies, because his work serves a purely commercial purpose. Yet it can still be judged as having or lacking some artistic merit as well as being more or less effective in selling a product. An army doctor is surely not comparable to this, since, though we may assess his medical skill and his ability to lead a medical team, we do not apply to him the usual military criteria for being a good officer or a good soldier. Second, and connectedly, army doctors are granted immunity from attack and other protections under the laws of war. They are granted it because they remain simply doctors and, as such, are expected to behave as any other doctor would so far as their medical role is concerned. Were they to be thought of as analogous to mechanics who fix broken down tanks I can see no good reason why they should receive such immunity. They receive it because the army doctor’s role is seen more broadly than just in terms of facilitating the war machines of states, for example as conserving the values of humanity. But I shall return to this issue later.

The second objection, that role requirements are not ipso facto moral ones, and so do not determine, for instance, what our army surgeon should do in the heat of battle, raises a difficult theoretical problem. Of several strategies for dealing with it, the easiest is to concede the claim for the sake of argument and go on to claim that the doctor’s role is an especially valuable one. Any attempt to modify it, as on the hybrid role conception, would be potentially damaging. Only in the most extreme situations would departing from the norms of the role be morally justifiable; and certainly not such systematic deviations from it as would be a policy of prioritizing the treatment of one’s own troops, whatever their comparative medical need. Various grounds could be offered for the special value of the role, whose performance is conceived as trumping most other moral claims. What might be allowed is that in a small minority of cases the army doctor is faced with a real moral dilemma. There is no conflict of professional obligations here since his medical role is embedded in the military structure. But there may be a conflict between the moral claims of this role and those that arise from the particular circumstances of war, such as preventing a possible

3 So far as I can see, this is how one might have characterized Michael L. Gross’s position (for example Gross 2010) prior to his chapter in this volume, about which more later.

4 This view, that ‘roles and role-duties are morally inert’ (Sciaraffa 2009: 108) has been described as ‘practice positivism’ (Applbaum 1999: 51).

5 Though, as the last paragraph of this chapter indicates, I am inclined towards a more radical response.
massacre of one’s own forces. If the doctor decides in this desperate situation to treat his own comrades so that they can fight on, leaving enemy casualties to die, then we would expect him to do so with considerable compunction and to feel remorse despite his judgement that what he does is right – the so-called ‘moral residue’ of his decision (cf. Williams 1965).

I move on next to a more down to earth objection to my account, namely that it leaves it mysterious why the army doctor might experience conflicting impulses in a situation where, I assert, he actually faces no moral conflict. It is once more to the nature of role occupancy that we must turn for an explanation. For to perform his role successfully an agent must internalize its requirements, and this involves an affective appreciation of their hold over him and of the significance of fulfilling them which gives rise to it. Given this, we can see why someone may feel torn even when he can acknowledge that there is no actual conflict between the requirements of the two roles. The teacher whose son is in his class knows that, as a teacher, he should give him no special treatment. But as a father whose role requires him to do the best for his children he feels the pull of concern for his son’s interests. Similarly, the army doctor may recognize that, as a doctor, he should give all his patients, friend or foe, equal treatment. Yet as a member of an army committed to fighting the enemy he may want to help his own side as much as he can, and he may even regret that professionalism prevents him from doing more than he already is, by giving its soldiers preferential treatment. His other roles, as their comrade and as a citizen of the state for which the army fights, will tend to reinforce these feelings. As a comrade he is minded to support his fellows, and in many respects they can expect him to do so. He has a special bond with them, but he must not allow this to interfere with his duty as a doctor, though it may need a special effort of will to prevent this. As a citizen with his country’s interests at heart he may feel indignation at the enemy’s behaviour. Yet this must not be expressed in antagonism towards them which might prejudice the way he treats them as a doctor.

In view of the account that I have offered, it is unsurprising that the army doctor’s experience of conflict may be intensified if he is put under pressure by his comrades or by the army command to act otherwise than his position as a doctor dictates. And there may be continued pressures which would, if they were acceded to, eventually change the way that army doctors do act. But we must remember that this role is, so far at least, enshrined in the international law of war. For international law to be revised, it would require a very considerable change of heart by citizens, leading states to alter their practice, modify the treaties by which they are bound and so on. For, as I have hinted, the immunity of doctors in war is not a mere convention, the result of an historical accident. It is precisely their medical neutrality which justifies it. Because his role is embedded, the doctor can be even handed in his treatment of friend and foe alike, just as a civilian doctor would be expected to be. It is right, therefore, that he is viewed in the same way as a civilian so far as his vulnerability to attack is concerned.

