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Editorial

After numerous encounters with military medical personnel from Hamburg to Mazar-i-Sharif, I realized how ethical issues are crucial and pressing matters in military medicine. The need for guidance in a time when the deployment scenarios and the responsibilities of medical personnel are changing substantially, made us choose military medical ethics as a key topic.

Reports from specific deployment situations illustrate how difficult it is to implement the rules of humanitarian international law in practice. Who should be treated first in light of scarce resources, the wounded comrade, the civilian, or the enemy?

According to the 1949 Geneva Convention, all parties involved in conflict are obliged to treat and care for the sick and wounded "humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria." Military medical personnel face the challenge of unifying two roles difficult to reconcile – doctor and soldier – each of which being subject to their own code of conduct. Which code should military personnel follow, the ethos of their civilian medical colleagues or the one resulting from a military frame of reference? Should they base their judgements and decisions exclusively on the principles of medical ethics, or is it possible for one specific field of ethics to meet the unique challenges of both professional worlds?

Medical ethics is rooted in the Hippocratic oath and today's most prominent principles of medical ethics can be traced back to the ethicists Tom I. Beauchamp and James F. Childress. These principles are: respect for patient autonomy, the principle of doing no harm, patient care, and a principle of justice. On the other hand, there are two central principles of warfare (*ius in bello*) which are established in International Humanitarian Law: the distinction between combatants and civilians, and the principle of proportionality of violence.

The controversial nature of these topics and the need for an international debate were also highlighted at the Military Medical Ethics Symposium held by zebis last year in the Catholic Academy in Munich. Over 50 military doctors, paramedics, military chaplains and officers discussed codes of conduct, ethical issues and international law, based on specific deployment situations, with experts in working groups.

"Saving the Enemy? Military Medical Personnel under Fire" – the third issue of "Ethics and Armed Forces" brings together expertise and experience as well as different professions and approaches. Practitioners and academics, medical personnel and civilian helpers contribute to the debate, providing insights from medical, military, international law and ethical perspectives.

Accordingly, the articles mirror the debate on military necessity and impartial medical care in armed conflicts from opposing ethical positions. The topical subject of "human enhancement" for soldiers is discussed, alongside with the fundamental question of the options and limits of cooperation between civilian and military helpers in conflict and catastrophe deployments.

I would like to thank everyone who contributed to the important international debate on military medical ethics in this issue. My thanks go to the authors, publishing editors and not least the editorial team.

Veronika Bock
Director of zebis

Care to the Wounded: A Core Duty of Humanity

by Paul Bouvier

A fundamental but neglected issue

In times of war and armed conflict, all parties have an obligation to provide care to the wounded and sick persons, be they from one's own troops or from enemy groups who are hors de combat, without any distinction. This duty is a core obligation of International Humanitarian Law (IHL).

In recent years, considerable attention has been devoted in philosophy, law, and political science to the treatment provided to enemies, notably in relation to global issues and terror. While interest focused on the prohibition of torture and on formulating a response to terrorism, little attention has been given to the duty to provide care for wounded or sick enemies, as if this was considered a secondary matter. It may be that this duty was considered as too obvious and widely accepted to deserve any particular attention; or, that it was hoped that the respect of this duty would naturally follow on from respecting the prohibition of extreme violence and torture. Such arguments, however, could be misleading. The duty to rescue and provide care to the wounded and sick is not a secondary, but a core component of IHL. Secondly, its scope has recently been questioned in publications on medical ethics in conflict situations. Thirdly, impartial care to wounded enemies might well be an essential step toward respecting dignity and preventing extreme violence and abuse.

This short article[1] explores some ethical aspects of this duty. Starting with the ethics of providing succor to a person in danger, it encompasses care for a wounded combatant and care to a wounded enemy, and suggests ways to address ethical challenges in this domain.

The duty to succor a person in danger

Do we have a moral duty at all to succor a person in danger? Or is providing succor just a nice thing to do on the part of people who like helping others? For Mencius in ancient times in China (372–289 BC), or Rousseau in modern Europe (1762), the answer was clear: to provide succor to someone in danger is simply to be human. For these writers, to feel pity to someone in distress and to act with humanity is completely natural; it is universal, and it is the source of all morality. For Rousseau, as for Mencius, this is the first moral duty, from which other duties are derived.

Other philosophers, however, came up against difficulties. Firstly, because this duty is born of pity and emotions. Immanuel Kant (1785) thought that moral philosophy should be founded on reason, and that a duty should become a universal moral law. However, if ethics segues into a radicalism of duty, the altruistic act becomes impossible unless it can be generalized and turned into a universal law.

A second difficulty is that providing succor exposes people to dangers, effort, and expenses, which might be considered as going beyond the call of duty. This has been the position of Beauchamp and Childress in "Principles of biomedical ethics" (1979), in which they developed an approach based on four principles: autonomy, beneficence, non-maleficence, and justice. As emphasis was placed on

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respecting the autonomy of the patient and the professional, little room was left for providing succor to a person in danger. For these authors, a doctor has a moral responsibility to stop at the scene of an accident "as long as the risk involved is minimal and to do so will only have a minor impact on his way of life. A doctor is not obliged to be a 'Good Samaritan', only a 'minimally decent Samaritan'."

Similar conclusions were reached by the liberal moral philosopher Ruwen Ogien (2007), who employed a graded concept of "Samaritanism" according to the level of risk for the rescuer. This "minimal ethics" only recognizes a restricted duty to provide assistance: the duty is limited, first by the risks run by the passerby or the relief worker; second, by the request or opinion of the person to be assisted. One has a duty to provide succor, and also a duty to safeguard one's own security and health as well as a duty to respect the autonomy of the individual in danger, and not to rescue him against his own will.

The utility of saving lives

Utilitarian approaches point out other difficulties. Rescuing persons in danger is expensive, and it may divert limited resources from other activities where the benefits would be greater. McKee and Richardson (2003) defined the "rule of rescue" as the ethical imperative "people feel to rescue identifiable individuals facing avoidable death." They note that rescue can conflict with a cost-effectiveness analysis, and may be criticized on the grounds of social injustice and public health. However, rescue has a social value: it responds to a reaction of "shock and horror", and people value the fact of living in a society based on relations of mutual respect. Therefore, cost-effectiveness analyses should integrate attempts to help people in danger.

The question of proximity is posed by Peter Singer (1993). He recognizes a moral duty to rescue a child drowning before oneself; but, he argues, we have a similarly great responsibility to help distant persons in need, by contributing to humanitarian action. There is, however, a difference between those situations, replies Scott James (2007), which lies in your relationship to potential beneficiaries. In the case of a drowning child, there is a specific individual who relies on you and only you for survival; you have a strong duty to act when you are in such a relationship of "unique dependence".

In short, the duty to rescue someone in danger is deeply rooted in human cultures, traditions, societies, and religions around the world. It applies, a priori, without limit or distinction; and it is circumscribed by other considerations: to preserve one's own security and life; to respect the dignity and autonomy of the person in danger; to make good use of limited resources, taking into consideration other people in need; to act efficiently and with competence. In this respect, people who have a particular role, skill set and means to act, such as rescuers, healthcare or humanitarian professionals, have a more compelling duty to take action. They also have a responsibility to maintain their competence and skills. Ultimately, as a human being I have a responsibility to act personally when I am in a situation in which the dignity or life of a person in danger depends on my own action, and in which I have the ability to act.

Care for wounded combatants

Ever since antiquity, medical practitioners have been present among armies, but their role was often left unclear, and forces were essentially devoted to combat. Wounded soldiers were abandoned on the battlefield, and transporting a wounded comrade to the rear was viewed as a way of escaping enemy fire. When Napoleon's surgeons Larrey and Percy invented a kind of "flying ambulance" (around 1797), surgeons started to provide care in the middle of the battlefield. Following their medical ethics, they provided care impartially

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to wounded people, enemies, and compatriots alike. They established rules of impartial triage for war casualties, and also defended the independence of medical services. This impartial and effective care for combatants earned them widespread recognition and admiration, to the extent that at Waterloo the Duke of Wellington directed cannon fire away from ambulances in order to give Larrey time to collect the wounded. From their practice on the battlefield, these surgeons established the bases of ethics in military medicine and in humanitarian action in war: humanity, impartiality, neutrality (inviolability), and functional independence of medical personnel and healthcare facilities.

After the battle of Solferino on 24 June 1859, Henry Dunant organized succors for wounded soldiers. He later made a pressing call to create relief societies that should be organized in times of peace. This resulted in the founding the International Committee of the Red Cross in 1863 and led to the adoption of the first Convention for the Amelioration of the Condition of the Wounded in Armies in the Field in 1864, which imposed on belligerent armies the duty to provide impartial care for all wounded combatants. Hospitals, ambulances, and personnel in charge of transporting and providing care for the wounded should be recognized as neutral, protected, and respected. For more than 150 years, the duty to rescue and to care for the wounded and sick who are hors de combat, is a primary duty set out in IHL.

Care for wounded combatants called in question

Some authors have questioned this duty, reaching conclusions which seem to weaken its scope or applicability. We briefly review issues raised by Michel Gross in a book on bioethics in war (2006) and in various articles. As a starting point, this author asserts that "the goal of military medicine is salvaging the wounded who can return to duty." This affirmation leads him to challenge some essential ethical and humanitarian principles. Firstly, he questions the duty of care of the state toward war veterans and wounded combatants: badly wounded soldiers, he writes, only enjoy the same right to medical care as any similarly ill or injured individual; a military organization must only provide palliative care as the minimum medical care for severely wounded soldiers. Regarding impartiality, he suggests that particular medical efforts and specialized medical care should be dispensed only to wounded soldiers who might go back to duty. Severely wounded or sick soldiers would only receive a lower quality of medical care, or only palliative care. Likewise, wounded enemies, once captured and hors de combat, would receive a lower standard of care or palliative care.

Regarding medical neutrality, this author asserts that physicians are not neutral, they owe allegiance to the side they are fighting with. These views open the way to major ethical drifts, namely participation of medical professionals in abusive interrogation. Physicians and healthcare professionals owe their full medical loyalty to their patient, always and in any circumstances[2]. They also have separate duties as collaborators to the organization in which they work; but these duties do not interfere with medical decisions and the care provided to the patient. Any breach in the commitment to the patient, in particular any breach in medical confidentiality, has disastrous consequences in the practice of medicine: it destroys trust and the doctor-patient relationship, and opens the way to exploitation of the patient and to abuse. Medical confidentiality must be fully respected, in any circumstances.

Functional independence from authorities and institutions is therefore an essential condition for the exercise of military medicine and healthcare in detention facilities. Military physicians

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and health services depend on military authorities specifically for security, logistics, and their deployment; in the practice of care their independence must be fully respected.

As regards care to a wounded enemy, Gross quotes surveys of medics and physicians, in which some express a preference to give priority to comrades, before providing care to a wounded enemy. He suggests that "preferential care for family and friends is a fundamental moral obligation," and accepts that at the platoon level, medics could give priority "based on friendship and intragroup commitment." He admits that at hospital level, at a distance of the battlefield, physicians must give impartial care.

These analyses mix different relations, roles, and duties. An ethics of care does not imply favoring family or friends: on the contrary, it implies establishing a "just distance" between the professional and the patient[3]. For instance, medical ethics expect doctors to refer family members to the care of other clinicians, precisely because their strong feeling can interfere with clinical judgment.

Strong emotions occur at all levels during crises and in armed conflicts. High emotional tensions do occur as well in health services, in providing care to a person suspected of a crime or a terrorist act. These emotions and perceptions must be managed; they do not, however, offer any justification for preferential care to compatriots rather than to wounded enemies. The ethical response does not lie in suspending impartial care, but rather in strengthening the organization of military medicine, in order to ensure functional independence, and in promoting education in medical ethics.

Many conclusions of this author derive from the idea that military medicine follows strategic aims. This conception opens the way to attacks on fundamental principles of medical ethics and international humanitarian law. This author eventually accepts the possibility that doctors may breach medical secrecy, and may take part in interrogations or in torture if this is considered to be in the nation's interests. As extreme as they appear, these positions derive from the idea that military medicine contributes to strategic aims. Healthcare and rescue are not subordinate to strategic or political interests, in any instance.

Towards an ethical response

Exploring the ethics of care for a wounded or sick enemy leads us to recognize strong ethical duties, and at the same time to contradictory emotions, ethical tensions, and challenges, both on the battlefield and in the provision of care. In order to address these tensions we propose the following ethical landmarks:

Humanity

Providing succor and care for a person in danger is an ethical imperative. This duty is not dependent on strategic or political considerations.

Impartiality

Rescue of and care for persons in danger must be provided according to medical criteria, without consideration of nationality, side in the conflict, or any other distinction.

Respect for and protection of dignity, health, and life

Persons falling into the power of an enemy are in a situation of extreme vulnerability and dependence. Authorities, rescuers, and healthcare providers have a duty to ensure that relief and care activities do not become opportunities for abuse.

Medical neutrality

Rescue activities and medical care are not contingent on strategic aims; under this condition they are able to provide non-discriminatory care for wounded and sick persons, and their mission can be respected and protected by all powers and sides in a conflict.

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Commitment to the patient

The pact of care between a healthcare professional and a patient is a core element of medical ethics. It is based on trust and confidentiality, and involves the professional commitment to provide a patient with competent and effective care.

Medical autonomy

In order to be impartial and fully committed to the patient's health and dignity, medical staff must have functional independence from political and military powers in the practice of medical care and related decisions. No strategic, political, or intelligence objectives should have any influence on the practice of healthcare. This autonomy must be reflected in the organization of care and in hierarchical relationships, with a clear separation between the military medical services and the operational command.

Carer-patient relationship

A trusting and personal relationship is an element of care, but traps arising from affective and emotional proximity or distance must be avoided. A "just distance" must be maintained, as in any care relationship. This may pose difficult challenges in contexts in which enemies have been perceived as inhuman or dehumanized. Humanization is part of care.

Respect for the life and safety of professionals

Rescue and emergency care may involve security risks and physical danger, notably in armed conflicts. The risks involved in these operations must be recognized, carefully evaluated, and mitigated. Ethics does not require sacrifice; it requires solicitude, generosity, and accepting some risks as part of rescue and care activities, in the spirit of responsibility.

Equivalence of care

Wounded or sick persons who are under the power of another force in a conflict, including detainees, are entitled to at least the same level of care as the general public in the country or territory, in relation to their needs.

Independent role of justice

Providing impartial care, maintaining medical neutrality, independence, and an appropriate therapeutic distance to the patient, is made possible in situations of extreme violence by the fact that justice is a separate task, with an independent role. This allows rescuers and health-care professionals to devote their efforts fully to their patients.

Establishing a proper carer–patient relationship can be extremely challenging in contexts marked by extreme violence and dehumanization; ensuring the security of professionals can conflict with the duty to provide succor and care in conflict areas; the provision of good-quality care can conflict with limited resources; and healthcare professionals encounter complex dilemmas as regards justice, ensuring medical confidentiality, or denunciation if they are informed of crimes committed or planned.

An approach of practical ethics is required in order to address such situations. These ethical challenges cannot be solved by ignoring one horn of the dilemma, or by following a procedure. The purpose of this work of "practical wisdom", is to invent the conducts that, in the given situation, best meet the ethical aim of humanity[4]. Decision-taking in difficult ethical situations requires a process of deliberation and discussion within a multidisciplinary group.

Care for the enemy is a core element of ethics

Succoring a person in danger appeals to a basic sentiment of humanity, involving feelings and emotions of compassion and pity. Witnessing a situation of extreme danger or violence causes a reaction of shock and horror; failure to act and provide succor leads to feelings of shame, indignity, humiliation, and a sense of failing one's own humanity. People feel ashamed when they feel guilty of passivity,

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powerlessness, or consenting to violence. They feel dehumanized. People who provide succor and impartial care, despite all obstacles, feel humanized. In his book "Humanity", Glover explores the circumstances leading to inhuman behaviors of men toward other men, and the processes of dehumanization. He cites one example of humanity, the action of a doctor who was working in very difficult conditions in Srebrenica. After the war, he said that the thing he was most proud of was that "when captured Serbian soldiers entered the hospital, they lay side by side with Bosnian soldiers."[5]

In their humanitarian activities in situations of war and armed conflict, ICRC (International Committee of the Red Cross) delegates witness such examples of humanity, and they devote much effort to promoting such human behaviors. They also witness many examples of abuse or extreme violence, on the battlefield and in besieged cities, in refugee camps and detention facilities. From their experience, ICRC delegates know all too well the terrible consequences of any divergence from ethical duties. The consequences are devastating, spread rapidly, and last for a long time. The prohibition of torture, inhuman and degrading treatment is absolute – for the sake of humanity and in recognition of the humanity of any human individual; yet this prohibition does not define humanity: it sets up absolute barriers beyond which the humanity of man is denied.

Providing succor and care for wounded and sick persons, whatever their side in the conflict, friends and enemies in war alike, is a paradigmatic situation of humanity.

1 This text is based on the article: Bouvier, P. (2013): The Duty to Provide Care to the Wounded or Sick Enemy, chap. in Baer, H./Messelken, D. (eds.): Proceedings of the 2nd ICMM Workshop on Military Medical Ethics, Bern/Zurich. The opinions expressed in this article are those of the author and not necessarily those of the ICRC.

2 Annas, G. (2008): Military Medical Ethics – Physician First, Last, Always, N Engl. J Med 359, pp. 1087–1090

3 Ricœur, P. (2001): Autonomie et vulnérabilité, in Ricœur, P. (2007): Le Juste 2, Paris, p. 104. (Autonomy and vulnerability, in: Reflections on the Just, Chicago, p. 271).

4 Ricœur, P. (1990): Soi-même comme un autre (Oneself as Another), Paris, p. 312.

5 Glover, J. (2001): Humanity – a moral history of the twentieth century, London, p. 152.

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Medicine as a Non-Lethal Weapon: The Ethics of "Winning Hearts and Minds"

by Sheena M. Eagan Chamberlin

For decades, military medicine has been formally used as a tool of strategy, sometimes called a 'non-lethal weapon' aimed at "winning hearts and minds." These missions often operate under larger programs that fall under the categories of humanitarian assistance or civic action. Medically oriented humanitarian assistance missions have become a significant component of contemporary deployments for militaries around the world. In contrast to their civilian analogies (such as Médecins Sans Frontières or International Red Cross and Red Crescent), these military programs are not uniquely medical in their intent and purpose. Rather, military humanitarian assistance missions have clear strategic goals behind their provision of medicine. These missions have been increasingly emphasized within the United States Department of Defense (US DoD) and expanding throughout the militaries of other nations; however, this expansion has occurred with little reflection or critical analysis.

This paper brings together a variety of resources and research strategies in an attempt to examine the ethical issues of these missions. Sources are drawn from archival work, primary source material (including official reports, doctrine, and published personal accounts), secondary source analysis, and a collection of oral histories gathered by the author. This paper prioritizes a descriptive approach to ethics: identifying and analyzing the ethical issues and moral dilemmas found in civilian medical assistance missions, and offering concrete solutions. This research specifically aims at recounting the moral realities and complexities of these missions as experienced by participants in an attempt to improve the moral experience of the physician-soldier. Larger normative questions regarding the moral permissibility of instrumentalizing medicine for political purposes, or instrumentalizing medicine in general, are beyond the scope of this paper, and addressed in other research.

