30

Health Care for Soldiers

FRITZ ALLHOFF

INTRODUCTION

This volume explores issues of social justice as it pertains to the distribution of health care. The exploration is wide in scope, but the third part thereof asks what we owe to specific populations. In this essay, I shall consider what health care should be afforded to soldiers, or, similarly, what soldiers should reasonably be able to expect from society upon returning home from the battlefield. For the purposes of this essay, I shall assume that soldiers on military deployment are to be cared for by military medical personnel, and I shall further assume that military medicine is adequate to serve the needs of our deployed soldiers. This is not to defend a substantive thesis regarding the status of military medicine, but is rather only to delimit the present project in terms of focusing on medical care at home rather than in the field. To be sure, there are important ethical dimensions of treating our soldiers in the field, but they fall outside of the scope of this essay.[1]

As a methodological note, I will not suppose that soldiers have a right to health care, and for various reasons. First, some of us do not believe in rights to health care, whether in general or for soldiers in particular. Many of the other contributors to this volume disagree,[2] but that debate is carried out in their essays. Regardless, supposing that soldiers have a right to health care will not engage the position of the person who does not believe in rights to health care; it offers a stronger dialectical position not to make this supposition in the first place. Second, whether soldiers have a right to health care is really neither here nor there with regards to a more tractable and pragmatic question, namely whether soldiers should receive *prioritized* health care (i.e., as against civilians[3]).

To expand slightly on this point, there are all sorts of reasons that we might prioritize health care for our soldiers. One candidate answer is that they have a right to it, or at least a greater right than civilians (e.g., given limited resources). But there are all sorts of other candidate answers as well. For example, maybe soldiers *deserve* prioritized health care; this desert need not suggest any sort of right. (Consider that we deserve courtesy from each other but have no rights violated when courtesy is not extended.) Or else maybe we should just be the sort of society that takes care of its fighting forces by giving them prioritized care. A failure to live up to this sort of duty or obligation would fail to display sufficient gratitude for all that our soldiers risk, and it would fail to show them the respect that they deserve.

Alternatively, we can propose that soldiers are owed prioritized health care under a sort of social contract: they defend us and, in exchange, we take care of them after they come home. This is, again, not necessarily rights-based, but rather is just part of the deal that we (implicitly or explicitly) ratify when sending them off and into harm's way. Finally, there are straightforward consequentialist reasons why we should provide for our soldiers. To wit, it would be hard to recruit soldiers—and therefore to maintain an effective fighting or defensive force—if the post-service provisions for their care were inadequate. Soldier morale (cf., efficacy) could also be diminished if soldiers feared for the status of their health care upon return home; a priority thereof would be one way to allay these fears.

In short, there is a wide range of reasons that soldiers might be prioritized for health care, only some of which presuppose rights. To survey the landscape more broadly and so as not to talk past those who do not believe in rights to health care, I shall suppose that all of these reasons are worth exploring. The ensuing discussion will not be neatly subdivided into deontological, virtue-based, social contract, or consequentialist-based approaches to morality, though each of these is important. I shall instead pursue various issues

topically, and as we proceed, considerations related to each approach to morality will be highlighted.

Finally, let us suppose that there are limits as to what sorts of health care society can offer, or at least is reasonably likely to choose to offer. To put it another way, this would be a very short essay if the primary thesis were that soldiers should have unlimited access to the highest-quality health care, as should everyone else. For the question about health care for soldiers to gain any interesting traction, it has to be the case that health care (for civilians) is limited; if everyone gets everything they want and or need, then, *a fortiori*, there is no reason to talk about priority for soldiers (i.e., we lose an interesting moral question). Maybe soldiers should have more or better health care than civilians, and maybe not. Regardless, if the provisions for civilians are high enough, then the conceptual space within which we can explore a different accommodation for soldiers is eroded. As we move forward, let us therefore suppose that everyone should have access to some quality of health care—without taking a stance as to why or how much—and consider what relationship soldiers bear to this standard. In particular, should soldiers stand at some comparative advantage for health care with respect to civilians?

