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Chapter 3

Civilian Care in War: Lessons from Afghanistan

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Introduction

Military doctors and nurses, employees with a compound professional identity as they are neither purely soldiers nor simply doctors or nurses, face a 'role conflict between the clinical professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer, the state, or in this context, military command' (London et al. 2006). In the context of military medical ethics this is commonly called dual loyalty (or, less commonly, 'mixed agency', see Howe 1986). Although other professionals in the military, for instance counsellors or lawyers, might experience similar problems of dual loyalties, it seems that the dual loyalties experienced by military medical personnel are particularly testing. In his article on dual loyalties of military medical personnel, medical ethicist Peter A. Clark, for instance, writes that:

> Military medical personnel, especially in a time of war, are faced with the most ethically difficult dual loyalty of doing what is in the best interest of their patient and doing what is in the best interest of their government and fellow soldiers. This conflict has existed for as long as we have fought wars. It is the most difficult because it is the state or the military exerting the pressure on the medical professional. (Clark 2006: 571)

Clark's description of military doctors working in Abu Ghraib and Guantanamo Bay contains by now familiar examples of this dual loyalty problem, as does, less well-known, the research into the functioning of Dutch military medical personnel in Afghanistan (Meerbach 2009; Bak 2010). What became especially evident from that latter research was that, although most military medical personnel were of the opinion that they could deal with moral dilemmas in a an adequate manner, the way they in fact dealt with the dilemma, for example, helping or not helping members of the local population with medication reserved for their own military personnel, differed very much from person to person. For instance, where one medical worker would bend the rules somewhat and use medical means earmarked for treating military personnel to help a local in need of medical attention, another

would not. Yet both would be equally convinced that they had done the morally correct thing and would therefore feel no regrets afterwards.

Although medical personnel that face dilemmas such as the ones described above are able to take a decision, and can provide arguments to account for it afterwards, the question is whether that is sufficient in cases like these. As said, the decision taken, and the arguments to defend it rendered afterwards, can vary greatly from person to person. To give an example: both the fact that means should be saved for their own military troops that might need them any moment, and the fact that helping locals could undermine the local health system, were brought forward as arguments contra helping. Others conversely argued that helping locals increased goodwill, and could thus lead to better information and more support from the local population which would, in turn lead to more security for the troops (Meerbach 2009). Although these two lines of reasoning seem to be of an opposite character, and lead to opposite conclusions, the arguments pro and contra helping locals have in common that they are rather self-serving. The question is how bad a thing that is. Most military colleagues of military medical personnel, considering military effectiveness most important, will think it is not. Their medical colleagues from the civilian world, with their own oaths and codes in mind, will probably beg to differ, holding that military medical personnel ought to act from a strictly impartial ethos.

The next section will give a short overview of the military and the medical ethic, and of the resulting dual loyalty problem for medical personnel working in the military. The section after that deals with the question how these sometimes conflicting loyalties relate to being a professional, something medical personnel are the paradigmatic examples of, but also something military personnel claim to be. It is against that background that the two subsequent sections elaborate on the medical rules of eligibility used in Afghanistan, and on the policies concerning military involvement in local healthcare, to see what the existing rules and policies are, and whose interests they serve.

Military and Medical Ethics: The Dual Loyalty Problem

Now, most manifestations of the military ethic as well as the medical ethic are quite consistent as to whose interests are most important, though it seems that they point in different directions. For example, if we look at the Hippocratic oath, no doubt the best-known professional oath, we see that,