The history of medical civilian assistance missions

Military medical professionals have been providing medical care to civilian populations since the beginning of formalized Army medicine in the United States. The types of missions discussed in this paper have been and are known under many names, depending on the specific program, historical period, national military, or branch of service. However, at a basic level all of these missions, regardless of their specific goals or title, share certain fundamental similarities: these missions involve the deployment of uniformed military medical personnel to provide medical care to civilian populations as part of an official military mission or program. For the purpose of clarity, the term 'medical civilian assistance' will be used as an umbrella term throughout this paper, as it has been used in my other work.[1] This term is inclusive of all programs that meet the above description, whether formal, informal, or ad hoc, and independent of their official title. Beyond that, avoiding the use of the term "humanitarian" sidesteps any confusion with other non-military, civilian, and nongovernmental organization (NGO) programs.

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The first formalized medical civilian assistance missions were operated under the large-scale and far-reaching Medical Civic Action Program (MEDCAP). This program began in the Vietnam War where military medical personnel saw and treated over 40 million local civilians as part of MEDCAP missions. In 1968, approximately 188,440 civilians per month received outpatient treatment from MEDCAP personnel, increasing to 225,000 outpatients per month in 1970. At the time of the Vietnam War, Vietnamese civilians had extremely limited access to medical care with a physician to patient ratio of only 1/93,000.[2] The US military had the resources to provide medical care to a population that lacked access and understood that the provision of this care had major strategic value. In light of this recognition, the provision of care was decidedly strategic in nature – The MEDCAP's main objective was to create "a favorable image of the [...] Government in the eyes of the people" with the improvement of patient or population health understood as a secondary goal or ancillary benefit. Other strategic goals of MEDCAP included larger psychological operations (PSYOP) and strategic objectives to include intelligence gathering.[2]

After the Vietnam War, MEDCAP was hailed as a great success due to the large numbers of patients seen, and the inferred large number of hearts and minds won. It was exported and has since expanded its reach around the globe to include: Central and South America, Africa, Eastern and Western Europe, Asia, and the Middle East. Due to the apparent success of MEDCAPs during the Vietnam War, military writers, commanders, and students at military command colleges have argued for the increased use of medicine to achieve military goals, including the increased emphasis on civilian medical assistance programs. Its perceived value as a military asset that accomplishes strategic goals without the deployment of force and violence is appealing to many within the military institution. Its ability to achieve military goals without the use of force has led students at military command colleges, and others within the military institution, to make use of the term "non-lethal weapon" when discussing and arguing for the validity of medical civilian assistance programs. Commanders see its potential use in future and current low-intensity conflicts (LIC), military operations other than war (MOOTW), and unconventional warfare.

Policy and practice have mirrored this line of thinking, as security policy has shifted towards stability operations that prioritize civic action and humanitarian assistance. Within the US, Department of Defense (DOD) Instruction 3000.05 states that military stability operations (MSOs) are a "core US military mission," that "shall be given priority comparable to combat operations ..." Similarly, the International Security Assistance Force (ISAF) has emphasized MEDCAP-style programs as a major form of deployment in contemporary engagements, and an increasing number of militaries are adopting these types of missions, instrumentalizing medicine for the military goals of "winning hearts and minds." Importantly, contemporary civilian medical assistance programs have not been altered since the model first adopted in Vietnam. While technology and locale may have changed, the program itself has not. The guiding doctrine, strategic goals, and priorities remain constant.

However, while policy has emphasized these programs and commanders have provided plaudits and legitimacy, others have been critical. Philosophers, ethicists, civilian physicians, and even the participants themselves have expressed disapproval and dissatisfaction. Despite the numerous negative experiences reported by participants, the expansion of these programs has occurred with little reflection or analysis. In fact, the ethical issues

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and critiques raised by program participants have more or less fallen on deaf ears.

The remainder of this paper will examine the ethical issues raised by medical civilian assistance programs. The ethical analysis will draw on historical research (doctrine, reports, and secondary source materials) and oral history data as a way of examining the moral realities of these missions. The stories shared by these physician-soldiers provide experiential knowledge with regard to medical civilian assistance missions and the unique ethical dilemmas that they present to those involved.

Physician-soldier experience: oral histories

Much of the primary source material available on these programs exists in the form of military reports. Unfortunately these documents do not speak to the ethical dilemmas that are the focus of this research. For this reason, oral history data is introduced and serves as the foundation for many of the conclusions drawn in this paper. Oral histories were collected through semi-structured interviews done by the author, under an IRB- approved research protocol. The population selected for these interviews was necessarily specific, employing purposeful non-random sampling. For this research, that population included veterans, retirees, and active-duty service members involved in medical civilian assistance work as part of their military service. All participants were physician-soldiers; however, ranks, ages, and years of service varied widely. Moreover, their participation in medical civilian assistance programs was diverse, ranging from involvement in Medical Civic Action Programs (MEDCAP) in Vietnam, Kuwait, Iraq, and Afghanistan to Medical Readiness Training Exercises (MEDRETE) in Honduras and Bolivia, among other ad hoc and informal civilian care work. Years of participation in these missions ranged from the 1960s to 2012. All participants were made anonymous from the outset to ensure confidentiality.

During all interviews, consenting participants were recorded. The recorded interviews were transcribed, coded, and analyzed along with field notes. Both in-case and cross-case analyses were utilized in line with the constant comparison method developed by Glaser and Straus. This methodology allowed for the organization of participant responses while analyzing different perspectives on central themes, ethical issues, and common dilemmas. This provided a systematic approach for comparing significant themes as they emerged from archival work, primary source material, as well as secondary source analysis and oral history data. Ultimately, these interviews provided oral histories and narratives of physician-soldier experiences that had not before been told, providing valuable insights into the moral realities of these missions and the ethical dilemmas felt by those directly involved.

Ethical issues

Across medical civilian assistance missions, physician-soldier participants have felt constrained by the conditions, limitations, and context of their environment. The ethical issue of providing “sub-par” medical care is often raised in relation to these missions. Within the context of medical civilian assistance missions, there are many restrictions. Locations are pre-determined for safety, as well as strategic value. For instance in Vietnam, Hamlets were selected for their political influence, instead of the medical needs of the population; this continues today in both MEDCAPs and MEDRETEs. Medication and equipment are often limited, and time is always in short supply. Medication is drawn from the medical depot system within the military supply chain and is thus commonly limited to adult doses, despite the fact that many of the patients

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continue to be children. Diagnostic equipment is sparse or nonexistent, and physicians often lack translation or interpreting services, creating significant issues due to the language barrier. Chronic care and follow-up are nonexistent, as missions involve only a one-day clinic in a specific location, meaning that they can often do little but identify health problems and distribute multivitamins and ibuprofen or aspirin. Physician-soldiers have also reported accounts of patient populations being restricted due to military or host-nation requirements. Often motivated by altruism, physician-soldiers have reported being hindered by the constraints of the mission, medical rules of engagement, and supply shortages.

These critiques are not just about working in a traveling clinic, developing nation, or conflict zone – frustrations that may be shared by their civilian counterparts working with MSF or a similar organization – this understanding represents only a cursory analysis of a deeper problem formalized within these programs. The frustration of providing what has been perceived as "sub-par medical care" is an expression of a complex programmatic and ethical issue; namely, that medical concerns are not prioritized within these military missions. Unlike in the context of civilian missions, where physicians may feel frustrated with their inability to provide care due to limited resources and environmental constraints, physician-soldier discontent and disapproval of these programs is intimately linked to the prioritization of strategic goals over medical goals. Military physicians often find it morally challenging that these programs emphasize their roles as soldiers and, specifically, as tools of pacification – "winning hearts and minds" – to the detriment of or distraction from medical goals. Participants saw the prioritization of military goals clearly, describing these programs to be "of limited value medically," but rather "an outstanding tool for propaganda."[3]

In the famous case of U.S. Army physician CPT Howard Levy, Dr. Levy refused to train Green Beret medics in dermatological skills in Vietnam. These medics were to use the dermatological skills to accomplish the strategic goals of the MEDCAP. Levy understood the work of these programs as "prostituting medicine for political and military purposes." During the trial of this case, a member of the Army Judge Advocate General explained the motivation behind MEDCAPs succinctly:

> *"We sought to use medicine as a means of approaching the enemy and imposing our will on his [...] The one great 'in' that you have is the medic because people are short on doctors and trained medical personnel in there; that the thing to do is sort of push a medic up there in front and let him get the confidence of these people by treating them [...]."*[4]

Howard Levy disapproved of this instrumentalization of medicine and specifically worried that the health of patients was not a main concern. The Levy case and other physician-soldier narratives are useful in highlighting the perspectives and moral reasoning of physician-soldiers. In fact, throughout oral histories, letters, and other forms of personal narratives, physician-soldier participants have recognized that military medicine has been used and sometimes abused in this way, alongside clear expressions of disapproval and discontent when its use is perceived as exploitation. The main reason underlying their disapproval of these programs, and the larger ethical condemnation of instrumentalizing medicine for political purposes, is based on the effect that the abuse and exploitation of medicine can have on patient care. The difference between instrumentalizing medicine and exploiting medicine is morally relevant and important to participants.

During the Vietnam War, MEDCAP operations were intimately intertwined with psycholog-

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ical operation battalions (PSYOP). This meant that MEDCAPs were aligned with forms of pacification propaganda that included specifically designed medication envelopes, loudspeaker announcements, gifts and T-shirts that promoted explicit messages.[1] During these medical civilian assistance missions, medicine was also instrumentalized, or perhaps exploited, as a means of gathering intelligence. Commanders exploited the trust of the patient–provider relationship to gather information, focusing on tactical intelligence. With the goals of pacification and intelligence gathering, medicine took a backseat.[1] Physician-soldiers have expressed in the course of oral history interviews that prioritizing intelligence gathering significantly harmed the trust that patients had in the healthcare team, and cast a shadow over the entire MEDCAP operation: "when you are using medical activity [to gather] information that reduces the trust of the population that you are taking care of." This confluence of priorities and policies contributed to the inability of physician-soldiers to provide adequate care, and their perception that medicine was exploited. Since the goals were strategic, the improvement of medical care was not the driving force; instead it was a sidenote to the achievement of the primarily strategic goals.

Physician-soldiers have reacted in different ways to their negative experiences as participants in these missions. Medical officers are often "voluntold" to participate or (less commonly) to organize these missions. Many are initially excited to participate, expecting a typical humanitarian assistance mission, unencumbered by military strategy. When the reality of the mission becomes apparent, many face the ethical dilemmas and conflicts discussed above, grappling with the instrumentalization/exploitation of medicine, the inability to adequately care for patients, the provision of sub-par medical care, and their morally complicated roles as physician-soldiers. Their lack of knowledge regarding the realities of these missions stems from several factors: physician-soldiers are often deployed with limited information regarding the mission, locale, or population and receive no pre-mission training. They are also rarely involved in the pre-mission or pre-deployment planning stages.

A particularly telling trend is that some participants have been so distraught and found these programs so ethically and medically problematic that they have refused to participate. There has been an increasing number of anecdotal reports of this – either physicians officially voicing opposition or unofficially refusing participation through tactful evasion. This refusal to participate in current programs highlights the moral realities and real-life ethical conflicts felt by the medical personnel involved in these missions. The intensity of their reactions also points to a need for change if these missions are to continue.

Written narratives, oral histories, and a recent study conducted by the Center for Disaster and Humanitarian Assistance Medicine (CDHAM) provide evidence that physicians are motivated by altruism to participate in these programs. The CDHAM study reported that nearly half of all physicians surveyed indicated that humanitarian missions were a factor in their decision to join the military.[5] In fact, "Many applicants to the USUHS [Uniformed Services University of the Health Sciences] expressed positive feelings about the potential to go overseas [...] humanitarian missions are one of the key factors that led them to apply to USUHS and to prefer a career as a military physician."[5] The survey results provide valuable insights concerning the motivation of physician-soldiers participating in medical civilian assistance missions. Their identity as military physicians is at least partly shaped by this humanitarian drive to provide medical

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care in a capacity they thought civilian life could not offer. The same CDHAM study showed that 60% of respondents reported that humanitarian assistance missions were influential in their decision to stay in the military.[5] Thus, the significance for the military is notable. These programs are key to retention and recruitment, serving as a significant factor in physician-soldier career planning. Due to the importance of these programs to military providers, their experience within these missions deserves closer attention. Medical civilian assistance programs have historically been a well-intentioned, misdirected, and frustrating experience for physician-soldiers. While they expected a humanitarian operation of beneficent medical care, they were faced with the reality of a military operation with only secondary medical goals.

Successful programs & other solutions

Importantly, physician-soldiers do not hold issue with every incarnation of this type of program. There are successful iterations of medical civilian assistance programs that have minimized ethical issues and moral dilemmas for participants. MEDRETE, a training-oriented reinvention of MEDCAP, is met with far less critique. Since medical education is a primary goal of this program, medical goals take on a guiding role. Physicians who have participated in both MEDCAPs and MEDRETEs report that the medical care provided in the latter is far superior. There are also successful versions of the MEDCAP that should be emphasized and recreated. These examples of success are programs that re-emphasize medical goals, avoiding the exploitation of medicine and instead accomplishing both medical and military goals. Internal medicine physicians have provided valuable contributions in the form of draining and injecting arthritic joints as well as draining abscesses. Surgeons have found success both medically (and with PSYOP strategic goals) with cleft lip/palate repairs and amputations. Pediatricians have seen a huge impact with deworming campaigns, and dentists had a significant impact on oral health by way of tooth extraction. Optometrists have also had considerable success distributing prescription glasses. Other missions focused on public health and preventive medicine to include vaccination and public health lectures in the native language. Although medical interventions are limited in this setting, physicians have been able to find avenues by which to make a therapeutic difference. Importantly, these missions involve physician-soldiers focusing on the kind of care that can be instituted over a short period of time while achieving a sustainable positive health benefit.

In contrast to missions where strategic goals were emphasized, and medical goals ignored, the missions mentioned above were planned and organized with the involvement of medical personnel. Historically, since MEDCAPs had a primarily military (or strategic) mission they were planned by non-medical commanders and officers, prioritizing strategy. Involvement in planning and organization is recommended – after all, as the only successful programs are those that were actively planned by medical officers to balance military and medical goals. Programs planned in this way are often perceived as providing better medical care to the locals, better training for the physicians, opportunities for bonding within the medical team, and superior overall experience for those involved, minimizing the ethical dilemmas encountered. Allowing physicians early involvement in the planning stages would help to realign the priorities of these programs, permitting medical goals to be emphasized and balanced. The realignment of these priorities addresses many of the ethical issues discussed in this paper, avoiding the exploitation of medicine, the provision of sub-par medical care and minimizing the frus-

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trations felt in the field by physician-soldier participants.

Despite the growing literature on military medical ethics, the ethical issues and moral dilemmas incumbent in civilian medical assistance missions remains a neglected area of study. The negative moral experiences and ethical dilemmas faced by those involved continue to go undiscussed. These programs have expanded their reach, and increasingly become the focus of military medical deployments and engagements with no change in structure or doctrine. Moreover, the narratives of physician-soldiers' have rarely been examined as "lessoned-learned."

The lack of discussion, doctrine, education, and training on the issues related to civilian medical assistance missions are noteworthy. The paucity of reflexivity, education, and discussion only contributes to and confounds the moral issues. Physician-soldiers are ill prepared for this instrumentalization of medicine and untrained in the delicate balancing act of their roles as both physician and soldier. Thus, military physicians and ethicists must contribute to the development of doctrine and educational materials. This population lacks training that teaches them how to deal with the unique complexities of being a physician-soldier.

There are many ethical dilemmas related to providing medical care in the context of the programs and missions discussed in this paper. These missions challenge physician-soldiers to be agents of a program with goals that may not prioritize medicine and medical care. The dilemmas surrounding the provision of inadequate care to accomplish strategic goals challenge deeply held norms of professional medical ethics. The moral frustration of merely distributing multivitamins, aspirin, or ibuprofen is clear in the coping mechanisms used to alleviate tension such as the often-told quip "All we have done here today is maybe given a couple of people ulcers from taking too much ibuprofen." The moral reality is that these participants are rarely troubled by the use of medicine as a strategic tool, or "non-lethal weapon"; instead, the core of their disapproval and basis for their dilemmas is the prioritization of strategy above all, and thus the exploitation of medicine; a balance is needed. This reality becomes evident in the fact that when medical goals are emphasized, and medical benefit is achieved, physicians find these experiences rewarding, positive, and unproblematic. However, when these military physicians are morally challenged by an order to provide medical care that they believe to be grossly inadequate they often feel conflicted.

Very few militaries are currently examining these issues, and only one is beginning to offer training and opportunities for moral reflection to medical professionals specifically dealing with medical civilian assistance. The moral complexities of these programs must be analyzed and discussed. More education, training, and policy are needed to address these issues. Ideally this moral education would involve both military medical professionals and their non-medical commanders so that ethical tensions can be eased, and medicine can be used appropriately, without being exploited.

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Military Healthcare Professionals in Conflict with International Humanitarian Law

by Cord von Einem

Some worrying developments appear to be taking place regarding the self-image of military medical personnel. My observations from training programs on International Humanitarian Law (IHL) and military medical ethics indicate that participating military doctors and medics often struggle with a lack of legal clarity as well as ethical concerns during their missions and training. So in this article I will elaborate on the rights and obligations of military doctors and medics in the law of war, and highlight the legal problems that arise during deployments.

The observations described in this article are taken from education and training events as well as conferences and discussions involving the ICMM Center of Reference for Education on IHL and Ethics (International Committee of Military Medicine, ICMM), whose participants are comprised in large part of military medical personnel representing all rank groups and specializations. The events were held in Europe and Africa as well as in the Middle and Far East. With regard to these observations, it makes no difference what cultural backgrounds the participants have, which countries they come from, or what levels of development or kind of education system exist in their countries of origin. Furthermore, for this illustration, it is very often immaterial how long participants have been in the service, or what rank group they belong to.

Conflict in the self-image of military medical personnel is becoming increasingly apparent. In contrast to those medics who see their role as having a strictly humanitarian character, this is affecting ever-increasing numbers, who, for example

- staunchly and actively participate in combat operations, or are willing to do so;
- regard it as their duty as a soldier to attend to their own military personnel before other people;
- or think it is legitimate, if needs must, to subject prisoners to harsher interrogation methods and, as a physician, merely to ensure the survival of the interrogated person.

These experiences and conversations among medical personnel at the training events led to some general considerations about how appropriate current methods are for teaching IHL in the medical service and for ensuring that this knowledge is retained. Are these legally worrying developments in the self-image and deployment of military medical personnel the result of an educational deficiency?

One thing is for sure: on their own, the Geneva Conventions and their protocols set out a host of rules that are of significant importance, especially for military medical personnel.

In the German armed forces (*Bundeswehr*), we know about problematic points of view, not least because of Afghanistan, but also via the NATO "lessons learned" process. The reality of deployment and the manner in which medical service assistance was handled in some cases in Afghanistan, created a particular emotional closeness between combat troops and medical personnel. For example, participation in

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patrols and sentry duty at forward operation bases (FOBs) brought demands for heavier weapons, combat training, and for protection symbols to be disguised. Readiness for self-defense changed into readiness to fight, so as not to have to leave fellow soldiers "in the lurch".

Who is a combatant and who is not? The Afghanistan example

"The enemy has changed the rules of the battlefield": An argument that medical personnel use to legitimize their own actions during operations. This justification is challenging both for instructors and in terms of planning exercises and operations involving medical personnel, since the conflicts referred to and the parties to the conflict first need to be subject to IHL before the topic can be discussed in legal terms.

The problem becomes clear with the example of Afghanistan:

While the nations that provided troops for the International Security Assistance Force (ISAF) unilaterally undertook to observe the humanitarian standards of IHL, in the opinion of many participants at events and among all rank groups, the inhuman behavior of the insurgents apparently created new requirements for the definition of combatants.