WHY SOLDIERS MATTER

To motivate the discussion about health care for soldiers, something should be said about why soldiers matter. Or, to put it another way, why are we countenancing a privileged status for soldiers' care? From the outset, let us take it to be a non-starter that soldiers should be any worse off *vis-à-vis* health care than civilians; certainly this is a coherent position, though nobody would defend it. Whatever other moral considerations soldiers are due, they are *at least* due the same consideration as everyone else.

This is not to say that soldiers should receive the same priority as civilians at civilian facilities; if there are adequate military facilities, then it might be unfair to the civilians for the soldiers to also have a claim on civilian facilities. For example, imagine that a soldier could go to either a military or civilian facility, yet chooses to exercise priority at a civilian facility despite available care at a military facility. In this case, a civilian might be unnecessarily displaced, so our system should not condone such practices. Rather, the issue is what health care should be available to soldiers somewhere, without taking a stance on where that place is. As it turns out, returning soldiers would most likely access health care either on a military base or in a Veterans Affairs facility; these facilities are reasonably available given an expansion of outpatient clinics during the 1980s. Nevertheless, the geographic coverage is not perfect and there are cases (e.g., emergency) when soldiers would need to access civilian facilities. At any rate, let us grant that soldiers deserve at least the same access to care that civilians are due, again without taking a stance on where that access should be provided.

Let us now return to the main theme of this section: why do soldiers matter? If our society were to entertain privileged health care for some population, why is it that soldiers could make a compelling claim therein? While an extended treatment of the military's value would take us too far afield for present purposes, a few key points should be uncontroversial. For starters, what is a soldier? For our purposes, let us understand a soldier to be anyone serving in the military. Some definitions draw distinctions between enlisted personnel and officers, though such a distinction is not appropriate in our context; there is no reason to suppose that either class should be treated differently with respect to health care.[4] Similarly, some definitions assume that soldiers are in armies, presumably as against some other branch of the military. Again, this is not useful to us, and we shall assume that military branch is unimportant in assignments of health care; all branches have similar moral status for our purposes.

More interestingly, we might draw a distinction between combatants and non-combatants. Certain military personnel, such as chaplains and medics, are owed battlefield immunity under the rules of war, which means, ideally, that they are not at risk on the battlefield. Therefore, it is possible that soldiers deserve special consideration given the risks they suffer while, at the same time, some military functionaries are excluded from this consideration (i.e., not all military personnel are soldiers.). However, the non-combatancy ideal is not always met in practice, whether given ill-intentioned enemies or vagaries of fast-paced conflict. Furthermore, introducing distinctions like this invites us to make even more fine-grained distinctions, such as whether the infantry should be prioritized in relation to their forward-deployed support staff (e.g., cooks). These sort of adjudications could be pragmatically intractable and, regardless, mask the central concern of this essay. Therefore, we shall understand "soldiers" to comprise all those serving in military forces: airman

or sailor,[5] private or colonel, medic or gunner, deployed or deployable.

Having now issued some preliminary commentary on what soldiers are, we can turn to their moral significance. As mentioned above, a thoroughgoing defense of the military would be inappropriate for this essay, so our task shall be to focus on common ground. To that end, militaries—and their constitutive soldiers—most obviously exist to defend their countrymen against foreign aggression. (The U.S. Army's motto is, in this vein, "This We'll Defend.") A central premise of just war theory, dating to Thomas Aquinas, is that the use of force can be justified when defending against aggression;[6] this premise persists in contemporary treatments as well.[7] And, to that end, countries are morally licensed in creating militaries, even when those militaries threaten lethal force against their adversaries.

This basic principle, though, can be complicated in so many ways. For example, we can debate what constitutes an act of aggression—that is, an act against which force can be justifiably invoked. If some state begins to amass troops at a border, can this be construed as aggressive (i.e., in the absence of *actual* force)? Or what if a state just threatens force? The so-called Bush Doctrine purported to expand the use of justified force, at least extending to pre-emptive usages (i.e., against imminent, non-actual attacks) and perhaps to preventive ones as well (i.e., non-imminent, non-actual attacks). There are other ways in which we can understand the roles of militaries to not be constrained by responses to aggression, such as when they are used in peacekeeping or humanitarian capacities. When considering these, it is at least usually the case that a military is not defending its own countrymen against the use of actual foreign force. Rather, it would be defending some third party against the possibility of domestic force, such as would be employed by a tyrant. In these cases, basic just war principles are put into tension with other moral values, such as the right to state sovereignty; this is not to deny that interventions can be justified, but rather to say that the issues are more nuanced.