although it comes in many varieties, the common denominator is that doctors should work in the interest of their patients. In general, there is no mention of parties outside the doctor-patient relationship, such as hospitals or governments. The military oath is different in this respect. Although it also comes in many forms, it as a rule stresses loyalty to a head of state ('I will be faithful and bear true allegiance to Her Majesty Queen Elizabeth the Second, Her Heirs and Successors', UK Army and Marines), constitution ('I will support and defend the Constitution of the United States against all enemies, foreign and domestic', US Army), republic and people (Bundeswehr) or queen, laws and military law ('I will obey to military regulations, uphold the law, and be faithful to the queen', Netherlands Armed Forces). The people at the receiving end (and today that would, for instance, be the local population in Iraq or Afghanistan) are not included. For military medical personnel the clear difference between the medical oath and the military oath, and the conflicting demands that can result from that, testifies to the fact that a doctor or nurse in the military serves in his capacity as a physician a different client to that in his role as a member of the armed forces. For non-medical military personnel the client, if we want to use that term, is the state or the people, not the local population in, for instance, Iraq or Afghanistan. For civilian medical personnel, on the other hand, it is manifest that it is the patient who is their client, and no one else.

Similar to the difference between the military and the medical oath, the value lists of the different armed forces mainly mention values (such as courage, loyalty, discipline and obedience) that further military effectiveness and the interests of the soldiers themselves, their fellow soldiers and the military organization (Robinson 2007). The values of the medical profession, formulated by its professional organizations, give precedence to the patient and the doctor-patient relationship. They state, for example, that the practitioner should always work in the interests of the patient, refraining from prescribing treatment known to be harmful, and respecting the patient's dignity.

Finally, if we look at codes of conduct, we see that military codes are often aimed at safeguarding military personnel against pestering, sexual intimidation or discrimination. These codes are thus mostly about regulating the conduct of soldiers towards each other, rather than their conduct towards those they are to protect. Codes of conduct for doctors, to the contrary, do emphasize the interests of third parties, namely the patients, as do those of, for instance, the police. In fact,

practitioners of medicine have their own worldwide association, the World Medical Association, with its own International Code of Medical Ethics. That code goes into great detail about the duties of a physician to his or her patients but has little to say about duties towards colleagues. It specifies that 'a physician shall owe his patients complete loyalty and all the resources of his science'.

Not surprisingly, attempts to adhere to these two different ethics, medical and military, can – and do – lead to conflicting loyalties in the case of doctors working for the armed forces. Military medical personnel can, for example, be put in a difficult position when their presence during unlawful interrogation is presented as in the interest of the detainee. Advising on the prisoner's physical limitations enables the interrogator to use, for instance, sleep deprivation without causing lasting harm. Guantanamo Bay has been referred to as an example of doctors overlooking, not reporting, advising, and even assisting in the abuse of detainees. In such cases, 'military medical personnel are placed in a position of a "dual loyalty" conflict. They have to balance the medical needs of their patients, who happen to be detainees, with their military duty to their employer' (Clark 2006: 570; see also Miles 2006). As we already noted in the introduction, different dilemmas of dual loyalty arise when medical personnel must choose (and they regularly have to) whom to help first: a seriously wounded insurgent or civilian or a somewhat less seriously wounded colleague. Providing healthcare with the aim of bolstering the support for a military mission, that is, to win the hearts and minds of the local population, is another source of tensions.

An International Dual Loyalty Working Group attempted a few years ago to resolve the dilemmas military health professionals face by offering a set of ten guidelines (Dual Loyalty Working Group 2002). The net result was basically a plea to give preference to the medical ethic over military considerations, that is, to be loyal to the patient, under almost all circumstances. Drawing on the findings of that working group, some have appealed for a rights-based framework which represents 'a priori moral reasoning that privileges the protection of vulnerable people from state-sponsored harm, no matter the alleged justification' (Meerbach 2009; Bak 2010), and for civilian oversight by means of 'a commission with membership that includes an adequate number of civilian health professionals

skilled in ethical issues and human rights' (London et al. 2006: 388).[1] Although recognizing that 'in wartime, the exigencies of battle pose unique challenges incomparable to the civilian context because of the scale of the threats to life, unpredictability, and the levels of violence' (2006: 385), and that under some circumstances military necessity justifies deviating from what is normal ethical medical practice, these authors agree with the Dual Loyalty Working Group's first guideline that 'the military health professional's first and overruling identity and priority is that of a health professional', and hold that 'medical ethics during wartime are not fundamentally different from those applicable in peace' (2006: 388–9). Benatar's and Upshur's plan, in an article in the *American Journal of Public Health*, for a 'totally independent' medical ethics tribunal that should make the decisions when dilemmas occur (the authors do not seem to take into account the fact that there is probably not always time to ask the tribunal to rule a decision) is somewhat similar: its deliberations should be guided by the principles of public health issues solely (2008: 2166). As such, most of these solutions are more a denial of the tensions than anything else.[2]