Were army doctors not to be neutral in the way they treated patients then the only justification that I can see for their immunity is that it would ensure continued medical attention for one’s own troops on the assumption that immunity is reciprocated. But the assumption of reciprocity might not be justified. In contemporary asymmetric wars it is unlikely that non-state forces will have the equivalent of a well trained and equipped medical corps to deal with casualties of either side. Their fighters may be ill disciplined and careless at best in their adherence to the laws of war, fired up with animosity against the state forces they confront and, indeed, against members of that state in general, including doctors. In these circumstances immunity would seem to be of little actual benefit to army doctors. If they treated it as a mere convention then they might be tempted, in consequence, to depart from the norms of their medical role in order to help their own side.
It must be admitted that in an era of asymmetric wars such an ideal will become harder to achieve. Once the enemy are no longer regarded as the moral equals of one’s own soldiers, but even, perhaps, as terrorists, it would not be surprising if judgements about whose treatment should be prioritized were affected. If this happens then the traditional neutrality of doctors will be under threat, his accustomed medical priorities now being influenced by considerations of moral desert. But this has wider implications for a doctor’s role generally, not just an army doctor’s one, and they are implications with which, I should judge, few people would feel comfortable. However sympathetic one is, therefore, to the position of army doctors caught up in asymmetric wars, we should still, I believe, hold to the principle of medical neutrality which their embedded role makes possible.

**Neutrality Defended**

Anyone who holds to the principle of medical neutrality needs to defend it against arguments for the existence of exceptions to it of a sort that would require it to be qualified. Michael L. Gross has produced arguments that the principle may be overridden, on the one hand, by considerations of military necessity and, on the other, by obligations of comradeship; and I shall consider these in turn.\(^6\)

I am in much less disagreement with Gross on the first point than on the second. Indeed, when he writes (Gross 2010: 131) ‘Rare exceptions do not invalidate the underlying principle of medical impartiality but merely set it aside in extreme situations’ I can agree with him, for I have mentioned myself the sort of situation I take to constitute such an exception, namely prioritizing one’s own slightly wounded to prevent a massacre. However I suspect that for Gross such situations would be much more common than this, since he states (ibid.: 131) ‘When military resources are scarce, impartial needs-based care impinges on a state’s ability to wage war effectively and constitutes an unreasonable burden thereby mitigating obligations to enemy wounded’. But military necessity, it must be remembered, ‘is not an overriding principle allowing breaches of the law of war’.\(^7\) It does not equate to mere military advantage, and therefore collateral damage to civilians, for example, can only be justified if the operation that causes it is strictly necessary. A similarly strict view should be taken about when the medical treatment of wounded prisoners can be set aside in favour of treating one’s own troops in order to return them to the battlefield. While I can see no general maxim for deciding this in particular cases, I want to insist that such decisions are taken by doctors acting autonomously as doctors.

There are two alternatives to this position which I reject. One is that the decisions should be taken by fighters, as I termed the purely military members of the forces. But they, I suggest, will inevitably tend to decide upon what serves their own interests in the particular situation they are in, which will give inadequate protection to wounded prisoners. The other alternative is that military doctors decide qua soldiers rather than qua doctors. Leaving aside the objection to this just mentioned, it raises again the spectre of hybridity against which I inveighed earlier. It is a spectre which seems to haunt Gross’s characterization of the doctor’s dilemma in terms of ‘dual agency’, where military necessity is set against ‘the demands of disinterested medical care’ (Gross 2010: 147). It is a characterization I question since I see no principled way in which a military doctor can decide when to act the soldier, to determine what is militarily necessary, and when the medical man. The decision on whether and when to act contrary to usual medical practice is one

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\(^6\) Chapter 4 in this volume. Bracketed page references are to this chapter.

\(^7\) ICRC *Handbook of the Law of War for Armed Forces*, quoted in Green 2000, 122 fn. 6
that can, I suggest, only be made by a doctor, who may realize that in certain sorts of emergency he must so act, just as in any role we sometimes have to act contrary to its usual precepts. The fact that the doctor in our example is a military one is irrelevant to the decision he takes.\(^8\) If this is the case then there will be no temptation to suppose that the principle of medical neutrality needs to be qualified to allow for exceptions arising from military necessity. It will be, as Gross rightly puts it, ‘merely set aside in extreme situations’.

I turn next to Gross’s argument that obligations of comradeship may sometimes legitimately outweigh adherence to the principle of medical neutrality, which, I think, then need to be qualified to allow for such exceptions, since these obligations presumably spring from the military doctor’s role. But the law of war which prescribes neutrality for those who occupy this role, and for which I have tried to provide a rationale, allows for no exceptions, so this is a conclusion which I cannot accept. Gross, however, suggests that military medical personnel do as a matter of fact ‘recognize a conflicting and often overriding obligation to provide their compatriots with the best medical care possible’, which ‘is not only a professional obligation but a duty that health care providers owe friends and comrades-in-arms’ (Gross 2010: 140). The parallel Gross sees is between giving preference to treating one’s own wounded over treating the enemy’s and providing ‘preferential care for family and friends’ (ibid.: 140) as against caring for people generally. While this last is a priority with which I of course agree, it is the parallel that he sees here which I question.