Despite these complications, the central tenet is still (mostly) unassailed: militaries offer a defense against aggression. Figuring out what "aggression" means might take some work, and we can grant that militaries do not always only defend their own citizens (whether in the above cases or others when we consider international coalition forces). To be sure, militaries do not always defend at all, as sometimes they aggress. They can aggress for land, for money, for natural resources, for religious expansion; the history of the world is rife with aggressive militaries. But these are militaries that get it wrong, that get away from their core moral imperative to protect.

If soldiers should be prioritized for health care, it is in virtue of this core moral imperative. Soldiers protect us from aggression, we who are unable to protect ourselves. In protecting us, they put themselves in harm's way, or at least they stand to be put in harm's way.[8] In other words, whether on a forward deployment in Iraq or serving as a stateside reservist, soldiers are liable to threat in a way that their civilian counterparts are not. There are ways in which we all face threats (e.g., terrorism), but those threats do not distinguish between soldier and civilian; at the same time, the threats soldiers face against conventional combatants are theirs alone. It is this asymmetry of risk between soldiers and civilians that grounds the moral celebrity of the former.

Returning to health care, it bears emphasis that the risks soldiers face are precisely those that health care aims to rectify. Soldiers' exposure is physical and psychological, and adverse outcomes in either regard are serviceable by health care. In this way, there is a direct link between soldiers and their claim to health care. The situation might be different, for example, if soldiers risked financial loss rather than physical or psychological loss; in this case, we might entertain a proposal that redressed financial harms.[9] Because of the symmetry between what soldiers risk and what society might offer them in return, consideration *vis-à-vis* health care makes more immediate sense.

While we will return to this point later, it would be a substantial moral failing if soldiers did not have adequate health care and, therefore, we were to have an inadequate military. To put it another way, our collective defense is an important moral value. While there are certainly limits as to how far we should go to provide for our own protection, it is nevertheless the case that reasonable costs thereof enjoy some sort of *prima facie* justification. Were health care for soldiers to be so woeful that they were sufficiently disincentivized from signing up for service, this would be bad insofar as our defense would be compromised. So, whatever other moral consideration we extend to our soldiers, let a starting point be that the mere maintenance of a defensive force is a moral value that at least enjoins us to minimally provide for our soldiers' health.

WHY TREAT THE WOUNDED

In thinking about our moral obligations to provide health care for our soldiers, a core distinction worth making is whether those soldiers are to be returned to the fighting force. If so, then our moral obligations to them are compounded by the moral status of that fighting force (viz., its defensive value). Thus far in the essay, the question has been whether soldiers should be prioritized for health care *after* returning home from war. And, while that will remain our primary focus, we can further elucidate that context by considering its contrary, namely what should be done with injured soldiers who can be restored to battlefield readiness. In this discussion, it will be useful to consider an essay by Michael Gross, which bears the same principal title as this section.[10]

Gross argues that, while military medical ethics emphasizes the return of soldiers to battle, soldiers who are unable to return to battle lack any sort of priority, whether for military or for civilian treatment. And therein lies:

> [a] fundamental conflict between the prevailing principles of military medical ethics and those of medical ethics in general. Military medical ethics is guided by the principle of military necessity and driven by the principle of "salvage", that is, the imperative to return soldiers to duty and maintain their health. Soldiers who cannot return to battle fall under the purview of nonmilitary or civilian medicine. Unlike military medicine, nonmilitary medicine is governed by the laws of medical need and focuses its efforts on saving lives and maintaining quality of life.[11]

In other words, there are to be two categories of soldiers, those that can be returned to combat and those who cannot. Military medical ethics focuses solely on the former camp. For Gross, the more severely injured soldiers (i.e., those who have now lost military value) are relegated to civilian care on the grounds that "military medical ethics . . . can offer no compelling reason to care for those wounded so badly that they will never fight again."[12] Once severely injured soldiers are remanded to civilian care, however, they enjoy no priority insofar as a soldier's care "cannot come at the expense of [a civilian's]."[13]

Gross therefore answers the central question of this essay in the negative; he denies that returning soldiers (i.e., those not going back to war) should be prioritized for health care as against their civilian counterparts. His reasoning, though, bears notice. Gross envisions a clear division of labor between military and civilian medicine in which the former restores soldiers to battle and the latter saves lives and maintains quality of life. And then, once non-returning soldiers are integrated into civilian health care, they compete with civilians for care on the grounds that all those who are sick or wounded are equally deserving of medical treatment. There are various challenges that can be raised to this reasoning, but let us just focus on a couple given space constraints.