It was almost impossible to define front lines and enemy groups in Afghanistan and many actors with unclear motivations benefited from continual violent conflicts. The insurgents' irregular combatants ignored the standards of IHL and used perfidious tools of war. Moreover, they moved in small dynamic groups without uniforms, barely identifiable amid the Afghan civilian population.

Not only combat troops but also military and civilian medical personnel evidently came under repeated attack by insurgents.

Yet to legally modify or change the definition of combatants, the forces deployed by the parties to a conflict must be or have acted as combatants in the first place, as defined in IHL.

However, IHL only provides for combatant status in international armed conflicts. A combatant here is a person who has the right to participate directly in hostilities (Additional Protocol I to the Geneva Conventions, Art. 43 (2)). Under IHL, only combatants – outside the bounds of self-defense – may carry out acts of harm based on the law of war.

Since it is a non-international conflict in Afghanistan, however, there is no combatant status under international law in this conflict.

It would be different if the insurgents in this non-international armed conflict were fighting against colonial domination and alien occupation or against a racist regime and exercising their right to self-determination (Additional Protocol I to the Geneva Conventions, Art. 1 (4)), in which case it would be necessary to assign a combatant status if certain minimum standards were met. But then the insurgents would need to have armed forces which are subject to an internal disciplinary system, which, inter alia, enforces compliance with the rules of international law applicable in armed conflict (Additional Protocol I to the Geneva Conventions, Art. 43 (1)). However, this is not the case.

One should therefore regard the insurgents in Afghanistan as terrorists or criminals who are breaking national Afghan law. Occasionally they are described as "illegitimate, illegal, unlawful or illicit combatants." However, no such special category is recognized or indeed necessary in IHL, either for international armed conflict or for non-international armed conflict.

Thus in the example of Afghanistan, the insurgents do not have the right to be legally clas-

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sified as combatants. If the situation were different, it would not be possible to punish them for their attacks, since combatants cannot be punished simply for participating in hostilities (Additional Protocol I to the Geneva Conventions, Art. 43 (2)), whereas civilians (which is what criminals and terrorists are), especially at the level of national law, can expect criminal prosecution for their acts of participation if they are directly involved in hostilities.

The soldiers deployed in ISAF were likewise not combatants, even if – owing to the commitment their countries had made – they were required to comply with the principles of IHL in their use of force during the ISAF mission. They were merely helping the national Afghan security forces to fight the insurgency.

Moreover, even the soldiers of the Afghan National Army (ANA) and members of the Afghan National Police (ANP) were and are not combatants. Soldiers in the ANA, however, represent the legitimate military power of the state and are permitted to fight the insurgents using military force.

Hence the call for a new definition of combatants based on the example of Afghanistan is not factually correct. When it comes to the question of adapting or changing this definition according to IHL, one should always ask:

- Is IHL even applicable to the underlying conflict?
- And if so, to what type of conflict is it applicable: international or non-international conflict?

A fine line between assistance and criminal liability?

For medical service personnel, a lack of clarity about definitions under IHL can have serious consequences – so much so, that if the personnel in question make any mistakes, they may run the risk of criminal prosecution slightly below the level of a war crime.

In recent years, particularly among the medical personnel of leading military nations, the belief has developed that medics should be permitted to use heavier weapons offensively, for example to gain access to and rescue the wounded, and even that they should support combat troops in critical battle situations, e.g. by firing at the enemy. This has been triggered by repeated reports of attacks carried out by parties to the conflict – especially obviously targeted attacks – against precisely these military medical personnel and their facilities.

The right to participate directly in hostilities is also called the combatant's privilege. Members of the armed forces of a party to a conflict are combatants and they have the right to participate directly in hostilities, whereas medical personnel and chaplains are excluded (Additional Protocol I to the Geneva Conventions, Art. 43 (2)). Thus persons having combatant status are permitted to fight against legitimate military targets. This means the power to injure or kill enemy combatants or persons who without authorization participate directly in hostilities (Additional Protocol I to the Geneva Conventions, Art. 51 (3)) and to damage, neutralize, or destroy objects which are classified as military objectives (Additional Protocol I to the Geneva Conventions, Art. 52 (2) sentence 2).

So whereas combatants, in accordance with their combatant immunity (Additional Protocol I to the Geneva Conventions, Art. 43 (2)), shall not be punished simply for participating in hostilities, if other persons – and this includes military medical personnel – participate directly in hostilities they can expect criminal prosecution for their acts of participation, e.g. homicide, assault, damage to property. This is especially the case since medical facilities or mobile units of the medical service

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immediately lose their protection under IHL in battle if they are used outside of their humanitarian purpose to attack or otherwise harm enemy troops; and so, with the backing of the law, they become a legitimate military target.

The call for military medics to be allowed to use force to gain access to and rescue the wounded in cases of doubt will also fall foul of IHL. The rules state that whenever circumstances permit, ceasefires or other local arrangements will be agreed to enable a search for the wounded, sick, and dead on the battlefield, as well as their identification, collection, rescue, exchange and evacuation. This might be hard to endure, but it originates in the same interests that may also legitimize collateral damage, namely the interest of nations in a balanced consideration of military necessity and humanitarian protection. The enemy (but also one's own forces) is therefore allowed to keep fighting, despite wounded personnel lying around on the battlefield.

The limits of self-defense

But if the employer issues weapons to medics, what are these weapons for? At any rate not to harm the enemy, e.g. to gain a tactical advantage – such as suppressing enemy fire on a patrol – or to prevent an enemy from carrying out legitimate operations, such as fighting enemy forces. They are to be used for self-defense against unlawful attacks on patients, personnel and material by any persons, regardless of whether they belong to the military or are civilians. The limits of self-defense at this point are an interesting, much discussed and – beyond the topic considered here – explosive subject, but one which is only even rudimentarily taught to an extremely small number of military medical students during their training.

So what is the right way to use these weapons? As we have seen, members of the medical service do not have the right to participate directly in hostilities, but they are permitted according to the right of self-defense to carry and use weapons to defend their own person, their patients, and their materials against attacks that violate international law.

The law of war does offer solutions or loopholes – though they are only rarely observed or used – in the event that a party to a conflict wishes to heavily arm medical personnel and let them participate in combat operations. But their "cost" is such that disadvantages are incurred at the same time, which probably accounts for their extremely infrequent use.

The law of war does not automatically force nations to make somebody a medic because of his or her medical training. Medics are protected under the IHL, but they are not given the combatant's privilege. If the administrative act of assigning exclusively medical tasks, the associated marking with the international protection symbol, and hence the claiming of protection under the provisions of IHL are not carried out, then there is nothing to prevent these personnel being heavily armed and participating in combat operations alongside combat troops.

But even though the law of war leaves this option open, this decision is not up to the individual (First Geneva Convention, Art. 7) but only the organs of state or corresponding decision-making levels in the military.

Attacks on medics – which law applies?

There is no way, however, particularly in asymmetrical conflicts, to rule out tactics such as deliberately attacking medical personnel as a way of ultimately eroding the willingness of combat troops to fight and take risks. An infantryman in battle will naturally think twice about taking a risk if he knows that he cannot receive immediate, competent treatment if he gets wounded.

But here too, regarding the question of whether these tactics in asymmetrical conflicts are a

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reason to make changes to IHL, it is first necessary to establish whether IHL is applicable to the underlying conflict in the first place. Conflicts in recent times, in the vast majority of cases, have been non-international in character and did not cross the threshold at which the law of war applies. Ultimately, then, calls to change IHL based on experiences in conflicts which it does not cover are tantamount to comparing apples with oranges. Thus, in cases which are not covered by the law of war, the question of who is allowed to participate actively in combat operations and who is not is a matter of national law or other restrictions outside the boundaries of IHL. At any rate, it would not be justified to change the law of war on this basis.

But let us suppose that IHL is involved. Then it would still be necessary to verify what really caused incidents: Did the enemy specifically intend to hit medical personnel, or was it perhaps the direct proximity of medical personnel and their facilities to combat troops and/or their facilities and equipment, or unfortunate circumstances, or military necessity? Because it may have been abusive or negligent behavior by one's own troops that provoked the attack, e.g. using armed force to rescue the wounded in battle, or military medical personnel participating in patrols or sentry duty at facilities that are not part of the medical service.

There is a long list of potential hazards for medical personnel which may bring them into conflict with IHL and/or national criminal law. It includes such things as participation in "harsh" interrogation methods or overseeing their safety, as well as giving preferential medical treatment to one's own military personnel. The last point in particular is often demanded by militarily superior powers, and especially here, the demand should be met with the response: "Do unto others as you would have them do unto you."

It is often overlooked, as is the case with other points of discussion, that changes to rights and obligations resulting from IHL always work both ways, i.e. against the enemy but also possibly to the detriment of one's own side. If one asks a combatant if he would like to be treated – whether by his own or enemy personnel – according to his nationality or medical necessity, it seems likely that he would prefer the latter. At any rate, no legitimization by "military necessity", which is an argument often raised in this context – exists in IHL. This has its significance in other areas of IHL, but not in the provisions concerning access to medical treatment.

Conclusion

As things currently stand, probably no nation and only a few members of the medical services can claim to be free of deficiencies in training concerning the aspects of IHL which are important for medics. At the same time, these deficiencies go beyond familiarity with laws and quite obviously touch on the ethical roots regarding the role of medics in violent military conflicts – and hence fundamentally affect the self-image of military medical personnel.

In some ways it is hard to escape the impression that the armed forces consciously accept deficiencies, not least for budgetary reasons, particularly since uncertainty makes medics more flexibly deployable in a conflict, and especially when political and budgetary requirements have an impact on operational principles in respect of the allocation of equipment and personnel.

But this is essentially to throw overboard precisely those values of the international community which – at least officially – we aim to defend in many of the conflicts in which we are involved, especially nowadays.

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Hence there is an urgent need, for the sake of upholding humanitarian principles, and not least to protect medical personnel from criminal prosecution, to continue with efforts to enhance and improve training and to preserve knowledge in these areas.

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Caring for Compatriots: Military Necessity before Medical Need?

by Michael L. Gross

Regarding its stance on military medical ethics, the World Medical Association (WMA) declares:

> *Ethical principles of health care do not change in times of armed conflict and other emergencies and are the same as the ethical principles of health care in times of peace.*

What is behind the assertion that medical ethics does not change in times of armed conflict? One answer may be the universality of the principles of medical ethics. Norms such as the duty to do no harm, to provide impartial care to the sick and injured, and to respect a patient's dignity, autonomy, and privacy should not vary according to circumstances. Thus the ethics of psychiatric, neonatal, pediatric or geriatric medicine, for example, are all the same. The circumstances vary, as do the conditions of the patient, but the ethics of medical care remain constant.

One is tempted, like the WMA, to draw the same conclusions about military medical ethics and to see service personnel as simply another kind of patient. During peacetime this is true. In many countries, service personnel and their families receive medical care from military medical organizations in the same way that nonmilitary civilians receive their care from the national health care system. And, in many cases, facilities overlap, particularly when government hospitals provide care to military and civilian patients alike. In these circumstances, the principles of medical ethics apply equally. Each patient, whether military or civilian, is treated in accordance with the principle of medical necessity that mandates that care be provided on the basis of a national plan that balances lifesaving care with quality-of-life care. To act otherwise would invite charges of bias and partiality. However, the situation changes dramatically during wartime, particulary on the battlefield where the principle of military necessity may conflict with and sometimes overwhelm the principle of medical necessity. In the sections below, I will first discuss the principle of military necessity and then explain how it affects patient care and patient rights during wartime.

Medical necessity and military necessity

Military necessity is often defined as "The means necessary to subdue an enemy and which are not forbidden by international law" (Additional Protocol I, 1977, Article 35). This definition is problematic in two ways. Firstly, it ignores the legitimate goals of war, that is to say the reasons why it is necessary to subdue an enemy. From a legal point of view, ignoring a nation's war aims is sometimes necessary because it is often difficult to discern where justice lies in practice. As a result, the law treats all combatants on the field equally as long as they do not commit war crimes. But morally, there is good reason to lapply this equal treatment only to those belligerents, whether a state or nonstate (such as a guerrilla organization), that are fighting for a just cause. Just cause includes fighting in self-defense or in defense of foreign citizens who face grave human rights abuses at the hands of their own government (as was the case in Libya or Kosovo, for example). On the basis of this reasoning, an oppressive regime like Syria cannot invoke military necessity to justify its military operations. In this case, no military

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action whatsoever can be classed as necessary. Secondly, restricting military necessity to means not forbidden by international law often begs the vexing question of when military necessity may permit a belligerent to override international law and resort to *prima facie* unlawful or unethical means of war? Put differently, is it sometimes permissible to violate international law or a principle of medical ethics when militarily necessary? The answer is "sometimes." Sometimes, as I will show in the cases below, it may be permissible to treat soldiers based on their identity rather than on the basis of military need. To see how this occurs, it is important to compare military and medical necessity.

The following table distinguishes between military and medical necessity:

	Military Necessity	**Medical Necessity**
	Collective/National	Individual/Collective
What is "good"?	***Maximum Lives*** – Citizens' Lives – Soldiers' Lives ***Maximize Quality of Life*** – Liberty – Territory – Security – Honor	***Maximum Lives*** – All Patients' Lives ***Maximize Quality of Life*** – Quality-adjusted life years (QALY) – Well-being – Normal functioning

This table highlights two points. Firstly, military necessity favors the collective interests of a state or a people over the individual interests of many of their citizens. As a result, it is common in wartime to enlist or conscript citizens for military duty where they will risk their lives to safeguard national security. To accomplish this end, policy makers, politicians and military officials are charged with defending the collective welfare. Medical necessity, on the other hand, is radically individualistic. Health care providers serve the needs of individual patients. To do this, a national health care system is expected to provide sufficient resources to care for all citizens equally according to their medical needs. No one is expected to sacrifice his or her interests for some greater good. There are, however, collective constraints. Certainly the funds allocated to medical care must meet some standard of justice that allows the state sufficient resources to fund other essential services such as welfare, education or security. Medical care is, therefore, limited. Moreover, individuals cannot be expected to be allowed to bankrupt the system. The state will not treat every illness. Nevertheless, the state will endeavor to provide each individual with the best care possible. To accomplish this end, health care professionals are charged with the caring for their patient as beneficently and professionally as possible.

The second point in Table 1 pertains to the definition of good that each kind of necessity serves. Both military and medical necessity hope to maximize the number of lives saved (of some individuals) and the quality of life (of other individuals). But the criteria for each are different. During war, military necessity compels the state to sacrifice soldiers to save civilians, while medical necessity usually makes no distinctions between the lives it saves. Medical necessity serves all patients. At the same time, the concepts military and medical necessity both encompass striving to maximize quality of life. But here, too, each defends a different kind of life. The state defends its collective, political life while medical necessity endeavors to save or improve an individual's human life. As such, the idea of quality of life differs when considering military or medical necessity. The quality of political life depends on many things such as liberty, territory, security and honor, the value of which often supersede that of individual lives in war. How many lives a nation will risk for these goods is a decision that a body politic must make when it goes to war. Medical quality of life is, of course,

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more narrowly focused and includes measures of happiness, pain, suffering, mobility, day-to-day functioning, and access to continuing care. Here, too, a society may allocate funds to enhance quality of life at the expense of costly care that may save some lives. There are no hard-and-fast rules to balance life and quality of life. Each society chooses on the basis of universal human rights and parochial concerns and norms. Nevertheless, political life provides the vehicle to sustain individual life and, therefore, will often take precedence when the political and the individual life conflict as they often do during war.

The relationship between military necessity and medical necessity is therefore complex because it pits different interests (collective and individual) as well as different goods (military/political/medical life and quality of life) against one another. To better understand the relationship between the two kinds of necessity and their impact on international law, it is important to see how the principles play out in the field. One relevant example is the provision of care for the wounded. In this context, the following question is pertinent: may military necessity permit medical personnel to treat compatriots first rather than according to medical need as the principles of medical ethics demand?

Medical care for compatriots during wartime

The iron rule of medical treatment during war is clear:

> *"Members of the armed forces who are wounded or sick shall be treated humanely and cared for without any adverse distinction founded on sex, race, nationality, religion or any other similar criteria … Only urgent medical reasons will authorize priority in the order of treatment to be administered. (Geneva Convention I 1949, Article 12)"*

To avoid any misunderstanding, the Commentary to Article 12 makes the following point:

> *„Each belligerent must treat his fallen adversaries as he would the wounded of his own army."*

Military medical personnel know the law but remain bound to an equally demanding rule: "Compatriot care, above all else." The reasons for preferring compatriots to enemies are based on military necessity and an obligation to care for one's compatriots when their lives are at risk.

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 gonorrhea stricken soldiers and return them to duty before treating those with more extensive battlefield injuries who would never return to battle.[1] Here, it is clear. Military necessity demands treating less critically wounded soldiers who can make a substantial contribution to the war effort at the expense of those who need life-saving care. This upends the ethical principle of impartial treatment based on medical need.

Similarly, medical operations in Iraq and Afghanistan since 2001 also prioritized military necessity. Although military organizations have contingency triage plans to prioritize care, the hard moral cases – having to choose between saving the lives of severely wounded soldiers or returning the moderately wounded to duty – are relatively rare.More common are questions about providing care to local civilians caught in the cross fire or caring for "host country" personnel who fight alongside US and NATO troops in Iraq and Afghanistan.

To support its soldiers, The US Army, for example, provides medical care at several levels. The Battalion Aid Station provides first

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aid and transport, the 20-person Forward Surgical Team offers immediate treatment, surgery and evacuation to a 248-bed Combat Support Hospital that provides resuscitation, reconstructive surgery, intensive care and psychiatry. And, when necessary, the wounded receive sophisticated treatment at a full-service trauma center in Landstuhl, Germany or in the US.

While this system is designed to provide the best possible care for US soldiers, American medical facilities also care for host country soldiers and local civilians wounded during American operations. While severely injured American casualties are evacuated to superior medical facilities, local military casualties must turn to a poorly functioning local system for further care. This two-tiered system limits care for host country wounded who, without access to sophisticated prosthetic devices, for example, will not receive the same reparative surgery US soldiers receive in the field. Host country civilians fare even worse. Coalition forces do not maintain facilities to care for local civilians and sometimes find it necessary to turn away civilian patients. Nevertheless, coalition forces will treat civilians caught in the cross fire to the extent of saving the 'life, limb or eyesight' of host-nation wounded. This is by and large emergency care; there are very few facilities for follow-up or chronic care. Nevertheless, two situations stand out. Firstly, pediatric cases present a special challenge. Being acutely aware of the adverse publicity of failing to provide anything less than maximum care for children, US medical facilities often offer extensive and sophisticated care to children. Secondly, and not to be considered any less problematic, is the care due to detainees. As prisoners of war, detainees are entitled to the same care provided to coalition soldiers and therefore receive better care than host country allies. There are, therefore, at least 4 or 5 different classes of medical patients: coalition soldiers, detainees, host nation soldiers, host nation civilians and, sometimes, children. All will receive different levels of care for identical injuries.

As this description suggests, it is not always possible to treat the wounded strictly on the basis of medical need. The availability of follow-up resources, clearly depending on national identity, dictates the care the wounded receive initially. Similar cases may not be and, perhaps, should not be treated similarly. This is, however, a *prima facie* violation of the neutrality provision of the Geneva Conventions which prioritize care solely on the basis of medical need. And although some commentators view the obligation to preserve neutrality and treat indiscriminately as absolute,[2] situations arise in wartime that temper this assessment. Firstly, the obligation to treat those who can contribute best to the war effort may override the duty to save lives when resources are scarce.[3] Secondly, medical personnel may apply an ethic of comradery or ethic of care and treat their own soldiers first regardless of the severity of their wounds because of a special obligation they feel they owe to their compatriots.