Professionalization and Loyalty

At same time, however, all these authors offering guidelines that put the medical ethic first are very much in line with the opinion of the World Medical Organization, laid down in the *WMA Regulations in Times of Armed Conflict*, and holding that there is no difference between medical ethics in war and in peace. 'Medical ethics in times of armed conflict is identical to medical ethics in times of peace', the WMA for instance states. 'Standard ethical norms apply', the WMA policy in addition stipulates, and 'the physician must always give the required care impartially' – which also implies that distinguishing between combatants and civilians is not allowed. This means that 'if, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their

[1] This commission should provide 'the needed balance in determining what kind of military necessity justifies deviating from the norms of ethical medical practice' (London et al. 2006: 388). There is fact some reason to worry here, since under the guise of military necessity the idea of civilian immunity can be reduced to 'a useless garment' (Slim 2007: 174). Necessity is a matter of interpretation, and that inherent ambiguity is something with 'enormous consequences for civilians' (Slim 2007: 174).

[2] They also seem to deny that the moral dilemmas that military medical personnel face are in fact that: dilemmas. What these solutions and their proponents instead seem to suggest is that these apparent dilemmas are in fact tests of integrity: it is clear what is the right thing to do, yet there is considerable pressure (from peers, or the prospect of furthering one's own interest) to choose the wrong course of action (see Coleman 2009). Loyalty to colleagues seems to be nothing more than such a pressure. However, if loyalty amounts to a value, and for most members of the military (including military medical personnel) it is in fact a rather important one, than there is a dilemma again.

patients'.[3] This is in accordance with the 1977 Geneva Protocol, specifying that 'the personnel taking care of the wounded that they shall ignore the nationality or uniform of the person they are taking care of' (Protocol I, 1977b, Art. 10, paragraph 453; see also Gross 2006: 137.).

What the WMA and the Geneva protocols seem to ask for is a universalistic ethic (see also Gross 2006), that is, an ethic in which everyone, friend or foe, counts for the same. They do so, however, in a context of violent conflict where such an all-encompassing ethic is in fact a difficult one to adhere to. Especially in war we cannot but expect to see little willingness on the part of the political and military leadership to take the consequences to all parties into account equally – if that willingness was there, there probably would not have been a war in the first place. In war, armed forces argue, the principle of salvage (that is, returning as many soldiers to duty as quickly as possible), not medical need, is, and should be, the guiding principle of all medical efforts. It is what serves not only the military as a collective 'fighting force' best, but, in the end, also the survival of the political community it serves. War thus transforms medical ethics (Gross 2006: 324). What is more, the position of a practitioner of medicine in a civilian setting is, in essence, different from that of military personnel deployed on a mission. The medical staff of a civilian hospital can put the interest of their patients above everything else without putting themselves in harm's way, whereas military medical personnel cannot at all times act in the interest of the local population without incurring more risks to themselves and to their colleagues.

For these reasons, and especially when we consider the fact that in the eyes of many the predominant task of a defence organization is still the defence of its own territory, the strong and exclusive emphasis on institutional loyalty in the military is perhaps not very surprising. Soldiers are, generally speaking, above all concerned about their own safety and the safety of their colleagues, which they (similar to politicians and the public) rate higher than that of the local population. They act, to use the jargon, from agent-relative reasons and not from agent-neutral reasons, meaning that the relationship in which the subject (stranger or colleague) stands to them matters (Parfit 1987: 27). This loyalty to colleagues and the organization (loyalty to colleagues seems to be a much stronger motive for most military personnel than loyalty to the organization, though) is the part of the military ethic that is most

[3] The WMA policy can be found at http://www.wma.net/en/30publications/10policies/a20/index.html.

at odds with what a 'regular' professional ethic entail. In the past, some have for that reason maintained that the military profession was ill-suited to develop into a 'true' profession (see for instance Van Doorn 1975).[4] In light of that emphasis on loyalty in the military, it is probably also not very surprising that when military medical personnel have to choose between their responsibility for their patients and the demands of the military, they sometimes have their obligations to their patients overridden by their sense of military duty (see also Clark 2006: 577).