First, if we take seriously the line that military medicine is solely concerned with sending soldiers back to battle, what stance should military physicians take toward the critically wounded? Let us imagine a class of soldiers who are seriously wounded and who, regardless of care, will not reappear on the battlefield anytime soon. With immediate battlefield attention, they might be afforded the opportunity to convalesce stateside and, absent such care, they will die. Further imagine some other soldiers with minor injuries; these injuries, if left untreated, will indefinitely preclude these latter soldiers from fighting but, with treatment, they will quickly return to the battlefield. In triage situations, Gross's account would have us let the first group of soldiers die such that the military force can reclaim the second group for service.

To me, this gets the wrong answer; the priority should be on saving lives. Gross's call to relegate the severely injured to civilian care simply does not work in this case since those soldiers will be dead without immediate care. His argument, though, is predicated upon this division of labor between military and civilian medicine and, in particular, what military medicine is supposed to be doing (i.e., maintaining the fighting force). Whereas Gross sees this function of military medical ethics trumping medical ethics more generally, I see the two sets of values competing against each other; for me, the military physicians are subject to dual loyalties, both to the injured and to the maintenance of the military.[14] How the tension is adjudicated has to do with the details of the case, but suffice it to say that the commitments of military medicine—even granting that they are as Gross says—should not always win.

Aside from more general intuitions that saving lives is more important than repairing soldiers, there is a second way in which Gross's position can be challenged. To wit, it is unlikely that any particular triage situation will ultimately make

the difference between winning and losing a battle, war, or really anything else that matters. The idea is supposed to be that military physicians are meant to restore soldiers to readiness; the reason for that is the former's professional obligations and the grounding for these obligations, presumably, is the moral value of the ultimate military objective. However, it hardly follows from this that soldiers have supreme moral status. For example, if the soldiers were aggressors in an unjust war, there would be no moral call to get them back on the battlefield, Gross's invocation of military medical ethics notwithstanding. Alternatively, let us tie together the earlier themes and assume that our soldiers are justly fighting in a just war. Gross would have military medicine treat the wounded—rather than save lives—even if those wounded would not make any difference in the conflict. To me, this gets it doubly wrong.

If one side were going to win the conflict regardless, Gross would still have the military physicians treat wounded while the un-salvageable die. Similarly if the side were going to lose the conflict regardless. How likely is it that some individual soldier would make a difference? As above, I submit that it is not likely at all. Instead, military physicians could save lives of the critically wounded, and this would definitely make a morally relevant difference, not the least to the soldier whose life is saved. This discussion does not figure centrally into our essay, but I raise these points to put pressure against Gross's more general thesis, namely that military medicine should only serve the maintenance of the fighting force; I disagree for the reasons given in this and the preceding paragraphs.

Military medicine should be concerned with the integrity of its associated fighting force, and the maintenance of that force is an important function of military medicine. That said, saving lives should sometimes come first. If this is right, then military medicine is not completely insulated from the ethos of civilian medicine, even if the two share somewhat different priorities. For our purposes, the converse issue is the more pressing: is civilian medicine completely insulated from the ethos of military medicine? To some extent, yes: civilian medicine does not care about the maintenance of a fighting force. This is not to say that a fighting force does not matter, but rather is just to say that it is not civilian medicine's job to carry out that function. For Gross, though, the separation is complete; recall his claim that a soldier's care "cannot come at the expense of [a civilian's]."[15] I disagree, and that disagreement motivates the rest of this essay. The central question here is whether civilian medicine should be blind to military status. Gross thinks so, and I disagree. In carrying out this discussion, we shall focus on two broad sets of considerations, pragmatic and moral.