Obligations toward comrades also portray the reach of military necessity. Consider the following case:

> *One US soldier and one Iraqi Army allied soldier present with a gunshot wound to the chest. Both have low O_2 saturations. There is only enough lidocaine for local anesthesia for one patient, and only one chest tube tray. One will get a chest tube with local anesthesia, and the other will get needle decompression and be monitored by the flight medic.*[4]
>
> *Who gets the chest tube and local anesthesia and why?*

When participants in an American workshop were asked how they would resolve the issue, their answer was unequivocal: "The wounded American." When I asked why, their answer

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was equally as confident: "Because he's our brother."

It appears, then, that military medical personnel are of two minds about the Geneva Conventions. On the one hand, they acknowledge the principle of medical impartiality. On the other, they recognize a conflicting and often overriding obligation to provide their compatriots with the best medical care possible. The first principle requires little justification. Medical integrity and efficiency depend upon treating the neediest cases first regardless of rank, gender or nationality. The second principle, however, is also compelling: Armies go to war to win. Winning requires fit troops and fit troops require superior medical care. It is therefore advantageous and, indeed, proper to treat compatriots first when resources are scarce. This is the reasoning behind battlefield and penicillin triage, whereby during war and when resources are scarce, many armies permissibly reverse their order of treatment and treat the neediest last. Instead of treating those cases most medically urgent, medical personnel will see to those who can return to battle the quickest. This means that some otherwise treatable patients will die while others, whose treatment might be delayed, will enjoy immediate care so they can fight on. The underlying logic is utilitarian and morally sound: Without reversing the order of treatment, troop integrity will suffer and military capabilities may falter. The outcome, defeat, is the worst possible. By this reasoning, injured enemy soldiers also move to the rear of the queue.

A similar but more complex logic drives the decision to treat one's brother-in-arms before all others in the case just outlined. In that scenario, the two patients were allies, not enemies. The military benefit of saving both was presumably equal. Still, caregivers express a distinct preference for their compatriots.

One reason is clearly utilitarian. Military sociologists have long noted the importance of "primary" bonding among soldiers and officers, particularly at the platoon level (40–50 soldier units). Primary bonding begins with teamwork and interdependence and slowly grows to engender trust, loyalty, shared commitments, mutual assistance and self-sacrifice. Small military units are not merely a collection of well-coordinated, self-interested individuals, but a cohesive band of brothers distinguished by a new identity: Comrade-in-arms. In this tight-knit environment, preferential treatment for comrades-in-arms is militarily advantageous because it preserves morale and a unit's fighting capability.

There is, however, an additional duty that obligates some military personnel no less than the principles of medical ethics. This obligation transcends utilitarian justice and its emphasis on distributing scarce resources efficiently and fairly and, instead, underscores the special relationships individuals have with those who are close by and to whom they owe a special obligation of aid regardless of cost and competing claims to treatment.

It is not hard to understand how preferential treatment for family and friends is a fundamental moral obligation. Parents are not expected to invest in the care of others before they attend to their own children. Friends, likewise, have a special duty toward one another that they do not have toward strangers. These are commonplace intuitions and underlie what the philosopher Virginia Held calls the "ethics of care." The ethics of care is unavoidably related to the unconditional sense of duty that individuals feel toward 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 reflects an emotive rather than contractual bond that calls for "personal concern, loyalty, interest, passion and responsiveness to the uniqueness

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of loved ones, to their specific needs, interests [and] history".

Guided by preferential principles, special obligations toward friends, family and compatriots inevitably raises questions of distributive justice: What if others are in greater need of care and attention? This is a compelling question – but the ethics of care is not about justice. Friends and family should aid one another without expectation of payment in kind, often at great personal cost and when knowing that the same aid might benefit a stranger more. To think too hard about rescuing a stranger when the lives of one's family or friends are in danger is, as Bernard Williams famously put it, "one thought too many." Is medical care for enemy wounded also "one thought too many"? If primary military units are like families, preferential treatment for compatriots may be as morally obligatory as those toward family members. The ties that bind comrades-in-arms are no different than those binding family members or friends and speak to an unconditional and unilateral obligation to help one another in need.

Transposed to the battlefield, the ethics of care has important ramifications. Consider these three different scenarios:

Equal injuries

In the case study from Iraq, both soldiers had similar wounds and an equal chance of survival. They were allies and saving one offered no superior military benefit. In the case of a tie, one could flip a coin and while a lottery accords with impartiality, it ignores the moral significance of the duties imposed by primary group membership. These duties are not negligible but should only serve as a tiebreaker after all other impartial criteria of distributive justice have been exhausted. In this case, then, treating the American first because he is a comrade-in-arms is morally permissible.

Grossly unequal injuries

Medics sometimes insist that they would treat a compatriot's slightest wound before attending to the enemy. On reflection, however, what they mean is that they would stabilize their compatriot first and then attend the enemy if their compatriot's wound is slight and the enemy faces severe injury or loss of life. In this case, the ethics of care is trumped by a different concern, namely the "rule of rescue," i.e. the obligation to aid others when the cost is reasonable and the danger to strangers is very great. On the battlefield, however, and without sophisticated diagnostic equipment or expertise, the relative severity of a soldier's wounds may not be readily apparent to the field medic. This may lead medics to treat on the basis of category I, wounds of equal severity, or on the basis of category III, wounds that are only moderately unequal. Either case may justify preferential treatment for compatriots.

Moderately unequal injuries

These are the hardest cases. Consider the following:

1. There are sufficient medical resources to save the life of one compatriot or two (or more) enemies.
2. Compatriots face disfigurement or loss of limb while enemies face loss of life.

Normally, the moral choices are clear. Saving two lives is better than saving one life; saving lives is more important than saving limbs. Nevertheless, the ethics of care may permit different judgments. In some cases, it may be morally permissible to save the life of one compatriot rather than the lives of two or more strangers (whether enemies or allies). Similarly, limb may sometimes trump life.

Why is this so? One reason invokes the parent who, acting according to the compelling demands of the ethics of care, will prefer to protect the welfare of her child at the cost of

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many other lives. Beneficence, the duty to aid others, weakens considerably when the costs to the rescuer are onerous, as they will be if the rescuer faces losing a child or other primary group member. When lives are at stake, our duties to friends and family are clearest and even the possibility of saving the lives of many strangers will not override a parent's (or soldier's) duty to save his own child's (or compatriot's) life.

When limbs are at stake, one can imagine several scenarios. In one, an artificial limb will restore significant functioning so that compatriot limbs do not trump enemy lives. But one might also imagine a situation where loss of limb severely impairs one's prospect of a decent life and here, the obligations that come from primary bonds may afford attention to limb over life.

Beware the slippery slope

A word of warning about giving too much weight to friends and family. While primary bonding is both essential for effective fighting and forges special and overriding moral obligations among group members, it cannot allow group members to run roughshod over fundamental moral norms or permit abject neglect. As doctors, nurses and medics provide care to compatriots, the ethics of care requires attention to the plight of strangers and reflects concern for basic human rights and what Held calls "moral minimums" of care.

Medics recognize this when they report a readiness to stabilize or sedate severely wounded enemy soldiers while they first attend to the less serious wounds of their compatriots. It also explains why medical personnel might treat wounded compatriots before wounded enemy soldiers but refrain from treating compatriots once they have already begun to treat wounded enemy soldiers. This may happen when surgeons begin caring for enemy soldiers only to be suddenly faced with an influx of their own. Anecdotal accounts suggest that doctors and nurses would not cease caring for an enemy to provide for their own soldiers. Apart from a justified concern that withdrawing care is akin to murder, it is also clear that medical personnel enter into a 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.

When resources are limited, hard moral dilemmas bedevil military medicine. Even when funded by a country as wealthy as the United States, wartime medical care is plagued by scarcity. Under these circumstances, providers are often torn between the norms of law and the ethics of care. These are not easy dilemmas to resolve but in cases like those described, medics, nurses and doctors should feel no moral compunction about providing priority care to compatriots.

Conclusion

War presents special challenges to medical ethics because military necessity and special obligation of care may override the principle of medical necessity and impartial treatment. The case described above is not the only time that military necessity may affect the principles of medical ethics. Other cases will include the imperative to develop certain kinds of nonlethal weapons to help wage war more effectively; forced-feeding hunger-striking detainees who risk their lives to pursue a political or military goal or developing enhancement technologies that use medical interventions to improve military capabilities.[5] In each of these cases, and others, military physicians must wrestle with their obligations as military officers and as caregivers.

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Ethics in the Field: The Experiences of Canadian Military Healthcare Professionals

by Bryn Williams-Jones, Sonya de Laat, Matthew Hunt, Christiane Rochon, Ali Okhowat, Lisa Schwartz, Jill Horning

During international deployment in contexts where military, humanitarian and development missions coexist, the roles of military healthcare professionals (referred to as HCP, these include the following: physicians, nurses, medical technicians, allied health professionals) often overlap and at times conflict. Military HCP may be asked to undertake the work of healers, soldiers, and development workers simultaneously or in succession which can create challenging ethical conflicts that go beyond those commonly dealt with in the medical ethics literature. In these situations, the principles of medical ethics apply but may be prioritized differently by various actors due to varying internal and external influences and perceptions. For example, triage and just resource allocation, treatment protocols and standards of care, informed consent, patient autonomy, and the protection and promotion of human rights may diverge depending on the situation. These issues become all the more pronounced during armed conflicts, where military HCP have to consider both their patients' interests and those of the fighting force. HCP may feel pressure: To participate in medical caravans in order to "win hearts and minds"; to certify soldiers as fit for combat when this might be debated; to violate patient privacy for military ends; or to treat soldiers, combatants, or civilians against their will. The potential for and variety of dilemmas is further amplified in coalition settings where multiple militaries, each with their own codes and procedures, are cooperating on deployments, including sharing medical facilities. Questions thus arise regarding the moral responsibility of military HCP in armed conflict: To which institution or profession do they owe primary allegiance? Which professional code(s) should guide their behaviour? And what should they do when they are bound by multiple and sometimes conflicting moral commitments?

These are not easy questions. The literature in bioethics – and military medical ethics in particular – can be a helpful starting point, but it is diverse and even polarized regarding the appropriate roles and responsibilities of military HCP. Further, this literature tends to be grounded in conceptual analyses, with little reference to empirical studies. In 2010, we – the Ethics in Military Medicine Research Group (EMMRG, www.emmrg.ca) – initiated an empirical bioethics project, with the support of the Surgeon General's Office of the Canadian Armed Forces, to study the ethical tensions and dilemmas experienced by HCP who had been deployed on international missions. The ultimate goal of EMMRG is to develop ethical tools or guidance to help military HCP be better prepared to respond to the ethical tensions that arise in professional practice by increasing ethical competence and confidence, which will in turn enhance the care they provide for patients. Here, we present a summary of the findings from our study[1].

What the medical ethics literature tells us

The literature on military medicine often discusses the political and social roles of HCP as well as their roles in relation to their patients. Views on military HCP roles can be grouped into three (not mutually exclusive) categories: 1) primacy of classic bioethics principles, 2) adherence to professional codes of ethics, and

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3) conflicts arising from dual/double professions and loyalties.

1. The primacy of classic bioethics principles

According to this view, in all circumstances and at all times, military HCP should act as HCP: Prioritizing patients' needs as required by medical ethics. This perspective has led some to consider it unethical for physicians to be in the military, and others to plead for a return to medical professionalism founded on the pacifist nature of the profession. Dilemmas arise when, because of perceived operational requirements and priorities, HCP feel obliged to subordinate patient interests or are not able to provide what they consider appropriate care. Military principles that aim to maintain the fighting force and obedience thus conflict with principles that underlie medical ethics, such as respect for patient autonomy and non-maleficence. There is a tension between the military and medical contexts and there is a tendency to assume that this opposition is the primary source of ethical problems for military HCP.

2. A problem of divergent ethical norms

Others believe that traditional bioethics principles are difficult to apply in situations such as military operations, where collective needs are also at stake, namely national security. Medical ethics, it is argued, cannot be the same in times of conflict as in peacetime. Ethics in times of war or in public health emergencies is special because it must be directed at a common good. The practical aspects of healthcare – including the technologies being used, the resources available, the diversity of patient populations – are also becoming increasingly complex. In the case of armed conflicts, HCP in the military must sometimes balance conflicting priorities regarding operational readiness or national security with medical ethics. Yet, according to the World Medical Association (WMA),

> *"Medical ethics in times of armed conflict is identical to medical ethics in times of peace [...] If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international conventions on human rights, international humanitarian law and WMA declarations on medical ethics".*[2]

HCP may thus have conflicting directives and norms in situations involving collective needs, between those of their employer (the military) and their profession (medicine, nursing, etc.).

3. A problem of dual professions

For some scholars, the ethical challenges of military medicine are due to the fact that two distinct professions are involved, each having its own code of ethics and specific roles; these cannot always (or ever) be reconciled. Conflicts between professional values and ethics create difficult tensions labelled as "dual loyalty" or "dual role" situations. However, the concept of dual loyalty includes a range of different concepts that require further definition, such as profession, professionalism, values, role conflict, conflict of interest, social/political responsibility, and the role of human rights in health. How and to which profession are HCP to identify when they are called upon to be (either separately or at the same time) healer, soldier, or development worker? And must this invariably be a choice between one and the other, or is it possible to be both military and healthcare professional?

Synthesis

One of the major limitations of the literature, however, is that the key actors (e.g. military HCP, combatants, non-combatants, governments) involved in the ethical challenges are often presented individually, without pointing to their dynamic interrelations, or with insufficient regard to contextual factors that shape military HCP experience of ethical dilemmas and tensions. Dilemmas are often examined independently and not presented in their full complexity. Consequently, in almost all cases,

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the HCP-patient relationship is viewed in opposition to other stakeholders (e.g. military organization, state, and society). Stereotypical judgments are often applied with regards to medicine and other healthcare professions (idealization) or the military (utilitarian approach, over-identification with combatants, authoritarianism). Discussions focus on different ethical obligations or responsibilities of HCP, but the limits of these responsibilities are rarely made explicit. Ethical tensions are raised to defend a point of view, either to: a) emphasize the pressure of military priorities on HCP, b) highlight the inconsistency of rules, codes of ethics, and humanitarian law with the military reality, or c) discuss policies and ideologies (human rights) that justify or reject the participation of HCP in armed conflicts.[3] Finally, theoretical analysis is often based on reported facts and anecdotal evidence (e.g. physician participation in interrogation) or conceptual analysis of problems (e.g. triage). In some rare cases, military physicians have written articles, books, and blogs to present their views or share their experiences. Few studies have asked military HCP about the kind of ethical dilemmas or conflicts that they face while working in a military context; there have, however, been comparable studies of humanitarian HCP that provide pertinent insights.[4]

What our empirical findings tell us

To better understand the nature of and means for dealing with ethical tensions and dilemmas arising in the context of military medicine, we interviewed 50 HCPs working in the Canadian Armed Forces who had been deployed in situations of armed conflict, natural disaster, or during peacekeeping missions. Our participants included physicians, nurses, physiotherapists, medical technicians (MedTechs), and a physician's assistant; the vast majority were officers; and they had experience on missions in Afghanistan, Bosnia, the Golan Heights, Haiti, and Sri Lanka. We noted early in our analysis that the sources of ethical challenges could be broadly grouped into the same four major categories identified by Schwartz and colleagues[5] in their study of the ethical challenges faced by humanitarian health workers: 1) resource scarcity, 2) historical, cultural or social structures, 3) policies and agendas, and 4) professional roles. These sources of ethical challenges were made particularly complex because of the nature of working in conflict zones or as part of multinational forces and for variable mission lengths (e.g. weeks or months).

Source 1: resource scarcity

Participants frequently talked about the challenges posed by resource scarcity, both in terms of medical equipment and personnel. For example, many physicians and nurses who were used to practicing medicine in Canada found it difficult to accept that they could not provide the same level or continuity of care "in-country" that they would expect to provide "back home". Additionally, our participants described tensions associated with the best allocation of available resources. For example, MedTechs on patrol or physicians at a Forward Operating Base in Afghanistan recounted dilemmas about limiting or withholding treatment from local nationals (civilian, police, military) because they had to conserve resources for Canadian or coalition (i.e. NATO) casualties. Others recounted examples of what they judged to be "problematic" heroic measures being provided by colleagues to locals or unnecessary or futile medical interventions on soldiers.

Source 2: historical, cultural, or social structures

Differences in cultural or religious beliefs were noted by many to be a source of important ethical challenges in the provision of care. In particular, issues around religious views about bodily integrity (e.g. amputation, end of life) were troubling or sources of discomfort for military HCP. Gender was also a concern, in three distinct ways: Female military profes-

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sionals working in highly patriarchal contexts facing challenges to their professional authority, HCP treating local female patients who had been the clear victims of gender-based violence, and the lack of autonomy of local female patients. Many participants were also frustrated (and even distressed) by the inequity in access to health services between Canadians and local nationals caused by the absence of more robust local health services, particularly when they knew that transferring patients to local health services would mean the patient's death due to a lack of resources, training, personnel, and infrastructure.

Source 3: policies

International laws and conventions provided background ethical guidance, but the primary policies that participants referenced were the Medical Rules of Eligibility (MROE) because this guide provided practical and clear decision-making criteria. For example, in Afghanistan, the MROE prioritized treatment of soldiers and detainees (but with inter- and intra-force differences), and restricted HCP interventions to the preservation of "life, limb, or eyesight". While providing clarity, the MROE created tensions, particularly when HCP were deciding whether to treat victims of collateral damage or sick or injured civilians. The application of the MROE (e.g. in discharge policies) also sometimes changed depending on the physician in charge, so HCP sometimes experienced conflicting views of what was considered "ethical care". This was exacerbated in cases where healthcare was treated instrumentally (e.g. for trust-building). Others described frustration and worry about patients for whom continuity of care was impossible. Finally, a recurring concern was the challenge (and distress) of providing care for children given that pediatrics is not part of standard military care and was outside the MROE.

Source 4: professional roles

The mixed nature of international combat forces and HCP, as well as tensions between the different HCP roles, created important differences in expectations and professional norms about the treatment of different types of patients (e.g. combatants and non-combatants), with particular tensions arising with US forces due to the involvement of US military HCP in interrogation. Interestingly, and unlike the emphasis placed on this issue in the literature, few of our participants mentioned problems with dual loyalty or not identifying themselves as part of the Canadian Armed Forces. While some clearly stated that they were HCP first, they also accepted that they worked for the military institution; others did not see any problem with being both HCP and members of the military, feeling that the two were integral parts of their professional identity.

Conclusion

Our findings clearly illustrate the complex nature of the ethical issues associated with international deployment for military HCP in situations of war, disaster, or peacekeeping, and how these issues are shaped by the professional identities of HCP and the military institution. HCP experience significant ethical challenges in the field, and for which they may sometimes feel ill prepared. Although distinct from mental health issues, in extreme cases and if not effectively resolved, ethical issues or dilemmas can become sources of moral distress resulting in refusal to go on future deployments and can contribute to symptoms or cases of PTSD or result in HCP leaving the military or, worse, causing harm to themselves or others; this then also affects the chain of command, the team, and military organization as a whole (i.e. retention rates).

