Chapter 4

The Limits of Impartial Medical Treatment during Armed Conflict

Michael L. Gross

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

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 greater responsibilities 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
1 profession and violates the covenant between physicians and the community that requires health 1
2 care professionals to abjure any personal interest in the patient and use their skills solely for the 2
3 interests of the sick (Pellegrino and Thomasma 1993: 36–7).
4 Nevertheless, national identity and national interests can be very important. In general, health 4
5 care must compete with other social goods such as education, welfare and national security. While 5
6 medical care for the neediest enhances the benefits that medicine provides society, it may fall short 6
7 of improving overall social utility if other areas are neglected. Life-saving care may, therefore, be 7
8 set aside for treatment that improves quality of life but also for more schools or aircraft carriers. 8
9 National security and military necessity may demand that medical personnel first treat soldiers 9
10 who can return to duty before treating the critically ill and so relegate severely enemy wounded 10
11 to the end of the line. The practice of medicine may be blind to national identity but social utility 11
12 is not. Nations are bound to care for and protect their citizens first. This concern is not merely 12
13 emotive. Prior care for compatriots preserves the integrity of the political entity, namely the state, 13
14 best suited to safeguard human security and development. Similar principles prevail in peacetime: 14
15 while no national health care system may discriminate among its citizens, it may surely exclude 15
16 foreign nationals who come knocking at the door. As in war, the welfare of one’s own often comes 16
17 first. The duty to care for compatriots may also upend the covenant solemnizing the relationship 17
18 between doctors and patients. While this covenant defines the rights and duties of physicians, 18
19 it coexists with other social covenants, rights and duties. Most vexing are those that stipulate 19
20 preferential, not impartial, care for family members and friends. It is not always easy for health 20
21 care professionals to sidestep these conflicting duties. 21
22 Reservations about impartial care are particularly salient during armed conflict where at least 22
23 three circumstances mitigate the force of the Geneva directives: military necessity, two-tiered 23
24 care in a battle zone and the ethics of comradery. First, military necessity may direct medical 24
25 workers to triage patients based on their fitness to fight rather than urgent medical need. This 25
26 radically discriminates against enemy wounded. Second, a state army cannot always provide the 26
27 same level of care for its compatriots, allies and enemies because medical resources are scarce. 27
28 In Iraq and Afghanistan, for example, the US Army established a two-tiered medical system that 28
29 offers significantly superior care to American soldiers and detainees than to Iraqi or Afghan allies. 29
30 Finally, and regardless of available resources, an ethics of care and comradery reinforce special 30
31 obligations among compatriot soldiers that may require some medical personnel to treat their 31
32 own comrades first regardless of medical need. All these circumstances lead us to reconsider the 32
33 principle of impartial care. 33
34 34
35 35
36 Military Necessity, Medical Care and Return to Duty 36
37 37
38 Military necessity highlights the means of war that nations must adopt to preserve the welfare 38
39 of the state, its army and its citizens and offers a cogent exception to treating soldiers based on 39
40 urgent medical need. All military medical organizations recognize that battlefield circumstances 40
41 may demand that physicians dedicate scarce medical resources first to those they can return to duty 41
42 and only then to those whose lives and limbs are at risk. An oft cited case describes ‘penicillin 42
43 triage’ during WWII when, in 1942, military physicians used scarce penicillin to cure gonorrhoea 43
44 stricken soldiers and return them to duty before treating those with more extensive battlefield 44
45 injuries who would never return to battle (Gross 2006: 138–41). More recently, British medical 45
46 personnel prepared guidelines for conventional triage and mass casualty triage during the Falklands 46
47 War. Conventional triage emphasizes medical need, caring first for those requiring immediate 47
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: 28 290). 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
1 mass casualty triage: shortage of medical supplies, overwhelming casualties in a very short period 1 2 of time and the immediate threat of troop degradation come together only rarely (Beam 2003; 2 3 Vollmar 2003: 755; Adams 2008). As such, military necessity suggests only a defensible exception 4 to the rule expounded in the Geneva Conventions. Rare exceptions do not invalidate the underlying 4 principle of medical impartiality but merely set it aside in extreme situations. The more morally 5 complex cases are those where resources are sufficient to treat all, but medical personnel choose 6 to treat injured compatriots before enemy wounded regardless of the severity of their wounds. In 7 doing so, they do not appeal to military necessity but to the duties of friendship and comradery. 9 discuss these cases in the sections that follow. 10