It is possible, then, to reject the WMA standpoint out of hand as an example of utopian thinking, as Michael Gross does in his *Bioethics and Armed Conflict* (2006). One could conversely argue, however, that the attitude the WMA asks for – loyalty to one's professional ethic instead of to one's organization, colleagues and countrymen – is nothing more or less than what is commonly understood to be one of the key characteristics of a professional. As a result military medical personnel are to deal with situations in which conflicting values – the safety of oneself and one's colleagues versus the safety of the local population, but possibly also between military virtues and more civilian ones – impose conflicting demands on them. The next two sections attempt to relate the theory to two practical examples already hinted at in the above: the treatment of civilians and the military's involvement in local healthcare, set against the background of the current ISAF mission in Afghanistan.

Treating Injured Civilians

Due to the nature of today's expeditionary missions, militaries are often confronted with local nationals in need of medical attention, and although military health care's primary role is to conserve force strength, giving medical assistance to civilians has become an important component of military operations (Neuhaus 2008). In fact, over the past decade, the majority of patients treated by international militaries have been civilian patients (Neuhaus 2008). Today, ISAF personnel are

[4] An important factor contributing to the strong organizational loyalty in military organizations is that, in fact, quite some conscious effort is made to *ensure* that military personnel become loyal employees, mainly by meticulously socializing them into the armed forces (and, possibly even more so, their own service). This socialization into the organization, instead of into a profession, is made easier by the fact that, where doctors, but also lawyers, receive most of their formal professional training before entering their job (the oldest profession, the clergy, forms possibly an exception), military personnel are predominantly trained in house. Furthermore, professional associations, compared to similar associations in other professions, traditionally do not play much of a role in the development of the profession (and as a result do not enhance loyalty to the profession), as they mainly look after the material interests of their members (Van Doorn 1975: 36). As a consequence, there are organizational values (in many forces still service specific), but, as yet, not really any values of the military profession. Nonetheless, not many authors today seem to take issue with the view that the military profession is, indeed, a profession.

confronted on a regular basis by Afghans in need of medical help, and sometimes they have injuries that are a result from the activities of ISAF or Afghan National Security Forces (ANSF). In other cases, however, sick or injured Afghans will seek medical treatment from ISAF personnel because civilian healthcare is either not there or not good enough. To avoid that commanders have to decide for themselves whether or not to provide healthcare, an imposition that could be a burden to them and something of a gamble for the Afghan seeking help, since 2006 NATO military medical workers in Afghanistan have to work by the so-called *Medical Rules of Eligibility*, offering guidelines for deciding whether or not to provide medical treatment to non-ISAF injured. These *Medical Rules of Eligibility* include a flow chart offering three options: the injured person is (1) a member of ANSF requiring emergency aid; (2) a non-combatant injured by conflict activity with ANSF or ISAF troops; (3) a non-combatant and the injury is unrelated to conflict activity.[5]