PRAGMATIC CONSIDERATIONS

In this section, let us consider whether there are pragmatic reasons for civilian medicine to acknowledge military service in determinations of care, whether as pertains to access or quality. In doing so, we now return to the central issue posed at the outset of this essay, namely the focus on stateside—rather than battlefield—care. The soldiers that we herein consider are ones who do not face any immediate return to armed conflict, otherwise their treatment would fall on military medicine. Still, there are several distinctions worth making. In particular, we might acknowledge that our soldiers could still be active duty (e.g., administrative or other detail), yet not salvageable for battle. Or else they could be active duty, injured or otherwise debilitated in some sense completely unrelated to their military service (e.g., diabetes owing to diet). Or else they could be reservists. Or they could be retired. While our definition of "soldier" above was meant to be widely inclusive, that inclusivity now runs together various morally relevant categories.

Generally, we might divide health care for soldiers into two types, rectificatory and reward-based. Rectificatory care restores soldiers from conditions that they would not have found themselves in but for their military service. Acute battlefield injuries are perhaps the most archetypical examples, but post-traumatic stress certainly counts, as could a wide range of other conditions (e.g., bad sunburn from being deployed in a desert). Reward-based care, on the other hand, treats soldiers for conditions not resulting from the military service; the "reward" idea is simply that this sort of extended care is a perk for military service. The various demographics introduced in the preceding paragraph easily map onto these two types of care and, morally, it will be more useful to refer to this simple distinction than to the various reasons that soldiers would be classified in either regard.

What, then, are the pragmatic issues worth considering in either case? As mentioned at the outset of this section, one pragmatic issue that

need not concern us is the restoration of the fighting force; we are assuming that challenge wholly to fall on military medicine. The principal pragmatic issue we should consider is whether soldiers' priority ultimately makes a difference for our safety. Why would it, especially if these soldiers are not returning to battle? The answer has to do with recruiting in the first place, particularly our ability to constitute a military able to protect us. If soldiers were to have a higher expectation of care, then military service would be incentivized. This is not to say that new recruits would carefully research their prospects for post-service health care, or that improved prospects would make a difference for them all. Rather, the idea is simply that better health care would lead to better recruiting outcomes. (Note that this claim cuts across the distinction between rectificatory and reward-based care; regardless, soldiers end up with improved health care.)

That said, a lot of things would lead to improved recruiting outcomes, including higher salaries. And it certainly cannot be the case that we should do whatever would lead to those outcomes, particularly insofar as there are myriad social projects competing with the military for our support. Here, though, the distinction between rectificatory and reward-based care becomes useful. In that regard, if we deny soldiers reward-based care, they are no worse off than they would have been had they not joined the military in the first place. Or, to put it another way, the lack of reward-based care does not provide a disincentive for soldiers to sign up, but rather forsakes the opportunity to provide an incentive.

There are various reasons to oppose reward-based care, though I will only mention a couple. First, while soldiers deserve our gratitude and respect, so do many other demographics. Teachers, for example, provide an important service to society, a service bereft of lucrative remuneration. If we thought that soldiers deserved reward-based care, then why not teachers as well? Or other groups? It just gets too messy to try to articulate a simple reason why soldiers stand apart from the rest as pertains to demands on our health care system. Unless, of course, we consider that soldiers—and maybe some other groups, like policemen—are liable to physical attack. But let us set that aside for now, returning to it shortly under the discussion of rectificatory care.

Second, if we are going to reward soldiers, why do it through health care? If the motivation is to incentivize their service, there are other ways to do it. And probably more efficient ones, too; health care turns out not to be of great importance to a healthy soldier, or at least to a healthy soldier who will not be redeployed. Other motivations include increased pay for our soldiers, or special consideration given to veterans when they apply for certain jobs, the latter of which does in fact take place. The point is that there is no obvious reason to pick health care instead of something else as a means of rewarding our soldiers. And, as Gross previously opined, there are probably reasons not to, namely ones having to do with fairness. Even if reward-based care could be defended, there is simply no good reason to pursue it, given a wealth of other (less controversial) possibilities.