Further, in comparing the bioethics literature (and specifically that focused on ethics in mili-

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tary medicine) with the experiences of Canadian military HCP who participated in our study, we noted a disjunction in some areas regarding what constitutes the "real" ethical problems facing HCP in their practice. For example, the issue of dual loyalty, so widely discussed in the literature, was not a primary source of concern. Instead, major challenges arose regarding issues that are also common in public health and especially in humanitarian contexts; that is, dealing with resource scarcity and inequity, the inability to ensure continuity of care, and having to accept that the level of healthcare provided "back home" is often impossible to deliver in international deployments. Where there is a clear alignment between our empirical findings and the bioethics literature is with regards to the lack of and need for better ethics education.

While Canadian military HCP undertake the same ethics training as the rest of the Canadian Armed Forces, military medical ethics training was felt to be ad hoc and inconsistent. As one participant noted, "[HCP] take it upon themselves to do some sort of medical ethics training if there is somebody on the team that decides that's something they should do" but "a lot of ethics in healthcare falls back to what you learn in … school, which is poor, it's poor at best." That it is being provided at all, often at the initiative of individuals who have had previous deployment experience, is a testament to the need for and value of providing more specialized ethics training for military HCP.

Ethics training must be grounded in the complex realities faced by military HCP working in diverse environments (e.g. whether in conflict zones or in response to natural disasters). Case studies based on such experiences would be excellent teaching tools to develop and use in pre-departure and continuing ethics education. Further, a recurring theme in our interviews was the importance of having both formal and informal opportunities (i.e. where "rank doesn't matter") to discuss as a team – pre-departure and in-field – the ethical challenges that arise in practice and to debrief following particularly difficult situations. Building on this, it would be possible, for example, to design mechanisms that reenforce dialogue as an integral part of ethics training (group discussions) as well as being the basis for in-field problem solving and decision-making.

Our study reenforced our initial conviction (partial as it may be, coming from a group of bioethicists!) that military HCP can benefit from context- and profession-specific ethics training. Our objective, now, is to find opportunities to continue working with the Canadian Armed Forces (and other militaries) to develop innovative ethics training tools (e.g. mixing in-class, mobile, and online formats) that are specifically designed to meet the needs of military HCP, both in terms of content and format. The ultimate goal is to be able to give military HCP the ethics training and tools they need to develop the ethics competencies necessary to navigate their various (and potentially conflicting) professional, social, and political roles while effectively addressing the ethical challenges that they encounter in practice.

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*The Ethics in Military Medicine Research Group (EMMRG) conducts empirical bioethics research in order to understand the ethical challenges experienced by health professionals working in a military context. The goal of this research is to develop practical ethical tools that can be used to help train and support military health professionals involved in international missions. The team is made up of bioethics scholars at the University of Montreal (***Bryn Williams-Jones***, PhD;* **Christiane Rochon**, *MBA, PhD candidate;* **Ali Okhowat**, *MD, PhD candidate), McMaster University (***Lisa Schwartz**, *PhD;* **Sonya de Laat**, *PhD student;* **Jill Horning**, *BA, Masters student), and McGill University (***Matthew Hunt**, *PhD).*

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There's Always Potential! Medicine and the Debate on Human Enhancement for Soldiers

by Bernhard Koch

Therapy – enhancement – doping

"Falklands war declared void. British soldiers were doped. Rematch next year." Even if sporting contests are sometimes likened to wars, happily no one has yet drawn an analogy such as this. Sport is supposed to be a game, but war and military force are deadly serious. But then given that war is such a serious matter, wouldn't it seem obvious to say that rather than leaving anything to chance, we should strive for an optimum – meaning best possible – outcome, i.e. victory? And that for the sake of victory, we should be prepared to go to any lengths, including doping or a military equivalent?

Doping means taking banned performance-enhancing substances or using illicit methods to enhance performance in sport. To a certain extent, doping is also part of a phenomenon called "enhancement": enhancing performance by medical or biotechnological means, which go beyond restoring or maintaining a normal condition, i.e. they do not simply have a therapeutic or preventative effect. If these performance enhancements affect human activities, they are referred to as "human enhancement".

In practice, there is no sharp line between therapeutic use of a substance and performance-enhancing use.[1] This shows already the complexity of the matter. We need only think of the discussions as to whether anti-impotence drugs like Viagra should be paid for by health insurance. A second difficulty is the simple fact that human beings are not biologically equipped to remain in their natural condition. For example, in Europe, clothing is essential – it is a very rudimentary form of enhancement. Human culture begins with the use of tools; this too is a method of self-improvement. But today, the human urge to optimize can go as far as "body hacking" (i.e. having technology implanted in your body and becoming almost a "cyborg"), and human genetic engineering, where the aim is to make improvements by manipulating the germline.[2] This research does not stop with the military, in fact it tends to be the other way around. As is so often the case, military research projects are the spearhead. In "Mind Wars" (New York 2006, reprinted 2012), Jonathan Moreno reports on "DARPA's neuromics program, which is aimed at finding ways to permit brains and machines to interact." DARPA – the Defense Advanced Research Projects Agency – is a Pentagon research department, and the aim of this research is to enable soldiers to control robots by thought. In 2011, the agency spent US$ 240 million on its neuroscience projects alone. But Western soldiers have to face enhancements not only as potential or actual users, but also enhancements used by their enemies. In "Black Hawk Down", Mark Bowden tells how during the U.S. Somalia operation in 1993, Somalian men would often chew khat. It contains an amphetamine-like stimulant called cathinone, which in some cases could lead these men to become aggressive or even violent.

Civilian use

Human enhancement entered the public debate particularly as a result of studies supposedly showing that the use of neuro-

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enhancement products – including conventional substances like caffeine, but also drugs – is on the rise among school and university students. Among these, methylphenidate – better known by its trade name Ritalin – is one of the most common performance-enhancing drugs in this field. "A study on methods of coping with stress and enhancing performance among nearly 8,000 students in Germany showed that 12% of students had taken one or more substances since starting their course to make them better able to deal with the demands of studying."[3]

Focus on performance and pressure to perform among soldiers

In a soldier's career, stress and performance are factors which play a truly critical role. Working in the military involves some of the most serious consequences imaginable. Any error during operations can mean a person being killed unnecessarily, or needlessly putting oneself in an extremely critical situation, or losing one's own life. When it comes to the crunch, soldiers are expected to give maximum performance – a fact that of course places them under enormous stress. Hence it is no surprise that whenever discussions turn to the future of the military, the human enhancement question arises. This is a question which creates special challenges, particularly ethical ones, for military medicine.

Human enhancement covers a wide range of meanings in the military field as well. For example, since 2001 the U.S. Army has paid for its members to have refractive surgery, i.e. corrective laser surgery on the cornea, which in the best case can eliminate defective vision – usually shortsightedness – so that the person concerned no longer needs to wear glasses or contact lenses. Such an intervention affecting the cornea is still widely regarded as being a therapeutic procedure. It only returns vision to a predetermined normal condition. In the case of German soldiers, the employer does not (yet) pay for this procedure, although the Advisory Board for Medical Care in the Armed Forces (*Wehrmedizinischer Beirat*) has expressed its support for this.[4] We also know that in the not-too-distant future, it will be possible to enhance our senses with technological implants such as nano chips. Wouldn't it seem obvious to make it a priority to equip soldiers, on whose sensory capabilities so much depends, with these enhancements?

Another area consists of the ways we cope with stress and pain, and suppress fatigue. Even in jobs where less is at stake, many employees consume a little caffeine to help them through the day. Given the severe consequences of mistakes, the hope that military doctors might be able to use medical "enhancers" to make soldiers more alert and increase their stamina during operations is entirely understandable. David N. Kenagy[5] describes how during the Iraq War in 2003, pilots who took off from the Whiteman Air Force Base in Missouri had to stay in the air for 35 hours to fly to Iraq and back. For others who flew to Afghanistan, it was 44 hours. Without help from enhancement medication, it would be impossible to get through situations like this.

There have been some sensational developments in the field of powered exoskeletons too, though research in this field has been ongoing for a number of decades. These are a kind of mechanical exterior shell similar to an insect's exoskeleton, with a motorized or hydraulic system that assists the wearer's limb movements. Exoskeletons can help to conserve energy, boost endurance (and the ability to carry loads), and enhance precision. Apart from soldiers, doctors – including military medical personnel – will perhaps make greater use of (at least partial) exoskeletons (e.g. on their arms) in the future, when they need to make extremely precise movements during surgery. As with mobile computer

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technology, one of the problems with these exo suits today is how to provide them with a compact power supply that will allow them to operate for extended periods. Maintenance of such enhancements for soldiers requires doctors – orthopedists – who also have engineering expertise. But is it acceptable at all for soldiers to "enhance" and "improve" themselves and have themselves improved in such ways? Is human enhancement compatible at all with our ethical concepts, principles, and judgments?

Should we allow enhancements?

In an ethical consideration of such new developments, we need to distinguish three questions: a) Are enhancements forbidden? Nick Bostrom calls people who answer yes to this question "bioconservatives". b) Are enhancements allowed? Using another of Nick Bostrom's expressions, we can call people who answer yes to this question "transhumanists". c) Are enhancements morally required or essential? We can call those who answer yes to this question "biooptimists". According to the rules of deontic logic, with the aid of negation we can reformulate question c) as a question in the form of a): Is it forbidden not to use enhancements?

If we take the consequences of an action as being the decisive ethical criterion, a duty to improve performance does seem rather obvious. Actions by soldiers often determine the life or death of people: their own lives, enemy lives, civilian lives. Soldiers have to go to the limits of their capabilities to achieve the best results, and if by biotechnological means these limits can be shifted in a direction which delivers better results, the duty of enhancement appears to be practically inescapable. Of course, any long-term harm that the enhancement causes to soldiers themselves needs to be offset against the real or perceived benefit. But since soldiers can be expected to accept certain professional burdens, it may be that the cost–benefit analysis still works out in favor of the enhancement. As in the armed drone debate, therefore, consequentialist reasoning entails a strong preference for technological advancement. Thus it appears that the biooptimists are right and a bioconservative position is indefensible.

A new normative field emerging

But it's not that simple. Although it is almost always futile to ban technology, not using it can be an expression of ethical awareness. Any such relinquishment seems to make a lot of sense when we consider the host of unresolved difficulties that human enhancement creates in the armed forces. To begin with, there is the question of how to prevent enhancements from violating the individual rights of soldiers. In the vast majority of cases, for example, we will consider it ethically necessary to ask soldiers for their consent for the enhancement. But the biooptimist must demand that even if a soldier refuses, it is acceptable to a certain extent to act "paternalistically", contrary to his wishes, to achieve the best possible outcome. Yet any such action would contradict the value we attach to the autonomy of adult human beings, and the respect that we owe them. It also seems ethically reasonable to demand that enhancements, once made, can be reversed. This is certainly the case with exoskeletons, but even with laser eye surgery the procedure is irreversible.

Enhancements for soldiers will affect their understanding of their own role, and possibly their role-specific duties. Soldiers who have received an enhancement might perhaps be expected to take on specific tasks which soldiers without the enhancement are not expected to carry out. Yet these soldiers may feel that they belong to a military elite, and view or treat their fellow soldiers with contempt. Possibly they will carry this elitist attitude – the sense and justification of which

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actually deserve a separate discussion – over into civilian life. Finally, there are certain characteristics resulting from the enhancement, such as improved sensory capabilities, which these soldiers do not lose upon bowing out of military service.

If it became established practice for a majority or at least a considerable proportion of soldiers to be equipped with these enhancements, the question arises of whether it would therefore be necessary to modify the rules of *jus in bello*. For example, should there be a weapons control regime – i.e. a kind of doping test – for enhancements, or should we assume that soldiers who have been given an enhancement have themselves become weapons? In this case, their use would need to be reviewed in light of international humanitarian law, in accordance with Article 36 of Additional Protocol I to the Geneva Conventions. Some scholars of international law and military ethics will perhaps argue that soldiers with enhancements contradict the "principles of humanity and the dictates of public conscience" of the Martens Clause – which sends us back to our starting point and raises the question of whether enhancements can be ethically justified.

The list of questions which today seem curios to us can be added to. For instance, it is possible to imagine a scenario in which animals, rather than people, are given a particular enhancement. But then any such "enhanced" animal could very well be construed as a biological and hence banned weapon under the law of war. Without doubt, proliferation problems will occur, since in the long run, a state or community of states can never monopolize the use of a technology.

Not least of all, however, is the fact that military doctors are affected by the ethical issues which arise in connection with human enhancement. For example, if two soldiers are wounded, one of whom has received what may have been an extremely expensive enhancement, then for economic reasons it would seem obvious to preferentially treat the soldier with the enhancement. But ethically one could argue that the soldier without enhancements, in a certain respect, has made the greater effort. Military medical personnel also face a challenge when deciding on the appropriate treatment of captured soldiers with enhancements. In many cases some kind of drug withdrawal therapy could be necessary.

Only one aspect, but a key one

Given the abundance of questions and issues, only a very general aspect can be singled out here to stimulate ethical discussion. The outcome mentioned above – that with regard to its benefit, technological innovation is usually preferable – is not surprising in itself, since the consequentialist thinking on which it is based itself constitutes a use of reason that is in line with technological progress. But there is more to ethics than weighing up consequences. Non-teleological points of view can and must be taken into account as well. One important aspect of this kind is the freedom to decide over one's body as a flesh-and-blood entity, not as a mere instrument for a person to use. We have a peculiar and unique relationship with our bodies. Although we "have" bodies and "are" not bodies, this having is of a different kind than having an extrinsic tool, such as a knife. A knife is good if it cuts well, Aristotle says. If we need good cuts, we have to sharpen the blade. This enhancement is necessary. Using a blunt knife can be dangerous and therefore irresponsible. But the body is not an instrument for a purpose. Rather it is itself the expression of our makeup as a flesh-and-blood person. We do not need – even despite all modern-day "needs" for cosmetic surgery – to optimize our bodies for other people's purposes. We may do so, however, as long as this does not unduly prevent others from exercising their freedoms.

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Doping in competitive sports, for example, is cheating, so it always restricts other people's freedoms. But doping and enhancement have in common that there is a serious danger that people who actually reject human enhancement are put under pressure by the usage of enhancements by other people (especially in competitive contexts.)

Within reasonable limits, sport and a healthy lifestyle are correct and important. For soldiers, these limits can be somewhat different than for people in other professions. But even if maximum performance is demanded from soldiers in their role as soldiers, they still remain people and flesh-and-blood beings who can decide for themselves how they develop in flesh and blood. To insist on a – biooptimistic – duty of enhancement is to exaggerate the power of consequence-based thinking. Hence one can responsibly decide for or against the enhancement. Other questions, however, are whether soldiers without enhancements should take on tasks which, for good reasons, soldiers equipped with enhancements can perform better, or whether particular enhancements should be banned. Enhancements can have a negative impact in the long term on the persons concerned, whether as a result of toxins given off by the materials used, or through addiction and dependency. In many of the highly diverse examples of human enhancement, there are no long-term studies on the effects. This means that doctors who administer such enhancements need to provide information about the unknown risks, and that the persons concerned can say no – including soldiers and military medical personnel. If enhancements are believed to entail massive dangers, it may even be necessary to consider a ban. This is particularly the case if the dangers concern not only the informed user of the enhancement but also persons who had no influence over its use, e.g. civilians who are threatened by a solider who "flips out" because of an enhancement.

Particular demands on military medical personnel

For military doctors, new questions arise, and old questions arise again. The key new question is the extent to which they should morally participate in such enhancements for soldiers. Of the old questions which arise again, I shall single out just one which is currently being discussed: Should military doctors – and, according to their professional ethos, this should be ruled out – now perhaps nevertheless play an accompanying or even assistive role in acts of torture, if they know that because of an enhancement the torture victim is almost completely insensitive to pain? In other words, this torture victim with an enhancement is not affected by the torture in the same way as one should assume of a torture victim under "non-enhanced" conditions.[6] "In changing human biology, we also may be changing the assumptions behind existing laws of war and even human ethics," writes Patrick Lin in The Atlantic Monthly (2/2012).[7] Maybe the ban on torture did not foresee the potential resistance to pain that can be achieved by biotechnological means, with the result that legal questions should be rediscussed in this regard. Or perhaps, conversely, this possibility will be used as an argument by those who in any case would like to water down the ban on torture, as a way of getting closer to their goal. The question of what exact effects enhancements really have will be a very long-term empirical research task, and it is more than questionable whether we should turn our backs on hard-won ethical standards because of arguments based on effects. But even if we had such studies, a far deeper problem remains: Perhaps enhancements – especially the neurological type – will provoke a shift in what we understand by origination of action. In this respect, ethical standards could actually come

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under enormous pressure. With what justification, for example, could a soldier still be held responsible for a war crime, if as the result of a neuro enhancement he is essentially acting under remote control? This should be counteracted in advance, and soldiers should be told that giving up the origination of action is itself not a responsible act. Soldiers should not agree to this surrender, and military medical personnel should not assist in it, if we don't want our entire field of ethics to collapse.

1 Cf. Bostrom, N.; Roache, R. (2008): Ethical Issues in Human Enhancement, in: Ryberg, J.; Petersen, T.; Wolf, C. (eds.): New Waves in Applied Ethics, Basingstoke, pp. 120–152.

2 One suggestion for anyone seeking an introduction to this extremely extensive debate would be to read Sandel, M. (2004): The Case Against Perfection, The Atlantic Monthly April, pp. 1–11, http://www.theatlantic.com/magazine/archive/2004/04/the-case-against-perfection/302927/ (accessed 4 June 2015).

3 Akademien der Wissenschaften Schweiz (2012 ed.): Medizin für Gesunde? Analysen und Empfehlungen zum Umgang mit Human Enhancement. Bericht der Arbeitsgruppe, Bern, p. 54.

4 As in an article published by the German armed forces association (*Deutscher Bundeswehrverband*) in 2011: https://www.dbwv.de/C12574E8003E04C8/Print/W28HEJVV857D-BWNDE (accessed 4 June 2015).

5 N.N. (2004): Dextroamphetamine Use During B-2 Combat Missions, in: Aviation, Space, and Environmental Medicine 75/5.

6 Torture should probably not be defined by its effects, but, like actions, from the intentions.

7 http://www.theatlantic.com/technology/archive/2012/02/more-than-human-the-ethics-of-biologically-enhancing-soldiers/253217/ (accessed 4 June 2015). I owe many of my examples to Patrick Lin's works on the topic.

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Conflict of Roles and Duties – Why Military Doctors are Doctors

by Daniel Messelken

Wars and violent conflicts result not only in the destruction of material goods but also always mean death, suffering, and injury for the soldiers or combatants involved and the civilian population in the conflict area. The suffering of those injured in war was described impressively and powerfully by Henri Dunant – whose ideas provided the basis for the Geneva Convention and inspired the Red Cross movement – in his book *A Memory of Solferino*. Doctors and medical personnel play an important role in such situations, since they can help to reduce suffering through their knowledge and efforts. For a long time, armies have employed doctors so that their soldiers can be offered the prospect of prompt medical treatment in the event of an injury.

This article briefly outlines what the medical duty is, and its special role in international law, before discussing the problems resulting from the dual role as doctor and soldier, which military doctors can expect to meet conceptually, and unfortunately in reality as well. With arguments based on international humanitarian law and ethics, this article shows that greater weight should be given to the medical role.

Humanity despite war

The first Geneva Convention in the 19th century, and international humanitarian law as applicable today, accord a special status to medical work and the persons performing it. Although military doctors are part of the military, they are regarded as non-combatants and are immune from attack. This special role entails obligations, since protected personnel are not allowed to participate in combat operations, and furthermore are required to treat all people who are injured or in need equally, regardless of nationality, rank, gender, and other non-medical criteria. Medical care should be neutral and bound solely to the principle of humanitarianism. Humanitarianism is a "*principe essentiel*" (Pictet) of international humanitarian law, and should be regarded as a counterweight to the logic of military necessity.