In case of the first option, the injured person is treated in the casualty chain of the Coalition Forces (ISAF or OEF). After treatment the patient is discharged or transferred to an Afghan National Army (ANA) or civilian hospital. If it is a non-combatant that has injuries that are a result of ISAF activity (the second option) the patient is also treated in the casualty chain of the Coalition Forces, even if the injuries are not too serious. In such cases of collateral damage medical support is given so as to not to lose the support of the local population (Bak 2010). Also, the rules leave room to help someone (or his or her relative) important enough to be of future use to ISAF (Bak 2010). After treatment the patient is either discharged or transferred to a local national or NGO hospital. When the injured person is a non-combatant and the injury is unrelated to conflict activity (the third option), treatment depends on the extent of emergency care required and the extent of spare capacity within the medical facilities of the Coalition Forces. If considered an emergency and capacity is available the patient is treated within Coalition Forces' medical facilities. In any other circumstances the injured person is transferred to a local national or NGO hospital. As to what amounts to an emergency the *Medical Rules of Eligibility* stipulate that civilians with injuries unrelated to conflict activity are only to be helped in case of injuries that are threatening to life, limb or eyesight.

[5] Non-combatants not only include the local population, but also media, contractors, personnel attached to UN agencies and humanitarian workers (Neuhaus 2008).

In general, in these rules the interests of own military personnel (and Afghan National Security Forces personnel) outweigh those of the local population. As a consequence, every so often Afghans in need of medical attention will not be helped, even if the means to do so are probably there; on a daily basis treatment of local nationals is refused or discontinued to keep enough capacity for coalition soldiers (Leemans and Van Haeff 2009). As a rule such decisions are taken by the military commander, not by the doctor; the latter, who has an advisory role, is thought to be less prone to take the operational interests into account (Bak 2010).[6] This partiality in the provision of healthcare can pose moral dilemmas for the medical personnel involved (Meerbach 2009), who face the choice between following the military line by strictly abiding the rules on the one hand, or taking a more lenient view on the rules, and thus acting upon their medical professional ethic, on the other. They, for instance, have the option to use means available abundantly (bandage, for instance), or to exaggerate wounds (and categorize them as threatening to life, limb or eyesight). One Dutch doctor somewhat overdid it by characterizing a harelip as life threatening (Bak 2010). Reasons for taking a fairly lenient view were divers. For instance, an infant at the gate with non-life threatening appendicitis will, if sent away, develop into a case needing emergency help in a day or so (Bak 2010). The wish to keep in practice, and avoid inactivity, was also mentioned as reasons for taking a merciful view were. Newer versions of the *Medical Rules of Eligibility* tend to be more specific in order narrow down the room left for interpretation – something also medical workers seem to welcome (Bak 2010).[7]

Military Involvement in Local Healthcare

In his article on dual loyalties, already referred to in the above, Clark poses the question whether there is ‘a need for guidelines to be established that assist military medical personnel in dealing with the issue of “dual loyalty”’ (2006: 571) As we have seen in the previous section, the answer has to be that such guidelines are, in fact, often already there, at least as far as injured civilians are concerned.

[6] Notwithstanding the fact that not all patients were eligible, in the Dutch-led Role 2 hospital in Uruzgan approximately 90 per cent of the patients treated were Afghans. The treatment of non-combatants with injuries, regardless whether they resulted from conflict activities, poses some problems, the foremost being that ISAF’s medical services are to support the mission by treating soldiers who generally are fit, healthy, and young, whereas local civilian patients include the elderly, children, and disabled; the kind of patients, obviously, the military casualty chain is not designed for. To provide proper care to such patients military nurses and doctors needed special medication, food and rooms to temporarily house the patients’ relatives.

[7] In practice, the degree and nature of care contributing nations provide, and the number of patients treated, can vary considerably. While the Dutch in Uruzgan referred all non-combat and non-critical patients to the local provincial hospital, the US hospital in that province abided by less strict rules, thereby attracting many local nationals preferring US military healthcare over the care provided in the provincial hospital.

However, as regards Clark's second, seemingly harder question – what should the guidelines for military medical personnel be? – medical professionals might wonder whether the present rules of eligibility sufficiently take into account the interests of all parties involved. However, in recent years we have seen military personnel serving in a different capacity; not as medical personnel that should attend to the medical needs of own military personnel first, but taking part in projects that specifically aim at building goodwill by providing medical care to the local population. As we will see, these at first glance fairly humanitarian efforts can be subject to dual loyalties too, insofar as they are not undertaken as something worthwhile by itself, but as something that should help to attain the goals of a particular mission, as indeed seems to be the case.