While we should be circumspect about reward-based care, rectificatory care makes perfect sense. We shall deal with the moral arguments for rectificatory care in the next section, but let us close this one by considering the pragmatic ones. The possibility that a soldier could be combat-debilitated while, at the same time, not prioritized for rehabilitation at home is a striking one. There are two adverse effects this potentiality has, which we might designate as recruitment and morale. Regarding the first, if injured soldiers are sent home and then not repaired, this will hardly go unnoticed; in fact, the notoriety of oft-troubled Veterans Affairs facilities bears this out. Gross rightly points out that there are no data to suggest a direct relationship between health care and recruiting, though he also acknowledges a reasonable background assumption that recruited soldiers would have access to "adequate" medical care.[16] Gross goes on to question how we should interpret "adequate" in this context, though it seems to me that rectificatory—as opposed to reward-based—care is a minimal standard in this regard.

Turning to morale, it has to be the case that, all else equal, military units of higher morale are more effective than those of lower morale. Were soldiers to doubt the prospects for rectificatory care, this could only be psychologically damaging. Interestingly Gross cites many examples of units that had low morale *despite* good medical care, but this just confuses necessary and sufficient conditions: medical care may well be insufficient for high morale while, at the same time, be necessary. And I suspect this is true, especially pertaining to units with high instant death rates (e.g., the bomb squad, for whom health care is ultimately less important) or those convened under certain religious convictions (i.e., those who do not fear—or else celebrate—death may not need heath care

to be effective soldiers). To be sure, the relationship between health care and morale is not trivial, but it would hardly be unreasonable to expect confidence in rectificatory care to be necessary for most soldiers' morale. If this is true—and again assuming that our fighting force is morally justified—then we have a *prima facie* reason to provide such care for our soldiers. Regardless, our case need not hang on pragmatic arguments, so let us now turn to the moral.

MORAL CONSIDERATIONS

Having now focused the discussion on rectificatory care, why should soldiers be prioritized for it? The obvious answer is that rectificatory care restores soldiers to the state that they were in before suffering injuries through their military service. Assuming that these soldiers will not return to battle—lest military medicine treat them—the options are now to prioritize them under civilian care or not. If they are not prioritized for civilian care, we have sent our soldiers into harm's way, and then not taken care of them once they came home injured. Such neglect could be ruled out by any number of moral principles, the most basic of which is that of simple reparation.

By analogy, consider a simple assault in which A harms B; A thereafter owes reparation to B. The appropriate reparation could be calculated in various ways—this being one of the things that juries do in torts actions—but let us suppose that A at least owes B for medical bills, if not for lost wages, psychological trauma, and so on. This simple analogy becomes attenuated, though, when considering our soldiers; it is not our society that (collectively) harms the soldiers, but rather the adversaries they encounter on the battlefield. Nevertheless, our society bears responsibility for sending those soldiers into harm's way, even if that responsibility is ultimate rather than proximate.

To clean the analogy up a bit, imagine that B works for A and suffers some harm under the latter's employ, in the regular course of work, and under no fault of B. In this case, A provides for B, perhaps under some form of workman's compensation insurance. (Workman's compensation also precludes the worker from suing the employer; note that the Feres Doctrine similarly precludes soldiers from suing the government.[17]) Soldiers who are injured during service fit this model exactly, and should therefore be provided for. That said, at least a few features of this conception require further explication.

First, who is it that sends soldiers to battle? Most proximately, it is their commanding officers. Ultimately, though, it is we, through our elected officials who, in turn, are responsible for military leadership and deployment decisions. And why is it that soldiers are deployed in the first place? The answer, ideally, is to protect us. While some of our citizenry might eschew the use of military force, that force is a legitimate outcome of our democratic processes—as are whatever other policy decisions some of us oppose—and therefore a force for which we bear collective responsibility. To say that we, each and every one of us, are not responsible for our injured soldiers is not just unpatriotic; it is also plain false. If our collective agency leads to the return of injured soldiers, we straightforwardly have an obligation to restore those soldiers to health.

Second, what does any of this have to do with *priority* for injured soldiers? Even if we grant the preceding arguments, maybe there are arguments lurking as to how society has a duty to provide for *all* of its sick and injured; in fact, such arguments appear in various essays throughout this volume. If we accept such arguments, then the imperative to provide for soldiers loses its force since they are no longer set apart from the rest of the citizenry. This line of argumentation misses the mark and explaining why elucidates an important point. Even if society has an obligation to provide for everyone's health care—an obligation about which I am dubious—the issue is not whether soldiers are accommodated therein, but rather whether there is some *additional* consideration to be afforded to them. And, of course, there is such an additional consideration, namely that we sent them to war to defend us and they came back injured. So whatever else—if anything—everyone else is owed, soldiers are owed more, thus grounding their priority.