The dual role of military doctors

Military doctors – who are soldier and doctor at the same time – do a job which particularly reveals the conflict between military necessity and the principle of humanity. The combatant and hence "harming" role of the soldier stands in direct contrast to the healing and caring role of the doctor. To some extent, therefore, military doctors are expected, conceptually to fulfill two roles. Yet these roles are not always compatible with one another, and this can lead to role conflicts or contradictory role obligations ("dual loyalties").[1] If the differences between the two roles are blurred in practice and in military doctors' horizon of experience, there is a danger that they will reflect upon these differences less and less, to the point of not giving them sufficient consideration. In today's conflicts, the blurring of the two roles is exacerbated by "embedding" medical personnel in combat units to guarantee rapid medical assistance.

Different role ethics

Anyone who is de facto expected to fulfill two roles at the same time will be faced with

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the question of which role ethics should be considered as being (more) relevant. It is true that the ethical rules for different roles do not necessarily or always conflict, but in the case of military ethics for soldiers and medical ethics for doctors, it must be assumed that the professional ethics result in conflicting duties.[2] Furthermore, military doctors are often bound by two oaths: the Hippocratic Oath and an oath of allegiance to the army.

Thus, on the one hand, there are military ethics obligations and rules. These are mostly derived from the just war tradition. Of primary relevance to soldiers are the rules of *jus in bello*, according to which force may only be used against combatants, and must be proportionate. Thus, even in war, the use of force is subject to rules. The key point, however, is that according to these rules, in certain situations soldiers are morally justified in attacking enemy soldiers. Then they can even use (potentially) deadly force – without themselves necessarily being in a situation of individual self-defense. A military oath or similar vow commits soldiers to serve their country; obedience, bravery, and camaraderie are often cited as soldierly virtues.

In the tradition of the Hippocratic Oath, doctors swear to devote their lives and energies to the health of their patients, to assist their recovery, and not to do them any harm. In modern medical ethics, according to the most influential approach, a physician's actions are in most cases measured against four principles: respect for the patient's autonomy, not doing harm, beneficence, and (distributive) justice. In one way or another, medical ethics considerations usually focus on promoting the well-being of individual patients. (Exceptions to this are sometimes made in research ethics and public health ethics, where in each case the health of a larger group is considered – but without completely losing sight of the individual patient.)

Soldiers and doctors are therefore bound by fundamentally different professional ethics. To put it crudely, one could say that soldiers defend their country and fellow citizens; doctors cure their patients. Whereas medical ethics follows an individual logic, focusing on the patient's well-being, military ethics adopts a collective point of view, aiming for national security and the survival of a group, and hence follows a collective logic.

Problematic dual role in reality

So now, if for the professional group of military doctors it is unclear whether they are bound by military or medical ethics, in practice they will quickly find themselves in a role conflict with loyalties toward both roles. Ultimately it matters little whether this role conflict actually exists or is "only" felt to exist in an individual case. In recent years, at any rate, there has been a series of cases showing that the (perceived) dual role and uncertainty regarding which role is applicable have in reality resulted in significant moral problems and even violations of international humanitarian law. Here one could mention the participation (or even just the presence) of doctors at interrogations which are immoral or illegal in themselves or because of the methods used; but the same goes for questionable triage criteria and non-medical bases for patient selection (rules of eligibility).[3]

Recently, the alleged need for medical personnel and their vehicles to be better armed has been repeatedly discussed, because (it is claimed) they frequently come under attack in present-day operations. Attacks on medical facilities in conflicts are undoubtedly a problem (on this point, cf. the ICRC Health Care in Danger project). However, one should ask whether such attacks can be prevented by arming medical personnel, or whether in fact the increasingly widespread embedding of medical personnel in military patrols – and

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hence the blurring of combatant and medical roles – actually makes such attacks more likely. It is not without reason that from an international humanitarian law perspective, an appropriate physical distance is required between protected units and combatants (cf. Geneva Convention 1, Article 19).

Another problematic blurring of medical and military roles can be found in campaigns to "*win hearts and minds*", in which medical care is instrumentalized for non-medical purposes. Finally it seems at least less likely that doctors will adopt – as is often assumed – a neutral point of view in the documentation of war crimes and the protection of people's rights, if they perceive themselves more as soldiers.

Importance and weight of the medical role

The examples set out above make it clear that from an ethical perspective, the superimposition of medical and military roles is problematic. Such an assessment is reflected in the rules of international humanitarian law and other important regulations, which require a clear separation of roles and assign medical personnel their medical role. According to these principles, military doctors are first of all doctors and, accordingly, are bound by medical professional ethics (even if they are employed and paid by the military). No justification is required for why they act as physicians and in accordance with the rules for doctors. Instead, justification is required if they are to deviate from this role.

This is made clear, for example, in Articles 16 (AP 1) and 10 (AP 2) of the Additional Protocols to the Geneva Conventions, in which it is stipulated that "[u]nder no circumstances shall any person be punished for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom." Rule 26 of the Customary International Humanitarian Law compiled by the ICRC is very similar:

> *"Punishing a person for performing medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited."*

Thus, under international humanitarian law, military doctors in their actions are very clearly bound to comply with medical ethics standards. Interestingly, the authors of international humanitarian law explicitly require military doctors to comply with medical ethical (and hence extra-legal) standards. In other words, the conduct of military doctors and medical personnel in war is determined not only by international law, but primarily by the rules of medical ethics.[4] Hence it can be assumed that the medical role takes precedence.

Of course the question still remains open as to which medical ethical standards apply and whether, in a conflict, these differ from civilian standards. The World Medical Association (WMA) provides the best-known answer to this question in its Havana Declaration. The first sentence reads: "Medical Ethics in times of armed conflict is identical to medical ethics in times of peace." There has been much discussion about this statement (or rather, this demand), and it is often criticized for its generality. The direct transferability of civilian clinical standards to conflict situations is disputed. Certainly in individual cases, and especially in extreme cases, differences may be unavoidable. However, this does not call into question the notion that for doctors, even in war and conflict situations, no other professional ethics standards or ethical principles should be applied.[5] Similar arguments are made by a series of important international organizations (including the ICRC and ICMM), that plan to issue a joint document this year on "Ethical Principles in Healthcare in Times of Armed Conflict and Other Emergencies". It explicitly states in the draft document that the principles and bases of medical ethics remain valid

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and unchanged even in the military context (or generally in emergency situations).

Concluding remarks

In the figure of the military doctor, two roles meet which are bound to conflicting role ethics. This role conflict is not only theoretical in nature – it is seen in reality too (as the examples above illustrate). Current trends of increasingly seeing military doctors as soldiers with special skills are clearly in conflict with international humanitarian law and (medical) ethical principles, both of which accord greater significance and a special position to the medical role.

The blurring of military and medical roles is particularly problematic when it is ultimately the responsibility of the individual military doctor to weigh up the roles against each other – if need be, even on a situational basis. Discussions indicate that military doctors with little experience, or ones who are stationed in combat situations, in some cases suppress their medical ethical and legal obligations and perceive themselves (primarily or exclusively) as soldiers. Group dynamics in small units can amplify this tendency.

From a military perspective, it is important that the special role of military doctors, with their obligations and restrictions, is known and recognized at all levels, including among non-medical personnel. It should also be systematically taken into account in operational planning. This requires the (political) will to respect and protect medical personnel and their independent, neutral medical duty in accordance with the principle of humanity. Ultimately this is also in the interests of the combatants, since this is the only way to guarantee that military doctors are, firstly, able to fulfill their moral and legal obligations, and, secondly, in an emergency are also available as military doctors, when their combatant fellow soldiers or other victims of violence and sufferers in the conflict are in need of medical assistance.

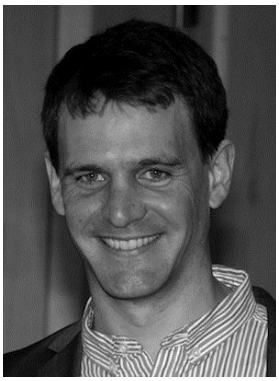
1 Cf. e.g. Allhoff, F. (2008) (ed.): Physicians at war – the dual-loyalties challenge, Dordrecht.

2 An interesting article on this point is Sidel, V. & Barry S. (2003): Physician-Soldier: A Moral Dilemma?, in: Beam, T. (ed.): Military Medical Ethics Vol 1, Washington, pp. 293–312.

3 For current discussions of issues in military medical ethics, see the yearly Annual Proceedings of the ICMM Workshops on Military Medical Ethics, Bern. http://publications.melac.ch [accessed 13 March 2015] and Gross, M. & Carrick, D. (2013) (eds.): Military medical ethics for the 21st century, Farnham.

4 For a detailed account of the role of military doctors under international law, cf. Mehring, S. (2015): First do no harm: medical ethics in international humanitarian law, Leiden.

5 On this point, cf. Nathanson, V. (2013): Medical Ethics in Peacetime and Wartime: The Case for a Better Understanding, International Review of the Red Cross 95/no. 889, pp. 189–213.



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Respect and Distance – *Médecins sans Frontières* and the Military

by Ulrike von Pilar and Birthe Redepenning

The framework of humanitarian assistance: the humanitarian principles

Humanitarian organizations need to keep a distance from armed forces in order to be able to work; at the same time they have to expect respect to be shown for their principles and way of working. Too often this expectation proves to be a tough challenge. Why? This is what shall be explained in the following pages, in this case from the particular perspective of *Médecins Sans Frontières* (MSF). Although MSF is only one of thousands of aid organisation, it is the one which international armed forces will most likely come across if and when they intervene in foreign lands.

MSF is a private international humanitarian association providing medical assistance to populations in distress. Like many humanitarian organizations, MSF assists those in need irrespective of their race, religion, creed or political convictions. Independent international nongovernmental organizations (NGOs) like MSF are different from UN organizations which are always politically dependent and also differ from the International Committee of the Red Cross (ICRC) which has an official mandate to operate in situations of conflict and a special responsibility to protect people affected by conflict.

While there is no legally binding definition of humanitarian aid, four principles are commonly understood to form the essential framework for humanitarian action: Humanity (which is more of a fundamental value than a principle), impartiality, independence, and neutrality. These are based on the Geneva conventions and the Code of Conduct of the Red Cross and Red Crescent Movement.

Humanity means that individuals are treated humanely and with respect for their human dignity in all circumstances. In that sense, humanity forms the basis of humanitarian aid; it justifies its use and importance because every person, being human, is entitled to life-saving assistance. Impartiality translates this shared humanity into practical work: Aid must be given solely on the basis of need, and as such should not allow for any adverse discrimination based on nationality, ethnicity, gender, sexual orientation, religion or affiliation to any particular political group. Impartiality also means that to the extent possible, the most vulnerable should be supported first. Aid that does not aim to be impartial cannot be considered humanitarian. Independence means that aid should not be constrained or influenced by military, political, ideological or economic interest; this principle is vital for any humanitarian organization striving to implement impartial aid programs. And finally, neutrality means that humanitarian organizations are not to take sides in situations of conflict and that aid should not be used to favor one side or support political or economic goals.

Evidently the reality of humanitarian aid is much more messy and complex even when aid organizations strive to live and work according to those principles.

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Blurring the lines: the instrumentalization of humanitarian aid

Beginning with the end of the Cold War and the collapse of the Soviet Union, international armed forces and humanitarian organizations have increasingly found themselves working alongside each other in cases of armed conflict: North Iraq at present and Somalia, Bosnia, Kosovo and Afghanistan in the early 1990s are cases in point, to name just a few. Many of these military interventions (so-called humanitarian interventions) have been justified, at least partly, by governments as having 'humanitarian goals': Supporting the affected populations or protecting the work of humanitarian organizations in the conflict areas. After 9/11, this process took a new turn, as governments started using humanitarian aid as one of several tools to counter terrorism and/or stabilize fragile situations, through a comprehensive approach that ties security to aid and development in the context of international crisis management.. The matter is far more complex than what can be illustrated in a single article or lecture – most of today's armed conflicts involve a range of state and nonstate actors, all of whom use and misuse aid and tend, for a variety of reasons, to restrict humanitarian access to populations in need.

The extent to which aid has become an integrated component of Western countries' foreign and security policies has increased so much over the past two decades that Antonio Donini, a well-known expert and researcher on humanitarian aid, wrote in his book "*The Golden Fleece*" in 2013 that "humanitarianism has become part of global governance, if not of government". For many humanitarian organizations, and certainly for MSF, this represents a critical breach of humanitarian principles – one that endangers the ability of humanitarian actors to provide help to vulnerable populations.

The very real consequence of this is a growing distrust towards humanitarian organizations by local authorities or communities in numerous conflict areas. This may stop humanitarian access to populations in need. In Pakistan, for example, MSF and other organizations have been struggling to gain access and acceptance while armed groups — state and non-state — have used a number of reasons to deny aid organizations access to locals. In 2011, when the U.S. government was said to have employed a fake vaccination program in the search for Osama bin Laden, the damage was almost immediate – and it will be long-lasting. Another example is the deployment of German government forces in northern Iraq to assist with the training of Iraqi security guards in 2015.[4] By integrating a so-called humanitarian response into a broad military-political approach, the German government purposely blurs the lines between humanitarian action and a political or military response that threatens humanitarian organisations' access to the area.

At the same time, access to people in need may be reduced when they avoid seeking assistance, because they have to fear retribution from one of the warring parties. MSF's field experience in the conflict-torn province of North-Kivu in the Democratic Republic of Congo illustrates this : "In October 2009, hundreds of women and children who had gathered for a vaccination campaign [...] came under fire in seven separate villages during attacks by the Congolese Army against the *Forces Démocratiques de Libération du Rwanda* (FDLR). These attacks occurred just after the medical teams had received security guarantees from all parties involved in the conflict to carry out the campaign in these areas, which were otherwise inaccessible to the national ministry of health. This use of medical aid as bait for military purposes shattered the trust of patients in health services, causing only more

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suffering for people already confronted with violence and displacement."(This account is taken from an MSF report.)

Increased insecurity for humanitarian workers are another direct consequence of the lack of trust. Indeed, when assistance is seen as part of a political or military agenda, aid workers may be at risk of becoming a target themselves. While there is no formal evidence to tie the integration of humanitarian aid into Western security policy to the increased violence faced by aid workers, most experts nevertheless agree that the rise in safety risks for humanitarian staff is also a consequence of the policies described above. Certainly Afghanistan proved to be a very dangerous place for relief agencies to operate in, because the integrated approach made it extremely hard – for the local population and the parties involved in the conflict alike – to differentiate between independent aid workers and members of the Provincial Reconstruction Teams (PRTs). At the same time, some aid agencies were also complicit in this confusion, as many of them accepted funding from Western states that were party to the conflict or sought military protection for their staff, which is incompatible with humanitarian principles, particularly the principle of independence. Recent studies, for example by Tufts University, have also shown that the underlying approach to staff safety is not effective.

Even today, Afghanistan remains quantitatively the most dangerous place in the world to engage in relief work: According to the Aid Worker Security Report 2014, the number of attacks on aid workers increased by 45 percent in 2013 compared to the previous year. This is in part due to military involvement in activities traditionally implemented by aid agencies and the resulting blurred boundaries between both groups. The consequences for the perception of the neutrality and independence of aid in the country have been dramatic, as MSF has repeatedly shown, including in the 2014 report *Between Rhetoric and Reality: The Struggle to Access Healthcare in Afghanistan*.

Tentative regulations for coexistence

Due to the massive increase in so-called integrated missions, the need to clarify the roles of humanitarian and political actors grew. This is why a number of rules and regulations have been introduced since the 1990s. These include, for example, Good Humanitarian Donorship (2003), the European Consensus on Humanitarian Aid (2007) and the Oslo Guidelines (2007).

These documents reiterate that humanitarian aid aims to preserve human life and alleviate suffering in situations of crisis. They also stipulate that aid must be needs-based and should not be used as an instrument towards political or military ends. The European Consensus on Humanitarian Aid adopted by the EU and its member states, for instance, states that "respect for independence means the autonomy of humanitarian objectives from political, economic, military or other objectives, and serves to ensure that the sole purpose of humanitarian aid remains to relieve and prevent the suffering of victims of humanitarian crises".

In a similar way, the 2009 Lisbon Treaty reflects the tensions between a commitment to humanitarian principles and comprehensive approaches to foreign policy and action. It states that "the Union's operations in the field of humanitarian aid shall be conducted within the framework of the principles and objectives of the external action of the Union."[2] This effectively institutionalizes the Union's comprehensive approach to international crisis management. Significantly, the principle of independence of humanitarian aid is explicitly avoided in the treaty. This negation or contradiction of humanitarian principles has been criticized by many humanitarian agencies as

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potentially further reinforcing the politicization of aid.

As we have seen, aid increasingly became subsumed under overall strategies to fight the "war on terror". As such, it came to be used as a reward for political good behavior or to deprive those groups who are politically unwelcome and/or considered terrorists (such as UNSCR 1373) of aid. Thus, a number of UN resolutions and laws (e.g. UNSCR 1373, UNSCR 1390) were passed at the time that criminalize any transfer of resources, including humanitarian aid, when these are intended for groups or individuals who are labelled as terrorist.[3] These laws have been adopted at UN and EU level and became national law in some member states. They make it a criminal offence when aid organizations negotiate with groups that are considered terrorists or offer support to the populations living under the control of such groups. Thus, despite all efforts, humanitarian organizations like MSF keep facing major obstacles when working alongside international armed forces. Therefore it should be clear why MSF refuses to cooperate with military groups and strives to work as independently as possible from military interventions.

Don't we all just want the same?

Do we even have to bother discussing the humanitarian principles and their implementation, and legitimacy on this extremely theoretical basis? Doesn't it all come down to MSF also wanting security and stability in armed conflicts and to promote peace, democracy, and human rights? In other words, don't we all want the same thing?

These are questions MSF is frequently faced with. The fact is, however, that while stability, security, democracy, and human rights may be desirable and praiseworthy, they are not the responsibility of humanitarian organizations. Their role is not to support any particular ideology or world view; it is merely to save lives and alleviate suffering. For MSF, it is important to insist on this distinction.

Of course, humanitarian action does not happen in a vacuum. Aid workers operate in a political context, often finding themselves knee-deep in local and international political debates. It could be said that there can, in fact, never be a truly neutral position to any conflict – certainly not in the perception of the local population or any number of involved armed groups. Humanitarian aid, too, always has a function and a motivation; however, one that is more in the eye of the beholder to judge than in our own eyes. Indeed, while MSF strives to remain as neutral as possible, sometimes, in exceptional circumstances, we raise our voice and take a political stance. Staying impartial, independent and neutral in today's complex armed conflicts is often a difficult balancing act. It is not our intention, in these arguments, to place humanitarianism above politics or deny that MSF itself sometimes has to make difficult compromises to try to help those people who are suffering the most in today's world.[5] But recognizing the complexities and challenges of humanitarianism in action does not legitimize the increased misuse of humanitarian aid evident in Western politics since the beginning of the 1990s.

The stakes are high: Today, there are millions of people affected by armed conflicts and crises that aid workers cannot reach. While there is more humanitarian aid today than ever before and the sector has immensely professionalized, aid is very unevenly distributed, and, all too often, not needs-based.[6] This is in large part a result of the instrumentalization, criminalization and abuse of aid resulting from the politics discussed above.