The recent operations in Iraq and Afghanistan, in particular, have led to a revival of counter-insurgency thinking that emphasizes the importance of increasing the legitimacy of the host nation authorities. Something that is to be accomplished by the 'winning of hearts and minds' of the local population (Egnell 2010), for instance by using military medical capacity to improve healthcare for the local population.[8] This mainly takes place under the headings of Medical Civic Action Programs (MEDCAPs) and of medical engagement. The first, MEDCAP, is commonly used in NATO as the generic term for the use of military medical capacity to provide healthcare to members of the local population in remote areas. A medical engagement refers to a medium or long-term medical assistance project *without* direct patient contact. Typically, a medical engagement may consist of a public health engineering project (such as the construction of a clinic), a health education or clinical mentoring project, or a project involving the distribution of health-related 'consent-winning' items (for example, spectacles, shoes or vitamins).

These MEDCAPs and medical engagements form the most visible military contribution to local healthcare, and they seem to fit well into the classification of hearts and minds operations as 'a distinct category of tactical activities – separated from traditional military tasks' (Egnell 2010). For instance, according to ISAF's standard operating procedures MEDCAPs and medical engagements offer an opportunity to build trust with the Afghan people, develop ANSF medical and CIMIC public

[8] The British field manual on military support to peace support operations refers to hearts and minds activities as programmes or projects in the field of humanitarian affairs or development for which commanders can receive funding (UK Ministry of Defence 2004).

health capability, and assist the Afghan government to deliver visible benefits.[9] The primary objective of MEDCAPs and medical engagements is therefore the promotion of support for ISAF and the Afghan government by providing practical assistance to the local population. Improving the health of the population in line with the Afghan government's public health strategy is only a secondary objective.[10]

It is especially this combination of the aims of security for the troops and healthcare for the local population that can lead to tensions and dilemmas.[11] For instance, a report on a US MEDCAP in Iraq in 2003 states that:

> Understandably, the operational objectives were pacification of threats to US forces and community stability by showing cooperation in humanitarian deeds. Counter to intuition, the provision of medical care only was a collateral benefit. The recognition that the task primarily was one of public relations was philosophically important to all parties involved. (Malish, Scott and Rasheed 2006)

A result of the fact that improving healthcare was not the main objective of these activities was that the:

> perception of success of the MEDCAP II program was widely divergent between operational and medical personnel. Command had no means by which to judge the quality of medical care or the effects of the care on popular opinion. As such, numbers-treated became the rubric by which success was measured, and thus, the goal of future iterations. Medical personnel, on the other hand, became disillusioned. Physicians were hobbled by limited histories, scores of healthy 'patient', the absence of diagnostic testing, and, most importantly, the lack of follow-up. Some believed

[9] Since training and development of ANSF is a main objective of ISAF, MEDCAPs and medical engagements are conducted jointly with ANSF medical teams in order to develop local military medical experience.

[10] Nonetheless, in Uruzgan various medical engagements undertaken by Dutch military personnel focused on capacity building. To target maternal mortality the Dutch contingent set up a special training to increase the quality and number of midwives in Uruzgan. In addition, personnel of the provincial hospital in Tarin Kowt were given training on a regular base (Rietjens, 2010).

[11] Aside from the not insignificant fact that the whole enterprise all seems to be built on shaky causal assumptions regarding the connection between aid and stabilization (Wilder 2008). It is, for instance, not that certain that the provision of health services really contributes notably to a population's willingness to view its government in a more favourable light (Waldman 2007). Wilder (2008) points out that the contemporary interpretation of winning hearts and minds in a setting of comprehensive approaches to stabilization and peace building has created a number of questionable assumptions regarding the links between stabilization and aid. First, it is assumed that reconstruction efforts have stabilizing effects on conflict. It is thought that aid will lead to economic development which in turn, will bring about stability. Second, aid projects are assumed to help win the hearts and minds and thereby increase support for the host government and for the international presence. Third, extending the reach of the Afghan government is assumed to contribute to stabilization. However, Wilder's research in Afghanistan indicates that all these causal assumptions underlying today's hearts and minds approach may be false (2008).