Finally, it is important to remember that impartial care based on the principle of military 10 necessity is only limited to soldiers who can return to duty. When deciding among compatriot and 11 enemy patients who are all so critically ill that even the compatriots among them cannot return to 12 duty, there are no grounds for preferential treatment based on military necessity. Military necessity 13 only permits preferential treatment for those who, after treatment, can contribute to a war effort. If 14 they cannot, then their status is no different from enemy wounded. For them, medical need alone 15 will determine priority of care, moderated perhaps such considerations as compliance and the 16 availability of follow-up care. Within a national health care system where all the sick and injured 18 have access to similar care, post-injury follow-up care will not affect the initial course of treatment. 19 Follow-up care, or more specifically lack thereof, can, however, be an important criterion of initial 20 care in military medicine. This happens when compatriot troops fighting abroad have access to 20 superlative medical care while their local allies, that is ‘host-nation’ wounded, have access only 21 to limited resources and paltry care. This is precisely the state of affairs in Iraq and Afghanistan. 22

Two-Tiered Medical Care in Iraq and Afghanistan 25

To support its soldiers, the US Army provides medical care at several echelons. At echelon I combat 27 medics in the field and/or a physician or physician’s assistant in an aid station provide first aid and, 28 when necessary, evacuation to an echelon II facility. At level II, a 20-person Forward Surgical 29 Team offers immediate treatment, surgery and evacuation to an echelon III, Combat Support 30 Hospital (44–248 beds) for orthopaedic, thoracic, oral and maxillofacial surgery, intensive care 31 and psychiatric treatment. However, the number of beds in these facilities is extremely limited. 32 For example, there were only 274 operational beds in Iraq between November 2006 and July 33 34 2008 (Richardson 2008: 49). When necessary, therefore, the wounded are referred to a full service 35 trauma centre in Landstuhl Germany (echelon IV) or to Walter Reed Medical Center in the US 35 36 (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 37 medical facilities also care for detainees, ‘host-nation’ soldiers and local civilians wounded during 38 American operations. While severe American casualties have access to superior medical facilities, 39 local casualties (with the exception of detainees who remain under American care), must turn to 40 a poorly functioning and under equipped local system. In both Iraq and Afghanistan, repressive 41 regimes and war have decimated the health care system as nurses and doctors fled the country and 42 facilities fell into disrepair (Library of Congress 2006: 8; WHO 2006). Substandard follow-up 43 care compels US military physicians to limit or modify their treatment protocols when treating 44 host-nation soldiers and civilians. This can significantly affect the initial treatment that physicians 45 choose and effectively creates two-tiered system that allocates care based on nationality. Because 46 advanced reparative surgery, surgical implants, prosthetic devices and facial reconstruction are 47
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; Filliung and Bower 2010; Bridges and Evers 2009).

5 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’.

10 In one sense, this is not legally or morally problematic because host-nation 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 as 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.
1 Equal Care for Detainees and Allies

2 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.

3 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.

4 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 terrorist 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.

5 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. Some have argued elsewhere that they do not: absent the prospect of returning to duty there are no grounds to 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.

6 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-nations 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
1 detainee care to the host-nation as the US did when it signed the Status of Forces Agreement2 (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).

3 American soldiers will receive superlative treatment when wounded. Host-nation wounded4 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 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 should12 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.

1 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. One31 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.