Third, it bears notice that soldiers voluntarily sign up for military duty. And presumably this volition attenuates their right to reparation as, for example, their case seems different from the one of (patently unwilling) assault. But what is it, exactly, that soldiers are volunteering to do? In most cases, they are not volunteering to head into the particular situation that leads to their harm; rather, they are ordered to deploy, ordered into battle, and so on. Nevertheless, they sign up for military service knowing full well what the risks are, or at least let us assume so for the sake of argument. Were one inclined to think that this fact compromises soldiers' claims to medical

priority—which is not to say that we all do—there are at least two reasons to think otherwise, one theoretical and one practical.

Starting with the theoretical, it is useful to consider a famous essay by Judith Jarvis Thomson in which she savages the argument that even raped women are "responsible" for their pregnancies and that, through this responsibility, their moral claims to abortion are mitigated.[18] Thomson's point is that there is something that even raped women could have done (e.g., had a hysterectomy, never left home without a hired army[19]) but that the mere existence of this sort of "partial responsibility" for the ultimate outcome does not abrogate their moral claims against wrongs. The situation is similar for soldiers insofar as they are ultimately ordered (i.e., forced) to put themselves in a harmful situation, away from their stateside base or rear-deployed station.

Surely, though, this has to be a horrendous analogy: soldiers can *expect* to be put in harm's way in such a way that Thomson's raped woman cannot. Maybe, but it really depends on what "expect" is supposed to mean in this context. The U.S. military, for example, comprises approximately 1.5 million active-duty soldiers, plus some 850,000 more in reserve units. Most of these soldiers never find themselves at risk on a battlefield, or even on a battlefield at all. As a simple statistical measure, then, the average U.S. soldier would expect him- or herself *not* to be at risk. To be sure, soldiers are more likely to be at risk than the average civilian, and they furthermore have no cause for grievance when placed at risk. The point, though, is simply that responsibility for military service does not automatically annul all claims for reparation thereafter any more than does a woman's venture into public.

Furthermore, there is a practical reason to think that responsibility does not undermine claims for priority: many soldiers do not volunteer for military service at all. While the focus of this essay has been implicitly on U.S. servicemen and servicewomen, some of the world's countries still effect mandatory military service (e.g., Israel, Switzerland, and others). While the U.S. has not had mandatory military service, it has had military drafts (e.g., for the Vietnam War), and some of those draftees might still have reasonable claims for health care. And, as a provocative comment to be left undeveloped, it is at least plausible that the soldiers who do enlist "voluntarily" nevertheless evince some sort of consensual defect, such as would be manifest by soldiers disproportionately emanating from lower socioeconomic strata and who have fewer meaningful alternatives to military service. In other words, "choosing" to join the military if one's financial or educational background precludes other options might not be much of a choice at all. It also bears notice that, were enough soldiers not willing to sign up for military service, we would probably effect some sort of conscription. In some sense, then, consent is redundant, if not for particular soldiers (i.e., those who did consent and might have otherwise avoided conscription).

CONCLUSION

The central question of this essay has been whether soldiers should be prioritized for health care. To that end, I assumed that soldiers who could be returned to battle would be treated by military medicine; it is therefore only soldiers who cannot be returned to battle for whom this question gains traction. If soldiers cannot be returned to battle, they fall under the purview of civilian medicine, or at least civilian domestic priorities (e.g., Veterans Affairs facilities). Then we can ask whether such soldiers should be prioritized as against their civilian counterparts, assuming that there is limited medical care available. As mentioned from the outset, many will simply attack this assumption, arguing that there should be adequate medical care available for all, perhaps even as a basic human right. If that is true, though, our inquiry evaporates; it is therefore useful to maintain this assumption, even if for no other reason than to explore the moral terrain. Ultimately, I drew a distinction between reward-based care and rectificatory care, wherein rectificatory care treated conditions arising from military service; reward-based care did not. It was then argued that soldiers should be prioritized (only) for rectificatory care, as this care restores them to the state they would have been in had they not bravely chosen to serve in our collective defense.

