Dual Loyalties in Military Medical Care – Between Ethics and Effectiveness

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Contents

'Colonel,' Hawkeye said, 'we appreciate your position.'

'Right,' Duke said.

'I will define ours,' Hawkeye said. 'It reads about like this: As long as we are here we are going to do the best job we can. When the work comes our way we will do all in our power to promote the surgical efficiency of the outfit because that's what we hired out for.'

'Right,' Duke said.

'We'll also show reasonable respect for you and your job, but you may have to put up with a few things from us that haven't been routine around here. We don't think it will be anything you can't stand, but if it is you'll just have to get rid of us in any way you can.'

> *Captain Hawkeye Pierce and Captain Duke Forrest talking to Lieutenant Colonel Henry Blake of the 4077 Mobile Army Surgical Hospital (MASH) during the Korean War*[1]

1. Introduction

Military doctors and nurses, working neither as pure soldiers nor as merely doctors or nurses, may face a 'role conflict between the clinical professional duties to a patient and obligations, express or implied, real or

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[1]   Hooker 1968, p. 22-23.

perceived, to the interests of a third party such as an employer, an insurer, the state, or in this context, military command'.[2] This conflict is commonly called dual loyalty. Other professionals working for the military may find themselves entangled in similar role conflicts. For instance, in recent years anthropologists have faced similar dilemmas: their knowledge could be used for identifying targets, and the American Anthropological Association Executive Board stated on October 31, 2007 that 'such use of fieldwork-derived information would violate the stipulations in the AAA Code of Ethics that those studied shall not be harmed.'[3] However, the dual loyalties experienced by military medical personnel – or medical personnel, temporarily, attached to the military – seem particularly testing and they appear to have been so over time. In his foreword to the MASH novel, from which the motto of this chapter is taken, Richard Hooker (a pseudonym for the collaboration between medical doctor H.R. Hornberger and sportswriter W.C. Heinz) depicts working conditions at the time:

> Most of the doctors who worked in Mobile Army Surgical Hospitals during the Korean War were very young, perhaps too young, to be doing what they were doing. They performed the definitive surgery on all the major casualties incurred by the 8th Army, the Republic of Korea Army, the Commonwealth Division and other United Nations forces. Helped by blood, antibiotics, helicopters, the tactical peculiarities of the Korean War and the youth and accompanying resiliency of their patients, they achieved the best results up to that time in the history of military surgery.

> The surgeons in the MASH hospitals were exposed to extremes of hard work, leisure, tension, boredom, heat, cold, satisfaction and frustration that most of them had never faced before. Their reaction, individually and collectively, was to cope with the situation and get the job done. The various stresses, however, produced behavior in many of them that superficially at least, seemed inconsistent with their earlier, civilian behavior patterns. A few flipped their lids, but most of them just raised hell, in variety of ways and degrees.[4]

The Korean War, as today's operations in Iraq and Afghanistan, amongst others, presented many combat situations prone to the occurrence of dual loyalty problems. According to Peter A. Clark:

[2]   London et al. 2006; see also Howe 1986.
[3]   <www.aaanet.org/about/policies/statements/human-terrain-system-statement.cfm>, accessed May 25, 2013.
[4]   Hooker 1968, p. 6-7.

> 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.[5]

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 the less well-known research into the functioning of Dutch military medical personnel in Afghanistan.[6] The latter research showed that although most military medical personnel think that they can handle moral dilemmas in a an adequate manner, in practice the solutions chosen (e.g., helping or not helping members of the local population with medication reserved for their own military personnel) differ very much from person to person. Where one medical worker is willing to use medical means earmarked for treating military personnel to help a local in need of medical attention, another is not, yet both will be convinced that they do the right thing. In general, two arguments contra helping local populations are being mentioned. Firstly, medical means should be saved for own military troops that might need them any moment, and, secondly, by extending military medical care to locals local health systems may be undermined. Conversely, it is argued that helping the local population increases goodwill, and may lead to better information and more support, in turn leading to more security for the troops.[7]

Although these two lines of accounts[8] seem to be of an opposite character, leading 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 will think it is not, as they will consider military effectiveness a greater good than medical ethical considerations. Their medical colleagues from the civilian world, however, will probably hold, with their own oaths and codes in mind, that military medical personnel should act from a strictly impartial ethos. What is more: although it is a good thing that medical personnel can make up their mind when presented with such dilemmas, the fact that different persons take different decisions, and find

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[5] Clark 2006, p.571.
[6] Meerbach 2009; Bak 2010.
[7] Meerbach 2009.
[8] Scott and Lyman 1968, p.46.

different arguments underpinning their choice, makes the situation some-what unpredictable for the locals seeking medical attention.