For MSF, certain fundamentals are indispensable for a coexistence with political and military actors:

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The humanitarian principles remain the key framework for defining aid. Some claim the principles have lost relevance or that they never had much meaning on the ground. But despite the challenges involved and the compromises that have to be made sometimes, for MSF, as well as for many other humanitarians and for many concerned politicians, the humanitarian principles remain a valuable tool for defining and delineating what humanitarian aid should do and how it should do it. Therefore, more knowledge of and respect for these principles is needed.

We also know this: Accepted, credible programs are our best safeguard against distrust. We aim to provide the best possible medical care we can. Helping local communities is usually the best way to ensure these communities trust us and our claim that we have no other aim but to help them. Our financial management is important for this reason. MSF relies mostly on private funds and, in cases of armed conflict, does not accept money from states involved in the conflict concerned. In certain prominent cases of armed conflict, like Syria, Afghanistan or northern Mali, we do not accept funds from any government. Altogether, MSF's work is 90 percent privately funded.

We talk with everyone (who talks with us). Providing healthcare to communities in volatile conflict areas requires MSF to demonstrate its independence and impartiality every day in a painstaking daily effort to communicate with all the actors involved in a conflict. We monitor the perception of us (well – we try). How a humanitarian organization is perceived locally influences its capacity to work and the safety of its staff. How a humanitarian organization is perceived internationally impacts on its capacity to wield political influence. This is a complex affair – many internal and external factors, often hardly understood, contribute to our counterpart's perception of our work.

We keep a distance from all political actors, especially the military. We almost never accept armed protection and we do not comment on political or military strategy in difficult cases of armed conflict. Therefore we are not official members of any UN coordination bodies and clusters. The UN is a political organization of its member states as well as being in charge of coordinating humanitarian assistance. As we have shown, this can become very problematic in conflict areas, when the UN plays both a humanitarian and a highly political role.

MSF will continue to call on governments to respect the independence and autonomy of humanitarian aid actors. European states, including Germany, must ensure an independent space for humanitarian aid and must also make sure that it can be clearly distinguished from other crisis management tools. In particular, states should stop labelling their political/military interventions as "humanitarian", or describing humanitarian aid as part of a wider political and security strategy.

1 "Es ist unsere humanitäre Verantwortung und unser sicherheitspolitisches Interesse, den Leidenden zu helfen und ISIS einzudämmen. Die Unterstützungsleistung der Bundesregierung tragen zur Linderung der unmittelbaren humanitären Notlage und zur Stabilisierung der Lage im Norden des Iraks bei." (Seite 6). Further: „Die deutschen Unterstützungsleistungen sind eingebettet in einen breiten politischen Ansatz, der von der großen Mehrheit der Staatengemeinschaft getragen wird und auf politischer, militärischer und rechtsstaatlicher Ebene wirkt." (Seite 7) and „Die militärischen Unterstützungsmaßnahmen zugunsten der irakischen Streitkräfte bleiben eingebettet in einen ganzheitlichen politischen Ansatz und werden in Ergänzung der weiterlaufenden Entwicklungszusammenarbeit, Wirtschafthilfe sowie der fortgesetzten humanitären Hilfe umgesetzt. Abhängig von der weiteren Entwicklung und Umfang der Ressort-Engagements wird dieser Ansatz weiter zu entwickeln sein." Motion of the German Federal Government „Ausbildungsunterstützung der Sicherheitskräfte der Regierung der Region Kurdistan-Irak und der irakischen Streitkräfte" (*Drucksache 18/3561*).

2 Ibid. Chapter 3, Article 188 J, Paragraph 1.

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3 Mackintosh, K. & Duplat, P. (2013): Study of the Impact of Donor Counterterrorism Measures on Principled Humanitarian Action, p. 18 ff.

4 In the 2011 book "Humanitarian Negotiations Revealed: The MSF Experience", MSF openly explores the kind of compromises the organization has had to make, their limits, and the challenges to neutrality.

5 Healy, S. & Tiller, S. (2014): Where is everyone? A review of the humanitarian aid system's response to displacement emergencies in conflict contexts in South Sudan, eastern Democratic Republic of Congo and Jordan 2012–2013, *Médecins sans Frontières.*

This article is based on the lecture and publication "Humanitarian action and Western military intervention – a view from Médecins Sans Frontières Germany" by Ulrike von Pilar, Corinna Ditscheid, and Alfhild Böhringer – Médecins Sans Frontières / Ärzte ohne Grenzen, Berlin

Ulrike von Pilar *is currently heading the team for humanitarian issues for MSF in Berlin. She is a mathematician with a doctorate in biomathematics from the University of Tübingen (Germany). In 1991 she started working with Médecins Sans Frontières (MSF) in Brussels, cofounded the German division (Ärzte ohne Grenzen) of MSF in 1993 and became MSF's founding president in Germany. From 1997 to 2005 she served as executive director of MSF in Germany. For the past few years, she has been the principal advisor for the Berlin Humanitarian Congress. From June 2009 until April 2012 she served on the board of MSF UK and of MSF East Africa. She has published a number of articles on humanitarian issues and in 2011 a book about the 40-year history of MSF.*

Birthe Redepenning *holds a Masters Degree in Non Profit Management and Public Governance. She completed her Bachelors Degree in International Cultural and Business Studies. From November 2011 from March 2014, she has worked at Médecins Sans Frontières (MSF) in the donation department. Since then, she has been working as assistant of the executive director, also supporting the Advocacy-team in the Berlin office.*

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Helpers in Danger – New Challenges in Armed Conflicts

Bombed hospitals and medical personnel under threat – war does not stop even for helpers. Kidnappings of employees of international aid organizations are becoming reality more and more. In recent years, the number of humanitarian workers who have come under attack in war zones and crisis areas has increased significantly. From 2012 to 2014, the International Committee of the Red Cross (ICRC) recorded 4,275 helpers and patients who fell victim to violent attacks in 11 countries. During the same period, there were 60 cases of medical facilities being misused as a military base. International aid organizations and also the UN are increasingly worried and are looking for explanations. Terrorist groups are frequently involved in attacks on humanitarian workers.

If enemies do not respect the protections conferred by the Geneva Conventions, and if they do not respect International Humanitarian Law, then all medical personnel are at risk. At least since the war in Afghanistan, the symbol of the red cross has lost its purely protective effect, and has increasingly become a target for attacks. Today, there is a fundamental concern that in military medicine a new way of thinking and accordingly "new values" may start to emerge. A wish for "new ethics" which make it acceptable to give preferential treatment to one's own fellow soldiers seems to be evolving. This can be attributed to ongoing asymmetrical conflicts and their atrocities such as the barbarity of the Islamic State (IS) in recent years.

In today's armed conflicts, military medical helpers face inner conflicts and dangers from all sides. This is not new, however, today it can be more dangerous to openly display a doctor's kit on the passenger seat rather than a machine gun. This is true just as much for humanitarian aid workers as for military doctors. Aid organizations often remain in crisis areas even though the situation is too dangerous. Does that make it their fault if something happens to them, and who should help them?

For many medical helpers, it is important to make a clear distinction between humanitarian and military missions and accordingly between NGOs and armed forces. However, when it came to Ebola during the course of this year, the first ever partnership between the Red Cross (DRK), the International Red Cross (ICRC), Doctors Without Borders (*Médecins Sans Frontières*, MSF) and the German armed forces was realized. They worked closely and successfully together, right from the preparatory stages.

Even helpers need helpers – in many respects. Right now, the medical department of the German *Bundeswehr* is working on new guiding principles. If in doubt, military medical personnel shall always decide "in favor of humanity". Coping with principles of humanity and the reality of today's armed conflicts is both challenge and opportunity for new guiding principles. Military medical ethics finds itself in a quandary, in several ways. All the more, contemporary, multinational, and balanced ethics education that specifically teaches moral and ethical skills will be indispensable in the future.

Gertrud Maria Vaske

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Chief Editor
"Ethics and Armed Forces"

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Healthcare in Danger – How Helpers Become Victims

Babak Ali Naraghi *has been in charge of the Health Care in Danger project since November 2014. He has more than 10 years of field experience with the International Committee of the Red Cross (ICRC) at various managerial levels in areas such as Afghanistan, Guinea-Conakry, Sudan, Uganda, and Sri Lanka. Since 2000, he has been based at the ICRC headquarters in Geneva, where he acted first as deputy then ad interim Head of Operations for North and West Africa. Naraghi holds a Master's degree in Political Science.*

In today's armed conflicts, all too often healthcare personnel and facilities become the targets of deliberate attacks, or are the victims of indiscriminate warfare. Medical ethics and impartiality towards patients are not upheld and the Red Cross ceases to be a symbol of protection. The immediate impact of such violence is straightforward for the sick and the wounded. However, the knock-on effect on the entire population and the country's healthcare system is even more dramatic. Hospitals are destroyed or close, healthcare personnel are killed or flee, facilities are unable to function for lack of essential supplies. Access to essential services such as primary healthcare, vaccination programs, maternal and child care, assistance for chronic diseases is simply denied. The issue at stake is immense.

One hundred fifty-one years have passed since the First Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field was adopted. The main principles laid down in the Convention are: relief to the wounded without any distinction as to nationality; neutrality (inviolability) of medical personnel and medical establishments and units; the distinctive symbol of the red cross on a white background as an emblem protecting medical personnel, establishments and units.

Since their establishment, Red Cross and Red Crescent National Societies have played an essential role as auxiliaries to the military medical services and together with the International Committee of the Red Cross, strive to provide victims of armed conflict and other emergencies with access to healthcare services. Nonetheless, one hundred fifty-one years after the adoption of the First Geneva Convention, the violation of the main principles laid down therein constitute a dramatic yet often overlooked humanitarian issue.

Alarmed by the challenges posed by today's armed conflict to the safe delivery of and access to healthcare, in 2008 the International Committee of the Red Cross (ICRC) started collecting and analyzing data on violent incidents jeopardizing healthcare in 16 countries affected by conflict or other emergencies. The 16-country study emphasized how the problem of insecurity and violence affecting the delivery of healthcare should not be regarded as the simple sum of single incidents, but rather, due to its consequences, as a complex humanitarian problem to which solutions lie not exclusively with healthcare professionals but more comprehensively in the domain of law and politics, in humanitarian dialogue,

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and in appropriate preventive measures devised by a variety of stakeholders.

The results of this study were presented to around 3,700 participants from over 180 states party to the Geneva Conventions in 2011 at the International Conference of the Red Cross and Red Crescent. This prompted the adoption of Resolution 5 – Health Care in Danger, giving mandate to the ICRC to initiate consultations with experts from states, the International Red Cross and Red Crescent Movement, and others in the health sector, with a view to making the delivery of healthcare services in armed conflict and other emergencies safer. The Health Care in Danger (HCID) project was born.

This initiative has since brought together various stakeholders such as legislators, policy makers, government health-sector personnel, arms carriers, humanitarian agencies, representatives of academic circles, and civil society leaders to identify concrete and practical recommendations whose implementation could ensure better respect and protection for healthcare delivery.

Tackling the issue of violence against healthcare from different perspectives, 12 workshops were conducted worldwide as well as direct consultations with the above-mentioned actors, including domestic legislation, state military practice, ethical principles in healthcare, the role of civil society leaders, the safety of healthcare facilities, ambulance and medical transportation, practice of non-state armed groups. Accordingly, a set of measures to improve safe access to and delivery of healthcare have been produced, including measures directly relevant to military operational practice in the following circumstances: conduct of search operations and arrests in healthcare facilities; manning of checkpoints, and conduct of hostilities in the proximity of a healthcare facility. Indeed, through the HCID data collection exercise, the ICRC continues to observe that military forces are among the major perpetrators of incidents against health care, particularly in the three contexts described above.

Many, if not most, of the recommendations elaborated in the HCID project are of a preventive character, so as to ensure, for instance, adequate preparedness of healthcare providers, authorities, or armed actors to anticipate challenges posed by insecurity and violence against healthcare delivery and/or mitigating their effects in the event of armed conflict or other emergencies.

The preventive character of HCID recommendations is apparent, particularly in the following areas:

- Military doctrine and training[1] that will contribute to ensuring safe access to, and delivery of, healthcare in the event of armed conflicts and other emergencies.
- Preparedness of healthcare facilities. Through adequate contingency planning the impact of violence against healthcare facilities can be mitigated, if not avoided completely.
- Training of healthcare personnel[2], not only relating to technical aspects of how to deliver healthcare, but also, and especially on their rights and responsibilities and on ethical dilemmas they may confront in the event of armed conflicts and other emergencies.
- Training and engagement of Red Cross and Red Crescent National Societies.
- Appropriate coordination between all stakeholders involved in providing emergency healthcare. This requires both plans for such coordination as well as scenario-based training during peacetime.
- Development of domestic normative frameworks[3] to implement international

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legal obligations relevant to the protection of the provision of healthcare in armed conflicts and other emergencies. To be effective in the event of armed conflicts and other emergencies, suitable domestic normative frameworks need to already be in place during peacetime.

Over the years, strong partnerships with relevant actors, such as the World Medical Association, the International Council of Nurses, the International Council of Military Medicine, the International Federation of Medical Students Association and the World Health Organization came into existence. Indeed, tackling the far-reaching humanitarian consequences of violence against healthcare requires efforts by different actors.

The issue is gaining momentum at the global level and a number of important achievements can be highlighted. For example, in December 2014 during the 69th session of the United Nations General Assembly the Foreign Policy and Global Health Resolution was adopted, together with other three resolutions. The four resolutions call on states to 1) protect the delivery of health care, 2) reinforce the resilience of national health systems, and 3) take appropriate measures to prevent and repress violence against healthcare; thus paving the way to stronger international engagement to ensure safer access to and delivery of healthcare.

Looking ahead, the International Conference of the International Red Cross and Red Crescent Movement, taking place in December 2015, will represent another important milestone. There, participants will have the opportunity to reiterate the importance of the issue, recognize its potentially far-reaching humanitarian consequences, both immediate and long-term, and commit to the implementation of the recommendations issued from the HCID project.

1 For details, see the HCID publication: "Promoting military operational practice that ensures safe access to and delivery of health care".

2 For details, see the HCID publication: "Ambulance and pre-hospital services in risk situations"; "Health care in danger: The responsibilities of health-care personnel working in armed conflicts and other emergencies".

3 For details, see the HCID publication: "Domestic Normative frameworks for the Protection of Health Care".

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New Values for Military Medical Personnel? Medical Ethics in Military Context

Ingo Patschke *joined the German armed forces in 1973. He has been Surgeon General of the German Bundeswehr (Inspekteur des Sanitätsdienstes) since 2011. He was awarded the Bundeswehr Silver Cross of Honor in 1994 and the Bundeswehr Gold Cross of Honor in 2000, and in 2002 he received the Bronze German Armed Forces Deployment Medal for flood relief efforts. In 2006 he was awarded both the German Armed Forces Deployment Medal for service with the International Security Assistance Force (ISAF) in Afghanistan, and the NATO ISAF medal. In 2014 he was presented with the Officer's Cross of the Order of Merit of the Federal Republic of Germany.*

In discussion rounds, I often get the sense that younger military doctors and medics sometimes hold a more radical view about certain things than the "old timers" – myself included.

Of the many different ethical dilemmas which we face in the medical service, I would first like to single out the conflict between the roles of physician and soldier. Publications by medical officers on this topic have been around for many years and in them they write from different perspectives about their understanding of their role, first as a doctor and then as an officer. I believe that particularly in light of overseas deployments, interest is increasingly focusing on the question that lies behind this, not only for the physician but generally for every member of the medical service: "What do we actually do in a combat situation – are we more medics or more combatants?"

At the moment, with the assistance of prominent ethicists, we are discussing the question of how we see ourselves as medics. Are there situations in which it is unavoidable or in which we are almost ethically obligated to take part in fighting – and what are the limits? Should we hide the Red Cross, so as not to become a target, or should we even go as far as to arm ourselves as heavily as possible?

This discussion is still a long way from being resolved. At a generals' meeting at the end of 2014, we examined this question as one part of an overall picture – the medical service's self-image.

Another dilemma can be seen when we act as a doctor, paramedic or medic during operations. How should we regard the relationship between ourselves and our patients in these circumstances, particularly given that we may be required to carry out a triage assessment? We can all recognize a mass casualty (MASCAL) situation, i.e. a situation in which the number of patients is too high for adequate treatment to be provided with the available resources. This means that even if the patient is one of our own soldiers, we still essentially carry out a usefulness assessment, in that we weigh up the chances for a patient who is very seriously injured against the possibility of being able to save many other patients who have lesser injuries. Thus there is a certain point when we lack personnel or material resources and we need to move away from individualized medicine as we know it in Central Europe, the United

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States, or Israel toward a consideration of the possibilities in such emergency situations.

But in my opinion this is not the actual dilemma. Rather, the ethical question is whether we should look after our own first, so to speak: Isn't an injured soldier who is a member of the *Bundeswehr* or my coalition more important and worthy of treatment than a civilian or – even worse – an enemy? After all, we are not the German Red Cross, we are the *Bundeswehr*'s own medical personnel. As a military medical practitioner, I should be aware that my actions have an impact in three ways. Firstly on myself as the person providing treatment: I set ethical and medical standards for myself which I intend to meet. Then of course my actions have an effect on the potential patient – and if this is an enemy patient, whether I treat him or not has a considerable impact on the enemy. And the third group is my own soldiers – the people who I am actually there for. They put their trust in me and demand that I put them first. The good reputation of the *Bundeswehr*'s medical service during operations also rests on the trust troops have in one another and particularly the perception that we are there for them – whatever the conditions.

If we detract from this good reputation by treating others as well as or before our own soldiers, they might see this as a problem that needs to be confronted. I think this is something we definitely need to keep in mind, especially from the perspective of our obligations during operations.

The third dilemma, as I personally see it, lies in the fact that war and enemies have changed over the years. When I was a medical officer and a young staff surgeon, the most likely threat that I could think of was a war between NATO and the Warsaw Pact nations stemming from a possible confrontation. In this scenario, one could appeal to international humanitarian law, and there were – at least in theory – rules concerning how I would be treated as a medic or medical officer by the enemy and how I, as a medical officer, I should treat my enemy if I should encounter him as a patient. Given the mutual ethical obligations, I felt there was a certain degree of balance.

In modern conflicts and asymmetrical wars – currently we need only look at northern Iraq – we see significant differences. To be honest, what we see here and saw in the past in Afghanistan is, in my opinion, a real problem. For me, the enemy in Afghanistan and – worse still – IS, have a different quality. Somehow I had an emotional understanding of the old type of enemy. This enemy was a person from my European cultural group. In principle his task was the same as mine, only reciprocal. In the new wars – these asymmetrical conflicts – in which terrible things frequently happen, I often lack empathy, and personally I would have difficulty acknowledging some enemies as pitiable individuals if I encountered them as patients. This definitely makes a difference. And in this I see a dilemma that, in my view, creates an ever greater gap between what is legally correct and what is right. The fact that international humanitarian law is becoming less and less applicable in these kinds of intrastate conflicts is a big problem, especially for the medical service.

Therefore I firmly believe that events, discussions, publications, and lively dialog relating to these topics are extremely valuable and appropriate for adjusting our moral compass and developing our awareness of what it is that we stand for. Our Basic Law (*Grundgesetz*), enlightened humanism, or our religion – to name just a few – are key values for our self-understanding and which, in my view, we should bring into position against the atrocities of modern asymmetrical conflicts.

