Treating the Military's Wounded

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In his essay, Michael Gross (2008) characterizes the goal of military medicine as returning wounded soldiers to duty and, therefore, raises a challenge for whatever grounds military medicine would have for treating soldiers who will be unable to return to duty. Of these latter soldiers, Gross (2008) proposes that we "disregard their status as soldiers and focus on their status as patients" (3); he goes on to argue that they should "compete equally with similarly injured and sick civilians for care" (3), enjoying no special privileges regarding either access to care or standards thereof. Of course, given the debt that nations are thought to owe their fighting forces, this is supposed to be a contentious conclusion, although Gross attempts to systematically rebut claims to the contrary. In this response, I wish to explore the supposition that the goals of military medicine either are or should be thus characterized, and, space permitting, to issue some comments on the negative part of Gross's project (i.e., why military medicine does *not* have special obligations to soldiers who will not return to the battlefield).

At the beginning of the essay, Gross (2008) characterizes the principle of salvage, which holds that "[s]alvage, not saving lives per se, is the major function of battlefield medicine." As defense of this position, he cites the *Army Field Manual*, which says:

> The mission of the [Army Medical Department] is to conserve the fighting strength. Combat health support maximizes the system's ability to maintain presence with the supported solider, to return injured, sick, and wounded soldiers to duty, and to clear the battlefield of soldiers who cannot return to duty (2000, paragraph 1.1 (d))

owever, this hardly strikes me as obvious and, insofar as it forms the basis for much of the rest of Gross's paper, I think that we should afford it some critical thought. If the principle of salvage does not hold up, then the rest of Gross's arguments would not go through: *whether* soldiers should be prioritized vis-à-vis civilian medicine would be moot if some compelling argument could be made as to why they should not fall under that purview in the first place.

The framework that I want to raise here, which has already been explored in both this (Allhoff, 2008) and more general contexts,[1] is that of dual loyalties. The idea behind this challenge is that, during times of war, military physicians have competing moral duties. The first set applies toward their military units—as might be understood by invocation of military necessity, chain of command, and so on—which are *non-medical*. The second set pertains to *medicine*, as might be motivated by, for example, the principle of beneficence: military physicians, *qua* physicians, should help those that are in need. During war, these two can come into conflict, as the case of battlefield triage undoubtedly indicates.[2]

As I have argued elsewhere, there are three ways to resolve this conflict (Allhoff, 2008). First, the competing loyalties could be commensurable, which is to say that they are somehow weighed against each other, and one set ends up outweighing the other set. Second, the medical duties could trump the non-medical duties. This is the sort of position argued for by Michael Walzer (1983) who, in a different context, postulated spheres of justice wherein, for example, medical decisions should only be made on medical grounds: invoking conservation of battlefield force would be patently inappropriate to determinations about where to focus our medical resources. Third, the non-medical duties could trump the medical duties. This seems to be the least popular line to take, although I have endorsed it in some contexts (Allhoff 2006). The idea here is that the medical duties, such as the principle of beneficence, simply do not attach to military "physicians" because these, properly understood, are not physicians per se, but rather some special sort of functionary within the military.

Applying these three approaches to the principle of salvage, then, there are three possible results. Let us explore these by consideration of a particular, if abstract, case. Imagine that there are two wounded soldiers and military medical resources to tend to only one. The first soldier will, regardless, not be returning to battle and will either suffer moderate injuries if treated now or else severe disability if triaged into civilian care. The second soldier will return to battle if treated now but, otherwise, will manifest minor injuries that will preclude him from returning to battle. Who should be treated?

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1 See, for example, Physicians for Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, Health Sciences Faculty, *Dual-Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms*. Excerpts reprinted in Allhoff (2008).

2 In addition to Gross's essay, see Adams, Marcus P., "Triage Priorities and Military Physicians" in Allhoff (2008).

The first approach says that actual details of the case matter: we would have to know what the specific injuries are, what the status of the military conflict is, what the chances are that this solider would be relevant to that conflict, and so on. This certainly seems, to many people, the most intuitive way to go. The second approach says that we have to tend to the person in the worse medical condition. While some people, such as Walzer (1983), defend this approach, it just seems completely implausible to me. For example, imagine that, if the one soldier is returned to battle, Good certainly triumphs over Evil and, otherwise, Evil certainly triumphs over Good. Further imagine that the stakes of such triumph are profound. For Walzer, none of this would *even matter* since such considerations are all extra-medical.

Finally comes the third approach, which says that the military factors are the only ones that matter. As extreme of a position as this seems to be, it is the one that I take the principle of salvage to be committed to: note that the *Army Field Manual* (2000) statement (cited previously) admits of no extra-military considerations. As I said, at least in some moods, I am sympathetic to this line, but it seems extremely counterintuitive. Gross (2008) has certainly not admitted to taking this view on board, but the position he advocates in his essay seems, at least to me, to require it. Insofar as we might have concerns with the approach, then I think Gross's views are implicated by association. Given space constraints, though, I will not explore this approach further.

I also want to make some brief comments about Gross's (2008) arguments against the appropriateness of medical treatment for those who will be unfit to return to the battlefield. One of my first reactions to his position was that there were reasons other than (immediate) combat success for treating these soldiers. Always the good philosopher, he anticipated these, particularly the ideas of military morale and political obligation. Regarding morale, he cites examples of armies with high morale *despite* poor medical care (e.g., guerilla armies in North Vietnam and Communist China). And Gross issues a legitimate challenge that the critic must address just how *much* medical care is necessary for good morale. Finally, as to the worry that fewer soldiers would enlist in the first place if there were not guarantees of superlative care, Gross worries that there is no data to address this question and that, regardless, we would still have to determine what level of care *would be* necessary to provide the appropriate inducement.

I fear, though, that some of this is more Sophistic rhetoric than substantive argument. The failure to be able to draw a line above which we have "enough" morale/enlistments hardly suggests that medical care is not *relevant* to these topics. It seems to me impossible that they are not correlated, or even highly correlated. If we were to stand outside a recruiting station and say to soldiers deployed in some active theater that their injuries would not be tended to by military physicians unless such treatment would "conserve the fighting strength" of their military units, we could hardly expect them to be excited about it. Ditto for prospective recruits. I think that both soldiers and recruits quite clearly have an expectation of care — whether justified or not — and that there would certainly be effects *somewhere* if it were widely disseminated that those expectations were to be flouted.[3] ■

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3. I further think that that some "Myth of the Metals" would both be inappropriate and unsustainable in this context. See Plato 1992. *The Republic*, trans. G.M.A. Grube. Indianapolis, IN: Hackett Publishing Company, Inc., 414a–415c.