The next section will give an overview of the military and the medical ethic and of the resulting dual loyalty problem for medical personnel work-ing in the military. The third section deals with the question how dual loyalties relate to being a professional, something medical personnel are the paradigmatic examples of, but also something military personnel claim to be. Against that background, 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 exist-ing rules and policies are, and whose interests they serve. Finally, we will present a conclusion.

2 .   M I L I T A R Y   A N D   M E D I C A L   E T H I C S :   T H E   D U A L   L O Y A L T Y   P R O B L E M

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.[9] If we look at the different versions of the medical oath we see that the common denominator is that doctors should work in the interest of their patients. There is no mention of parties outside the doctor-patient relationship, such as hospitals or governments. The military oath also comes in many forms, but as a rule stresses loyalty to a head of state (UK Army and Marines), constitution (US Army), re-public and people (Bundeswehr) or king, laws and military law (Netherlands Armed Forces). The people at the receiving end, for instance the local population are not included. For military medical personnel the clear dif-ference between the medical and the military oath testifies to the fact that doctors and nurses in the military serve in their medical capacity a differ-ent client than in their capacity as members of the armed forces. For non-medical military personnel the client is the state or the people, and not the local population. For civilian medical personnel 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, different armed forces mainly mention values (such as courage, loyalty, discipline and obedience) that further military effectiveness and the inter-ests of the soldiers themselves, their fellow soldiers, and the military orga-

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[9] For a different view: Schulzke 2013, p.44.

nization.[10] Although there is evidently still a role for these soldierly virtues, they are not particularly helpful to the local population of the countries that military personnel are deployed to. The values of the medical profession, formulated by its professional organizations, do 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, researching codes of conduct, we see that military codes are often aimed at safeguarding military personnel against pestering, sexual intimidation, or discrimination. They are more about regulating the conduct of soldiers towards each other than about regulating their conduct towards those they are to protect. Codes of conduct for doctors, to the contrary, emphasize the interests of third parties, namely the patients. In fact, practitioners of medicine have their own worldwide association, the World Medical Association (WMA), 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'.

Attempts to adhere to these two different ethics are likely to cause conflicting loyalties for military medical personnel. They are, for instance, 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 sleep deprivation without causing lasting harm. 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'.[11] As we already noted, different dilemmas of dual loyalty arise when medical personnel must choose whom to help first: a seriously wounded insurgent, or civilian, or a somewhat less seriously wounded colleague. Having to provide healthcare with the aim of bolstering the support for a military mission is another source of tensions.

In an attempt to resolve the dilemmas military health professionals face, an International Dual Loyalty Working Group offered a set of ten guidelines.[12] The net result was a plea to give preference to the medical ethic over military considerations, and to be loyal to the patient under almost

[10]   Robinson 2007.
[11]   Clark 2006, p. 570; see also Miles 2006.
[12]   Dual Loyalty Working Group 2002.

all circumstances. Drawing on that appeal, some have called for a rights-based framework that represents 'a priori moral reasoning that privileges the protection of vulnerable people from state-sponsored harm, no matter the alleged justification', 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'.[13] According to London et al., this commission should provide 'the needed balance in determining what kind of military necessity justifies deviating from the norms of ethical medical practice'.[14]

Although these authors see 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', and that under some circumstances military necessity justifies deviating from what is normal ethical medical practice, they at the same time hold that 'the military health professional's first and overruling identity and priority is that of a health professional', and that 'medical ethics during wartime are not fundamentally different from those applicable in peace'.[15] This view also underlies the plan 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: only principles of public health should guide its deliberations.[16]

Most of the solutions outlined above are more a denial of the tensions than anything else. Moreover, they 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.[17] 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, again, there is a dilemma.

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[13] London et al. 2006, p. 387 and p. 388.
[14] London et al. 2006, p. 388.
[15] London 2006: p.385 and p. 388-389.
[16] Benatar and Upshur 2008, p. 2166.
[17] Coleman 2009.