My thanks to Major Jacob F. Collen, MD, for providing this case for discussion. See also Sessums et al. 2009.
1 and 22 per cent agreed that POWs, that is wounded enemy soldiers, should only be treated after all 1
2 allied forces are treated no matter how severe their wounds. 2
3 It appears that military medical personnel are of two minds about the Geneva Conventions. On 3
4 one hand, they acknowledge the principle of non-discrimination and medical impartiality. On the 4
5 other, they recognize a conflicting and often overriding obligation to provide their compatriots with 5
6 the best medical care possible. Medical care, in this case, is not only a professional obligation but 6
7 a duty that health care providers owe friends and comrades-in-arms. These duties do not merely 7
8 supplement the impartial criteria for allocating medical care but may replace it altogether and offer 8
9 substantial moral grounds for preferential treatment for compatriots. Morally, the imperative to 9
10 treat one’s brother first finds strong justification in associative obligations and the ethics of care. 10
11 11
12 Associative Obligations and the Ethics of Care
13
14 At one level, offering priority care to friends or family members when others are in greater need 14
15 violates the principles of impartiality, non-discrimination and opportunity that are central to 15
16 medical ethics. At another level, however, preferential care for family and friends is a fundamental 16
17 moral obligation. Parents are not expected to invest much in the care of others before they attend 17
18 their own children. Friends, likewise, have special obligations toward one another that they do not 18
19 have toward strangers. In both cases, special obligations to tend to those closest to us replace the 19
20 principles of justice and utility that usually guide medical care. The question is: which paradigm 20
21 applies to military medical ethics? On the face of it, it appears that questions of professional duty 21
22 are paramount. Yet in wartime, exemplified by the case just cited, special obligations of care 22
23 deserve careful consideration.
24
25 Moral philosophy has always taken note of ‘associative obligations’ that reflect the 24
26 overwhelming moral importance of intense, interpersonal relations among members a small, tightly 26
27 woven and interdependent family or community that demand preferential care for those who are 27
28 close (Simmons 1996). Few doubt that friends and family owe duties of aid and assistance to one 28
29 another that they do not owe to strangers. At one level these duties are grounded in commitments 29
30 of mutual aid: friends implicitly agree to help one another in times of need. In other instances, 30
31 there are good social reasons for associative obligations because they preserve such institutions as 31
32 friendship and family that are essential for well-being and survival. At another level, however, is 32
33 an ‘ethics of care’ that transcends mutual aid and social utility and invokes unconditional duties 33
34 that certain individuals owe one another by virtue of a special relationship between those who can 34
35 provide life sustaining care to those who need it. The ethics of care invokes an emotive rather than 35
36 contractual bond that calls for ‘personal concern, loyalty, interest, passion and responsiveness to 36
37 the uniqueness of loved ones, to their specific needs, interests [and] history’ (Held 2006: 95). 37
38 Guided by preferential and discriminatory principles, special obligations toward friends, family 38
39 and compatriots inevitably raise questions of distributive justice: what if others are in greater need 39
40 of care and attention? In all but the most extreme cases, however, this question does not arise. 40
41 Special duties of care reflect moral principles that operate independently of universal principles 41
42 of justice. As such, expected utility is not always a relevant moral principle. Friends and family 42
43 should aid one without expectation of reciprocity, often at great personal cost and when knowing 43
44 that the same aid might benefit a stranger more (Mason 1997). This is a common intuition. To think 44
45 too hard about aiding a stranger when the life of one’s family or friends is in danger is, as Bernard 44
46 Williams famously put it, ‘one thought too many’. Is medical care for enemy wounded also one 46
47 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 care together by strong personal ties of friendship, comradeship, 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 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, 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...
1 from treating compatriots once they have already begun to care for non-compatriots. Apart from 2 a justified concern that withdrawing care is akin to murder, it is also clear that medical personnel 3 enter into special relationship once they begin treating any wounded soldier. This new relationship 4 carries strong obligations of care of its own that cannot be readily abandoned. 4 5 As this last remark indicates, professional obligations exist alongside associative obligations 6 at all levels of care. At the level of primary, battlefield care professional obligation to provide 7 impartial care attenuate and fall to obligations of friendship and comradery but become increasingly 7 compelling at the higher echelons of care where medical personnel operate in an institutionalized 8 setting. Here, the duty of care to comrades-in-arms recedes in face of the immediate relationship 9 between a health care professional and her patient. As such, the prevailing model of care reverts to 10 one of strict, impersonal professionalism that demands that physicians treat impartially according 11 to need. This does not mean that obligations of comradery are not present, but only that one would 12 expect them to weaken as the relationship between health care professionals and the patients 13 become less personal. 14 15 16 17 Conclusion: The Limits of Impartial Care during Armed Conflict 17 18 19 Despite the clear directives of the Geneva Convention, impartial treatment of soldiers wounded 20 is not always morally defensible. Military necessity, the demands of compatriots and the special 21 obligations of care often mitigate demands for impartial need-based medical care during war. 22 Defending preferential treatment in the name of military necessity and social utility invokes what 23 Brian Barry (1995) has called ‘second-order’ impartiality. Recognizing the occasional need and 24 desirability of relationships anchored in privileged concern for others, moral philosophers are 24 prepared to reject first-order or universal impartiality as long as preferential care is justified by 25 impartial second-order principles such as utility or contract. Impartiality, in other words, anchors 26 favouritism. In this way, military necessity may allow military medical personnel to treat wounded 27 compatriots to return them to duty while deferring care of more seriously injured enemy soldiers. 28 Utilitarianism will, to some extent, also justify rules that restrict access to a national health care 29 system to compatriots or permit occupying forces will to provide second tier care to host-nation 30 nationals. To do otherwise would rapidly deplete military resources and threaten the well-being of 31 all. 32 33 Some defenders of special obligations, however, reject Barry’s argument as incomplete (Held 33 2006). While impartial principles sometimes offer grounds for preferential care, there are other 34 cases where implementing impartial principles of justice will significantly harm family and friends 35 thereby forcing one to choose between justice and care. When relations are close and fundamental 36 and friends, family or comrades-in-arms in need of aid, the special obligations of care are not 37 merely a tie-breaker but often command priority. 38 39 In military medicine too, there are the conflicting imperatives of justice, community and 40 friendship. Justice is a fundamental feature of good medical care while friendship, loyalty and 41 devotion are the foundation stones of an effective military environment. Each carries significant 42 moral weight. At the higher echelons of care the two might conflict and leave physicians to carefully 43 navigate between impartial treatment and priority care for compatriots. At the most basic level of 44 care provided by combat medics and physicians, however, there should be little conflict. Here the 44 special, associative duties of care largely replace the demands of impartial justice. 45 46 The tension between the demands of impartiality, the imperatives of military necessity and 47 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 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.

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