> that the program 'violated basic ethical standards of medical care'. (Malish, Scott and Rasheed 2006)

Helping locals with an eye to furthering operational goals is thus a source of frustration for medical personnel. Their ethic prescribes that patients are important as such, and that care should be provided independently of 'what is in it for us'. Such experiences are a further illustration of the fact that the military medical personnel do not always consider military effectiveness to be their sole or even primary interest. In this case they seem to have been disillusioned about the fact that they could not provide local nationals with healthcare that meets their professional medical standards.

On a more general plane, the fact that military involvement in civilian healthcare is undertaken for other reasons than providing healthcare to those who need it raises the question of whether military healthcare activities that may seem to meet local needs on the short-term, can conflict with reconstruction principles such as sustainability and capacity building. Although the ISAF guidelines state that all MEDCAP and medical engagement activities should be planned in conjunction with the provincial Director of Public Health (DPH), this unfortunately not always happens. Many MEDCAP and medical engagement activities are still carried out in isolation from the local government and NGOs. Most of these efforts have a short-term focus, are more concerned with the quantity of people reached than with the quality of care provided, and can undermine the trust of the local population in their own health care system (Alderman, Christensen and Crawford 2010). As expeditionary missions are conducted temporarily, the provision of military healthcare to civilians is inevitably only for the time being, and often there will be little impact that is going to endure beyond the end of the mission. So, notwithstanding the fact that both the World Health Organization (WHO) and the Afghanistan Research and Evaluation Unit (AREU) point to the long-term nature of reconstructing Afghanistan's health sector, Western militaries provide the Afghanis with no more than temporary health care, whereas civilian organizations as a rule plan to stay in the area for a period of five to ten years. What is more, since military units are primarily responsible for security, there is always the chance projects aimed at the development of healthcare will be terminated abruptly if the security situation deteriorates (Rollins 2001).

It therefore seems that short-term military reconstruction interventions to increase stability and legitimacy in the countries of deployment, as well as the acceptance of the international presence, can be inconsistent with and, even undermine, long-term development (Rubenstein 2009). In the health sector particularly, short-term engagements should be considered carefully since improved health outcomes are reversible if access to services is interrupted, unlike for instance, gains in education.[12] Moreover, when future military contingents cannot maintain comparative levels of care, civilian expectations may be thwarted, which in turn might lead to security risks for own troops. Also, NGOs report that services run by or in conjunction with the military, for instance in Afghanistan, can endanger the population as well as local and international service providers (Rubenstein 2009; Rietjens and Bollen 2008). As soon as insurgents understand that a health intervention is designed for strategic purposes, health facilities and workers will in all likelihood become a target (Ryan 2007), jeopardizing the safety of development projects and personnel in the vicinity (Rubenstein 2009). In areas in Afghanistan where the Taliban are strong 'the challenges of implementation are nevertheless beyond the humanitarian and development competences of the military'. For example, in the Korengal Valley newly constructed clinics were destroyed the moment they were finished (Egnell 2010).[13]

It is mainly because of these concerns that, while very popular during the first years of the operation in Afghanistan, much less MEDCAPs are carried out nowadays. General Petraeus, for instance, stated in a letter of 9 November 2010 to ISAF commanders that MEDCAPs should only be used in areas where there is no health care provision and when it can be sustained until others take

[12] It is for such reasons that the development community has argued that both humanitarian principles as well as principles of (health) reconstruction, such as ownership, sustainability and capacity building, risk to be sacrificed by military involvement in healthcare reconstruction in an attempt to attain military strategic advantages (Rubinstein 2009).