We – the older generation – should assume responsibility here in the discussion and can-

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not leave everything to the younger generation, even if they undeniably represent the future of the medical service. We should prepare our young people for situations which could arise in war or in such conflicts so that they can develop an intellectual concept of these dilemmas and ethical expertise for dealing with them. We really should promote dialog with the younger generation about these potential issues. In the last two years, we had a wave of conscientious objection within the medical service. A great number of those who wished to assert their right to conscientious objection were clearly financially motivated by the possibility of earning good money outside of the German armed forces. But I do not deny that there were some among them whose "eyes had been opened" by a difficult operational situation, who could not come to terms with it, and decided they could no longer carry on in such an emotional and ethical quandary. Consequently they sought a way out of the *Bundeswehr*. In my view, it was and is right to enable them to do this, since the right to conscientious objection should be observed in a democracy.

So let's keep talking and hope to have many stimulating and controversial discussions on this topic. Medical ethics in military contexts will continue to create major challenges for us in the future.

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Who Helps the Helpers? The First German Military Chaplain on an Ebola Mission

An interview with Andreas-Christian Tübler by Gertrud Maria Vaske

Andreas-Christian Tübler *is an Evangelical Lutheran military chaplain and has been head of the military chaplain's office for Appen/Heide/Seeth since 2010. He is part-time lecturer at the German Federal Armed Forces Command and Staff College and has taken part in various overseas missions. In 2014, he spent two months with the German federal armed forces' training contingent in Mali (west Africa). In 2015, he volunteered for the ebola humanitarian aid mission in Liberia, where he assisted soldiers as well as the German Red Cross.*

It was the outbreak of Ebola which led to the German armed forces, German Red Cross (*Deutsches Rotes Kreuz*, DRK), International Red Cross (ICRC) and Doctors Without Borders (*Médecins Sans Frontières*, MSF) working together for the first time in Germany's history. They established synergies in their Ebola prep courses, and benefited greatly from each other's capabilities during this humanitarian mission. Andreas-Christian Tübler was the first German military chaplain in Liberia. He was there in the field for the helpers and victims.

Vaske: Luckily, few people contracted the disease when you were in the field during the Ebola mission, but there was still a constant fear of infection. What exactly was the purpose of these missions and what was your role as military chaplain?

Tübler: The task and objective of these missions both for the German armed forces (*Bundeswehr*) and the Red Cross was to break the infection chain. The goal was to break the Ebola infection chain from its outbreak to its end, to provide first aid for people who were infected, and to establish security for the populace. The military chaplain's task is to offer stability to *Bundeswehr* soldiers – we didn't know exactly how big the threat would be. We were certainly prepared to expect many Ebola deaths during the training stage in Hamburg. As it turned out, this fear was groundless, but nevertheless, every patient in our facility during the first two days was treated as if they could have Ebola until there was a conclusive blood test, and this meant being on standby 24/7.

What exactly were you able to do in Monrovia, the capital city of Liberia? What was your daily work routine?

The daily routine began at 6 a.m. and ended at 9 p.m. Among other things, we needed to be present at the adjacent camp (a 200 x 200 m tent city for the wounded and injured) to talk with people, including *Bundeswehr* personnel, the Red Cross, and finally local people. At the end of the day, we returned to our hotel, talked about our experiences with the soldiers, and organized our free time together (religious services etc.).

What exactly were you able to give the soldiers and volunteer helpers? How were you able to help them?

I don't know if you can pinpoint it specifically; I was there to hold talks in the back-office area,

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i.e. behind the scenes of what was going on in the camp, and to give the soldiers reassurance that they were doing a good job. I talked with the people involved about the problems that they had in particular situations. For example, we did not have any Ebola patients, but we had a series of HIV patients who needed our special attention and that was not always so easy. You saw serious injuries or necrotic limbs; and the psychological situation of patients and carers was ambivalent. That's why things needed to be talked through with everyone. Ultimately, my job is to offer a sympathetic ear to the people in the field.

What do you say to the people on the ground to relieve their specific concerns?

It is about making sense of experiences and particular situations in the form of conversations (question and answer). I experienced the situation firsthand and I visited patients myself, including HIV patients. Although I wasn't in the suspected Ebola area, I was in the area where there were people who were seriously ill with other infectious diseases. You can try to devise a joint strategy or vision for the future, e.g. in thinking about how to improve the situation in the country, strengthen the healthcare system, or by providing external funding – but of course that alone is not enough. There is corruption, high levels of poverty, and people tend to act out of self-interest. There needs to be "external supervision", for example people who manage hospitals on behalf of others. We jointly developed these considerations.

The pharma industry found a drug to fight Ebola. Why is it still necessary to continue the work?

Ebola could break out again any day. You can't assume that this disease is beaten if there are no new cases after four weeks. As a disease, Ebola has been known about for more than 30 years. It wasn't until there was a specific threat from people traveling into Europe that government and industry took action – this should change. A white helmet force should be specially trained for infectious diseases to enable faster intervention. Also, there are many villages and areas that we have not been to yet, as they are inaccessible due to poor infrastructure. Of course it may be that there are still Ebola patients in these places, but we simply don't know it. Liberia, Sierra Leone, and Guinea are a gray zone, since no one can say for sure whether Ebola is beaten. That's why there is still a need for caution.

How afraid were you of catching Ebola?

People were not afraid, but there were always overtones of apprehension. In November last year, we were told to expect many deaths. Fortunately it didn't come to that. I was less afraid because I knew that if we protected ourselves properly, washed our hands and took all precautions, we could actually live with the risk quite easily.

Ebola provoked fear, sympathy, and a desire to help. For the first time, the German armed forces, Red Cross, and Doctors Without Borders worked together in preparatory courses and in the field. How well did you work together?

All things considered, it went very well. The level of cooperation was excellent; we saw that after the mission as well. After the mission, we had a joint mission follow up, in which we discussed our experiences and even made new friends.

Things went very well at management level too. The trouble is that the task situation – but that could be partly me – was not so very clear. It was a question of the allocation of tasks. As the *Bundeswehr*, we were only supposed to have a supporting role, but we did far more than that, including providing medical assistance. The Red Cross was head of mission, but in future there could be a clearer defini-

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tion of who has to perform what task profile. Otherwise it was good: Transparency creates trust and for subsequent missions it should be determined what the task is and when the mission is to be considered complete. I don't think there were any major points of criticism about the mission – quite the opposite, in fact. The fact is that both sides learned from each other and prejudices were put aside.

Do you think that such joint efforts in civil missions should be encouraged in the future? What synergies could result from that, especially for the military chaplaincy?

Quite possibly. Especially if we're talking about aid missions and not combat missions, I can definitely envisage pooling resources. Provided that the task situation (who does what?) is clear for the individual areas and institutions, such partnerships can be implemented with Doctors Without Borders, the German Society for International Cooperation (*Deutsche Gesellschaft für internationale Zusammenarbeit*, GIZ), or other partners.

Military doctors are doctors and soldiers. As a military chaplain, did you find that military doctors or helpers were in a situation where this dual role was very much perceived as a conflict?

Not during the last mission. There are situations in combat missions in which this conflict of roles can come up. Personally I have not experienced this conflict.

The case here was that the doctors were completely professional, both in the Red Cross and in the *Bundeswehr*. All doctors had experience being deployed overseas and they all knew what they were getting into; they were real professionals. But professionals with a soft heart who had a keen awareness of the concerns and needs of people affected locally. I found that very positive. So they saw no conflict in their role. On the contrary, they felt really comfortable in their role.

You have worked overseas as a military chaplain several times, not only in the Ebola mission. Which missions were especially precarious and where did the life-threatening dangers lurk?

The fact is that the situation is never totally relaxed. Even in noncombat missions such as the education missions in Mali, danger is always implicit and there is always a residual risk. There could be an attack on the way to visit the embassy (fortunately that has never happened, since the *Bundeswehr* takes all the necessary steps) or of course you could get an infectious disease. It doesn't have to be Ebola – it's bad enough if you get malaria or other diseases. The German armed forces do everything to reduce this risk, but nothing in the world is entirely safe or risk-free.

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Beware of the "Slippery Slope" – Healthcare Professionals between Medical Ethics and Military Duties

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In connection with the profession and status of the medical officer, we consistently encounter a conflict between the roles of doctor and officer – actually this recurring theme appears as a kind of metaphor for a wide variety of conflicts (of conscience) that tend to be vaguely sensed rather than tangibly defined. And indeed, perhaps there is no other area of the military in which so many contradictions (some of which concern basic assumptions about which there is general consensus in society) are more apparent than in the role of the medical officer, who pairs two conflicting job profiles. We can also see this if we look at the history of the world wars, during which time some military doctors sacrificed themselves for their patients while other parts of the military medical services willingly allowed themselves to be abused; with complete disregard for any kind of medical ethics.

Ethical standards and legal requirements

The duties of a soldier and the limits to a soldier's legitimate use of force result from national and supranational legal norms; in Germany, for example, these limits are set out within the national framework of the German Basic Law (*Grundgesetz*), the Act Concerning The Legal Status of Soldiers (*Soldatengesetz*), and criminal law, and are internationally defined mainly in international laws of war and in International Humanitarian Law. The basic ethical consensus for the medical profession has been passed down from antiquity in the Hippocratic oath. Today it lives on in a somewhat modified and updated form, yet unchanged in essence, in the Declaration of Geneva (the, incidentally, other declarations of the World Medical Association likewise set important ethical standards). Some key points are to serve humanity, to respect secrets, and that the health of the patient should be the first consideration, irrespective of nationality, ethnic origin, political affiliation, social standing, or any other characteristics of the patient. But in addition to these ethical – though not legally binding – requirements, there are legal norms which define fundamental ethical values according to their nature: The professional

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codes for physicians, regulations for licensed practitioners, the German Federal Medical Code (*Bundesärzteordnung*) and similar legislation for all types of licensed practioners, International Humanitarian Law, and many more. All of these make it clear that it is not at the discretion of medical officers to decide what their role is, but rather that their role is determined by ethics and by law, and that penalties can be imposed if limits are breached. To acknowledge this is extremely important for the debate, given that it is often assumed that medical personnel retreat into noncombatant role for a variety of self-serving reasons – or use it as an excuse.

This is where the contradictions start to become apparent: It is part of a soldier's job description, and part of their legitimate and lawful duties to confront other people with armed force, to injure them, and ultimately perhaps to kill them. By contrast, the task of physicians (as formulated in the Model Professional Code for Physicians in Germany (*Musterberufsordnung*), which is quoted several times below) is "to preserve life, protect and restore health, alleviate suffering [...]." Soldiers' actions are guided by their mission, whereas "medical activity must be in accordance with the welfare of the patient" and "physicians are forbidden to engage in any other activity that is irreconcilable with the ethical principles of the medical profession." In the military, the principle of command and obedience applies, but doctors claim to be members of a free profession and "may not accept any instructions from non-physicians concerning their medical decisions."

These obvious contradictions produce specific ethical dilemma situations, characterized by the medical officer having to decide between competing and mutually incompatible courses of action. The range and dimensions of these dilemmas can only be outlined briefly here: There is an unlimited obligation toward the patient, but doesn't a medical officer need to defend the interests of his or her employer in terms of the operational readiness of troops and fair distribution of resources? What counts more: Instructions from superiors in this hierarchically structured system that is the German armed forces (*Bundeswehr*) or physicians' freedom, i.e. physicians' obligations toward the patient's well-being and their own conscience? And during operations, doesn't the question arise as to whether it can be ethically justifiable to give one's own soldiers preference over neutral persons or even enemies if this disadvantages the latter? Which of the operational tasks that are demanded or expected by some troops are actually compatible with the image of the physician and his professional ethics and when are the ethical and legal boundaries breached? What is more important: the patient's well-being or mission fulfillment?

A look at history

The two following examples show how differently the mission of the medical profession has been interpreted and what a contradictory and unfortunate role some military doctors played in German history. These examples demonstrate the conflict between concern for the well-being and healing of the individual on the one hand and the military mission and hence the (at any rate supposed) common good on the other. During the First World War, the medical service was faced with a completely new phenomenon, for which the terms "war neurotic" (*Kriegsneurotiker*) and even "war trembler" (*Kriegszitterer*) were used. These were soldiers who had been seriously traumatized by their experiences of trench warfare under constant bombardment. This manifested itself in extreme shaking and tremors or paralysis. Treatment methods were developed in military psychiatry that were geared more to disciplining than healing the soldiers. The notorious Kaufmann cure consisted of applying elec-

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tricity (or, more accurately, electric shocks) to the body; other "treatments" included isolation, military drills, and other deterrents. It was assumed that traumatized soldiers mainly lacked strength of will; often they were accused of feigning their symptoms. Thus it was not – as would have been ethically appropriate – the patient's well-being that was the focus of physicians' efforts, but rather the interests of third parties – the opinion that military doctors, through such restrictions and discipline, had to serve "kaiser, people, and fatherland" above all else. Sigmund Freud later likened the military psychiatrists who used these methods to drive soldiers back into combat to "machine guns behind the front".

In preparing for and conducting the Second World War – this is our second example – many senior medical officers and scientists, even if they had not become ideologized by the National Socialists, were corrupted while fulfilling their scientific or professional ambitions. They allowed themselves to be exploited by and made subservient to a criminal regime conducting war of aggression and destruction. They felt themselves to be "doctor-soldiers" and in some cases were even directly involved in authorizing or carrying out inhuman medical experiments that were in no way compatible with medical ethical standards. Yet no doubt even these criminals would not have regarded their criminal acts as being unethical or non-medical, and would instead have offered the justification that they had sacrificed the few to save the many with the findings obtained from these experiments.

Thus it becomes clear, just from these two examples, how fragile medical ethics can be given a misunderstood sense of duty or under the pressure of actual or supposed military necessity and how quickly this fragility can lead to a descent into an ethical abyss or even to committing crimes.

From macro to micro Level

Members of the *Bundeswehr* medical service at times face the accusation, with reference to Germany's past, that any form of military medical service is ethically contentious in itself. Military doctors, so the argument goes, along with other licensed practitioners and medical assistant personnel, do not act (or provide treatment) on the basis of any humanitarian motivation or fundamental convictions. Instead, their efforts (as happened in the two world wars) are aimed solely at maintaining or restoring fighting capacity. It is impossible to conduct war without medical services, which means that doctors share in the responsibility for wars. Transferring these historically derived accusations to the *Bundeswehr* medical service is untenable, however, since the *Bundeswehr* is fundamentally different to its predecessors. Prior to the Kellogg-Briand Pact (war renunciation treaty) of 1928, war was regarded as a legitimate policy tool, with the result that the armed forces of the German Empire were an instrument for asserting national interests. Despite this treaty renouncing war, the Wehrmacht let itself be abused in and by a dictatorship to wage a war of aggression, conquest, and destruction. The *Bundeswehr*, in contrast, is an army controlled by the German parliament and tasked with defending a free and democratic state as well as, in operations that are legitimate under international law, basic liberal and humanitarian values. On this basis and in light of binding legal standards applicable to the military which I outlined above, the *Bundeswehr* medical service can already – on a macro level – justifiably expect to have a basic positive ethical attitude. As I see it, an important addition would be to make the basic idea and fundamental rules of the Geneva Convention – i.e. the concept of neutrality for noncombatants and the prohibition of their active participation in and support for combat operations – a maxim of one's actions, even if (as in the Afghanistan mission)

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the technical legal applicability is in question. This is the only way to prevent our own value system leading us to absurd conclusions. The "slippery slope" argument also comes into play here: there is indeed a danger that because of the strong predominance of the legally exceptional situation, medical personnel will find themselves on a slippery slope and no longer recognize or acknowledge the rules laid down in international law.

Yet it is not only the self-perception of medical officers and all medical personnel which is important, but also the perception of others and acceptance of this special status in other corps, especially among combat troops and in the military leadership. Thus we are entering the meso level, and hence, referring to the positioning of the medical service in the overall structure of the *Bundeswehr*. More than is currently the case, the medical service needs to effectively communicate that its members are not only subject to the provisions of International Humanitarian Law, but are also bound by a system of values specific to their occupation, the standards, obligations and protective functions of which are regulated with legally binding force at a national and international level. The examples from history show what unfortunate consequences can result from the misinterpretation, abandonment, or indeed exploitation of this value system for other purposes, both in respect of patient well-being and the lasting credibility of the medical profession and all medical personnel. Only if this is understood and accepted can it keep medical officers and medical personnel from becoming structurally involved in tasks which are incompatible with this status; this is the only way to prevent these actors being thrown into avoidable dilemma situations due to the ignorance of third parties. Members of the medical service are not "auxiliary infantry" or a hidden military reserve, and nor does their status allow them to avoid dangerous or unpleasant activities. Rather they are simply subject to different rules, which should be acknowledged in the overall structure of the *Bundeswehr* with no "ifs or buts" as one facet of the rule of law.

Yet ethical dilemmas can always arise – not only at these two higher levels, but also and especially at the micro level (the level of the people working in the medical service, in their everyday actions) during both operations and routine duties. As mentioned above, on closer inspection, conflicts with individual patients or among medical personnel, conflicting loyalties, and vacillation between commitment to the patient and actually or apparently contradictory instructions or service regulations are constantly present: Should one follow one's own professional opinion, or should one give in to external influences? How can patients' expectations be reconciled with professional principles or available resources? How important are official interests when it comes to diagnosis, treatment, medical leave, and physician–patient confidentiality? What relationship develops with patients who would prefer to see a different doctor they trust rather than the designated military physician?

Certainly it is possible to explain, resolve, or at least move closer to a solution to these and many other ethical dilemmas by referring to highly complex and philosophical ethical theories and concepts. But it is vitally important that people who work in the medical service have a problem-solving strategy which they are able to apply in their everyday (military) medical activities. "Principle ethics" – as devised by Tom L. Beauchamp and James F. Childress in their textbook The Principles of Biomedical Ethics – is widely known in clinical medicine and well-suited to application in daily medical practice. It is based on four principles: Patient autonomy, non-maleficence (doing no harm), beneficence (acting in the other person's best interests), and justice – i.e. there is a very widespread consensus and a high

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level of understanding regarding the general validity of these categories. Whereas patient autonomy, non-maleficence, and beneficence solely and exclusively relate to the patient, the principle of justice takes the interests of third parties into account as well. These principles are evaluated and weighed against each other, enabling an overall assessment and decision which, although subjective in terms of the weighting of arguments, is nevertheless justifiable and comprehensible.

But in somewhat modified form, principle ethics as developed by Beauchamp and Childress can be applied to other fields such as military medical areas of conflict and dilemma situations. Thus numerous instances of ethical doubt, particularly those patient-related cases which occur in everyday medical treatment, can be resolved using this tried-and-true tool. The three patient-centered principles – non-maleficence, beneficence, and patient autonomy – safeguard the interests of soldiers who are assigned to the *Bundeswehr* medical service, just as the principle of justice ensures that the legitimate interests of the employer and fellow soldiers (who may be put under greater strain or in danger due to the absence of patients) are taken into consideration in an ethically sound decision-making process.

If ethical conflicts arise in the medical service's internal and external relations, i.e. among members of the medical service or with respect to third parties, principle ethics can be modified so that the do-no-harm and do-good principles relate to the persons concerned, and patient autonomy is replaced with a principle of human dignity or self-determination, while the principle of justice remains and continues to represent the legitimate interests of third parties. For example, it is conceivable that these modified principle ethics could be applied when members of the medical service themselves need to define their position between medical ethics and military necessity.

It has only been possible in this article to briefly outline the many facets of the *Bundeswehr* medical service's professional self-image and the ambivalence between medical ethics and military necessity; there is certainly need for a more in-depth treatment. However, there is historical justification for arguing – and it can hardly be disputed – that education and training in medical ethics for members of the *Bundeswehr* medical service need to be significantly stepped up. And it is equally important to clearly communicate the special features and rules that are effective in the medical service, both within the *Bundeswehr* and to the public.

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