First, in the general case the only relevant role is that of friend or family member. In the case under discussion, however, the military doctor is not only a comrade whose comradely obligations are to be weighed only against a general ‘duty of beneficence’ (ibid.: 130). He is a doctor with obligations which spring specifically from this role. It would be unprofessional of him to neglect these disinterested obligations to give preferential treatment to comrades, however understandable it might be.

Second, I do not regard duties to comrades-in-arms as on a par with those to family and friends. Comradeship is not, it seems to me, a personal relationship in the same way that friendship and family relationships are. This is because friendship and family relate people as the particular individuals they are, rather than just as the occupants of social roles.\(^9\) They relate them thus partly because of the place each has in the other’s personal history, as against in their present occupations. This contrasts with the way in which comrades, and colleagues more generally, are related; for it as cooperators in an activity in virtue of which they have the roles they do that these are related to each other. Their reciprocal obligations are not open-ended in the way that those of family and friends are, nor are they, like these, mutually negotiable (Jones 1984: 94). Rather they are specified by the standard expectations associated with the roles through which the relationships are generated – the roles of soldier, teacher, or whatever. For a soldier, I shall argue in a moment, these expectations do not include preferential treatment contrary to medical neutrality.

Yet, it might be replied, has not Gross made out a case for regarding comradeship as being analogous to friendship when it involves ‘primary bonding’ at the level of small military units, even if ‘secondary bonding’ at a higher level of organization is not? (Gross 2010: 141). Here, however, it seems to me that Gross may have confused the personal/impersonal distinction with the close/distant one, whereas they are actually independent, although admittedly both mark differences of degree. Colleagues can be close, enjoying intellectual intimacy if they are academics, say. But their

\(^8\) Though it is doubtless not irrelevant to the fact that he will be able to base his decision on knowledge of the military operations that are in train, of which a civilian doctor may well be ignorant. The point is that with the same knowledge they should make the same decision.

relationship is too limited to be thereby personal. Conversely, some personal relationships, for example in the family, may not be close, but this does not diminish what is expected from them. So too, I suggest, Gross’s ‘primary bonding’ involves closeness but does not necessarily give rise to personal relationships akin to friendship, though no one need deny that friendships can be formed on battlefields as they can anywhere else.

I come next, then, to my claim that comradeship does not impose obligations upon military doctors which absolve them from acting neutrally in treating the wounded of both sides. My argument may be viewed, I would suggest, as a development of Gross’s argument for the acceptability in certain circumstances of mass casualty triage, or reverse triage as it also called, where those with less serious injuries are prioritized over those with more serious ones, contrary to normal medical practice. His argument is that ‘there is a broad presumption that soldiers, upon enlistment, consent to and understand that military needs trump personal interest and well-being’ (Gross 2010: 130). Therefore they may be said to having agreed to being treated in accordance with the criteria of reverse triage in appropriate circumstances. But if they have consented to this why should they not also have consented to being given medical treatment which is equal, rather than superior, to that given to the enemy, in accordance with the laws of war? For have they not, upon enlistment, tacitly agreed to abide by these laws, even though these sometimes work to their disadvantage, since in the long run the laws of war benefit all soldiers? In particular, those who find themselves wounded and in the hands of the enemy would benefit from medical neutrality, so it is reasonable to suppose that, ignorant of their fate in war, soldiers would assent to this principle rather than insist that comradely duties override it.

Related reasoning would show that citizens, through the statesmen who represent them in the formulation of international law, could also agree to the principle, as, in the long run, benefiting those who fight for them. In that case they would not expect preferential treatment for their compatriots. And compatriots are, anyway, at an even further remove from friends and family than comrades are, despite Gross’s tendency to lump all these categories together. Or rather, they are at an even further remove unless one assumed an extremely questionable herderian politics of identity, which I am sure that Gross himself would not.

I conclude on what may be regarded as a concessive note, albeit a contentious one. I have wanted to argue that the doctor’s military role is irrelevant to the decisions he should take on the battlefield, noting that his military role includes his having comrades-in-arms. I have, however, allowed that what he should do as a doctor is not always what he does and thinks he is right to do all things considered. Not only in the sort of case which Gross characterizes in terms of military necessity but also, perhaps, if the military doctor gives preferential treatment to a friend or family member in desperate circumstances we too may think he acts rightly, though he does not act in accordance with the precepts of his medical role. In the latter case he acts, say, as a friend, and we judge his act right because this is what that role prescribes. What should not be assumed, I suggest, is that there is some overarching criterion by which we can assess in which of the roles he ought to act. The burden of proof lies on those who advocate such a criterion. Pluralists, by contrast, see moral justification as running out before such a criterion can be reached. This is a theoretical issue

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10 Here we may notice that there are also civilian applications of reverse triage.
13 I count myself in this category, so that I believe that citing role requirements in particular circumstances may sometimes constitute a moral stopping point. See fn. 11 above.
which cannot be pursued further here, pertinent as it is to the question of what resources we might have for resolving the military doctor’s dilemma.14

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14 I am grateful to Ashgate’s anonymous reviewer for suggesting improvements to this chapter.
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