[13] Not surprisingly, both within the military and the humanitarian community there are serious doubts concerning the utility of military engagement in humanitarian and development projects (Egnell 2010). Canadian Major-General MacKenzie is reported to have said that 'soldiers are not social workers with guns. Both disciplines are important, but both will suffer if combined in the same individuals' (Adinall 2006). The aid community, holding that improved health care should not be a mere means to achieve political stability but is something that is in itself worth striving for (Waldman 2007), seems to agree for at least two main reasons. First of all, the military often lack humanitarian expertise, experience, and training needed to conduct these types of activities effectively. While providing healthcare impartially to those in need forms the essence of the medical oath, some worry whether military medical staff have the necessary humanitarian expertise to perform these 'good deeds' in the right way. Although the military may command a part of the necessary resources, it perhaps does not know how to put their resources to good use (Bollen 2002), with the result that military projects in the sphere of development and humanitarian affairs often underperform in terms of cost-effectiveness and sustainability (Egnell 2010). Secondly, by engaging in these projects, militaries are blurring the lines between military and civilian actors. Both recipients of aid as well as the conflicting parties may find it difficult to distinguish between providers of assistance and combatants: 'if the humanitarian community is associated not only with the intervening powers, but also with the political and military agendas of the larger intervention, the humanitarian space – access to suffering communities on both sides of the confrontation line, based on the humanitarian principles – risks being eroded' (Egnell 2010).

over. For the rest, MEDCAPs should be avoided, although Petraeus (and the ISAF Standard Operating Procedure on Military Medical Engagement in Health Sector Reconstruction and Development) makes one important exception: that is when 'force-protection considerations outweigh the potential harmful effects' (Petraeus 2010). If that is the case, MEDCAPs are still acceptable, and that again seems to suggest that, in the end, as far as militaries are concerned, and in spite of how their own military medical personnel might feel about it, considerations of military effectiveness prevail in military medical ethics.

Conclusion

The concerns regarding MEDCAPs, and General Petraeus's pragmatic response to those concerns, but also the dilemmas experienced by military medical personnel when they have to decide on the treatment of local nationals, illustrate that behind the many moral questions military medical personnel face today is the conflict between loyalty to a group – one's colleagues or organization – on the one hand and a more universal ethic on the other hand. In general, the interests of colleagues and the organization win through. The two cases elaborated on in this chapter show that there are rules and policies to assist military medical personnel in their work, but also that these rules and policies do not equally weigh the consequences to all parties. The rationales behind today's 'hearts and minds' approach are, for instance, to a large extent self-serving. Winning over the local population is considered essential for the success of today's missions, as it is thought to yield better information and more cooperation from the local population, and thus, in the end, increased security for the troops. That seems to suggest that current efforts to improve the healthcare situation of the local population in Afghanistan might come to a halt if the expediency argument no longer carries much weight. At first sight, that might seem a rather dismal conclusion. Yet, as it stands, the largest part of military codes, oaths, value systems and culture seem antagonistic to the idea that the plight of local civilians counts for the same as that of a Western soldier. Military effectiveness and loyalty to organization and colleagues still hold central place in the military ethic (Robinson 2007), and hence also in the military medical ethic.

This ethic took shape, however, at a time in which the interests of the local population played a lesser role, as the main task of Western militaries was the defence of their own territory. It is evident

that the tasks of most militaries have widened in scope, which essentially means that they have to deal with more than just opposing forces, and one might expect that, with the shifting nature of warfare, from wars of self-defence to humanitarian interventions, military necessity may play less of a role in the future (see also Gross 2006: 330). In today's operations, the combined forces of law, politics, an increased moral sensitivity, public opinion, and extensive media coverage, both at home and abroad, put increasing pressure on military personnel to take the interests of others, rather than just the organization and colleagues, into account; in recent years more so than ever before (Cook 2004; Olsthoorn 2010). Although this poses questions and dilemmas for military medical personnel they were not likely to encounter in earlier days, one might also ask the question whether, at a time that many armed forces consider the promotion of universal principles as their main ground for existence, the development of a more encompassing military medical ethic, with the main focus of loyalty being the professional ethic instead of the organization, is still too far-fetched.

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