Notes

1. See, for example, Allhoff 2008a, Adams 2008, List 2008.

2. Though see Baumrin 2002.

3. For the purposes of this essay, I shall take "civilians" to be the contrast class to "soldiers." This might run together various relevant categories, such as the status of military contractors (i.e., civilians working for the military). I leave open whether military contractors are properly conceived of as soldiers; nothing in the remainder of this essay hangs on an answer to this

question. There are ways in which military contractors deserve the same consideration as (traditional) soldiers (e.g., service to country) and ways in which they might not (e.g., higher remuneration). That said, it is simply less cumbersome to speak of soldiers and civilians than soldiers and non-soldiers, so I adopt the former.

4. Or let us at least suppose this is true outside of battlefield triage situations. For more discussion regarding this context, see Allhoff 2008a and Adams 2008.

5. Interestingly, the common equivalence between "soldier" and "member of the army" means that there is no dedicated word for members of the army that sets them apart from soldiers in other branches of the military.

6. Thomas Aquinas 1948, Question 40, esp. Article 1.

7. See, for example, Walzer [1977] 2006. For how just war theory is challenged by the contemporary advent of terrorism, see Allhoff 2009. See also Allhoff, 2012.

8. It could be noted that there might be various reasons why soldiers enlist or are commissioned; that is, their motives might well be varied. However, this point fails to obfuscate the risks to which they are ultimately subject.

9. In some ways we do, such as when veterans—whose earning power is somewhat curtailed through military service—receive extra consideration for certain sorts of jobs. Maybe, though, the justification for this practice is expressive support for their service rather than any direct financial accommodation.

10. Gross 2008. For a broader reply, see Allhoff 2008c.

11. Gross 2008, p. 3.

12. *Ibid*., p. 10.

13. *Ibid*., p. 11.

14. Allhoff 2008b.

15. Gross 2008, p. 11.

16. Gross 2008, p. 6.

17. *Feres v. United States* 340 U.S. 135 (1950). Soldiers can, however, file claims for disability with Veterans Affairs.

18. Thomson 1971.

19. *Ibid*., p. 59.

References

Adams, Marcus P. (2008). Triage priorities and military physicians. In *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff. Dordrecht: Springer, pp. 215–236.

Allhoff, Fritz, ed. (2008a). *Physicians at War: The Dual-Loyalties Challenge.* Dordrecht: Springer.

Allhoff, Fritz. (2008b). Physicians at war: the dual-loyalties challenge. In *Physicians at War: The Dual-Loyalties Challenge*, ed. Fritz Allhoff. Dordrecht: Springer, pp. 3–11.

Allhoff, Fritz. (2008c). Treating the military's wounded: reply to Gross. *American Journal of Bioethics* 8(2):15–16.

Allhoff, Fritz. (2009). The War on Terror and the ethics of exceptionalism. *Journal of Military Ethics* 8(4):265–288.

Allhoff, Fritz. (2012). *Terrorism, Ticking Time-Bombs, and Torture.* Chicago: University of Chicago Press.

Aquinas, Thomas. (1948). *Summa Theologica*, translated by the Fathers of the English Dominican Province. New York: Benziger Books.

Baumrin, Bernard H. (2002). Why there is no right to health care. In *Medicine and Social Justice: Essays on the Distribution of Health Care*, eds. Rosamond Rhodes, Margaret P. Battin, and Anita Silvers. New York: Oxford University Press, pp. 78–83.

Feres v. United States 340 U.S. 135, 1950.

Gross, Michael L. (2008). Why treat the wounded? Warrior care, military salvage, and national health. *American Journal of Bioethics* 8(2): 3–12.

List, Justin M. (2008). Medical neutrality and political activism. In *Physicians at War: The Dual-Loyalties Challenge,* ed. Fritz Allhoff. Dordrecht: Springer, pp. 237–253.

Thomson, Judith Jarvis. (1971). A defense of abortion. *Philosophy and Public Affairs* 1(1): 47–66.

Walzer, Michael. (1977/2006). *Just and Unjust Wars*, 4th ed. New York: Basic Books.