3. Two Professions, Two Loyalties

Although perhaps unfeasible in the eyes of the military, all guidelines that put the medical ethic first are in line with the World Medical Organization's *Regulations in Times of Armed Conflict*, which hold 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 continues, 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 patients'.[18] This is in keeping with the 1977 Geneva Protocol that specifies that 'the personnel taking care of the wounded that they shall ignore the nationality or uniform of the person they are taking care of'.[19]

The WMA and the Geneva protocols represent a universalistic ethic in which friend and foe count for the same.[20] However, in the context they address, such an all-encompassing ethic is difficult to adhere to. In war there is little willingness on the part of the political and military leadership to take the consequences to all parties into account equally – there probably would not have been a war in the first place if that willingness was there. In his critique on utilitarianism, Walzer has pointed out that the valuing of 'each and every person' in the same way will not work when 'solidarity collapses.' And precisely that is what happens in war, when 'cost/benefit analysis has always been highly particularistic and endlessly permissive for each particular. Commonly, what we are calculating is our benefit (which we exaggerate) and their cost (which we minimize or disregard entirely).' In the end, 'no "enemy life" has any positive value; we can attack anyone; even infant deaths bring pain and sorrow to adults and so undermine the enemy's resolve.'[21]

Armed forces hold that in war the principle of salvage (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 the military as a collective 'fighting force,' and the survival of the political community it defends, best. War thus transforms medical ethics.[22] Also,

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[18] <www.wma.net/en/30publications/10policies/a20/index.html.>, accessed May 25, 2013.
[19] Protocol I, 1977b, Art. 10, paragraph 453.
[20] Gross 2006, 2013.
[21] Walzer 2004, p. 39.
[22] Gross 2006, p. 324.

the position of a practitioner of medicine in a civilian setting is essentially 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 always act in the interest of the local patients without incurring more risks to themselves and to their colleagues.

For these reasons, and because in the eyes of many the principal task of a defence organization is still the defence of its own territory, the strong emphasis on institutional loyalty in the military is not that surprising. Soldiers are 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. 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 at odds with what a 'regular' professional ethic entails. In the past, for this reason, some have maintained that the military profession was ill-suited to develop into a 'true' profession.[23] 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, military personnel predominantly are trained on the job. 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.

In light of this emphasis on loyalty, it may not be very surprising, nor necessarily a cause for condemnation, that military medical personnel sometimes have their obligations to their patients overridden by their sense of military duty when they have to choose between their responsibility for their patients and the demands of the military.[24] One could reject the WMA standpoint as an example of utopian thinking, as Michael Gross does in his *Bioethics and Armed Conflict*.[25] However, one could also argue that what the WMA asks for – loyalty to the medical ethic instead of to one's orga-

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[23] Van Doorn 1975.
[24] Clark 2006, p. 577.
[25] Gross 2006.

nization, colleagues, and countrymen – is a key characteristic of the medical 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. Such conflicting demands and the resulting experienced dual loyalty dilemmas are believed to increase levels of insecurity and stress and to have detrimental effects on both military and medical effectiveness. The next two sections will relate the theory to the two practical examples already mentioned: the treatment of civilians and the military's involvement in local healthcare, set against the background of the International Security Assistance Force (ISAF)'s mission in Afghanistan.

4. Treating 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.[26] Over the past decade, the majority of patients treated by international militaries have been civilian patients.[27] Today, ISAF personnel are 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). However, in other cases Afghans will seek medical treatment from ISAF because Afghan civilian healthcare is 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. Essentially, there are three options: the injured person is a:

(1) member of ANSF requiring emergency aid;
(2) non-combatant injured by conflict activity with ANSF or ISAF troops;
(3) non-combatant and the injury is unrelated to conflict activity.

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[26] Neuhaus 2008.
[27] Neuhaus 2008.

Non-combatants not only include the local population, but also media, contractors, personnel attached to UN agencies and humanitarian workers.[28]

In the first case, the injured person is treated in the casualty chain of the Coalition Forces, ISAF, or Operation Enduring Freedom (OEF). After treatment the patient is discharged or transferred to an Afghan National Army (ANA) or to a civilian hospital. If a non-combatant 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.[29] Also, the rules leave room to help someone (or his or her relative) important enough to be of future use to ISAF.[30] After treatment the patient is either discharged or transferred to a local national or NGO hospital. In case of a non-combatant with an injury that 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. 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 when injuries are threatening to life, limb, or eyesight. If not, the injured person is transferred to a local national or NGO hospital.

It appears that the interests of own military personnel (and ANSF personnel) outweigh those of the local population in these rules. Every so often Afghans in need of medical attention will not be helped, even if the means to do so are there; treatment of local nationals is refused or discontinued to keep enough capacity for coalition soldiers.[31] Such decisions are taken by the military commander, not by the doctor; the latter has an advisory role as he is thought to be less inclined to take the operational interests into account.[32] Military medical personnel, meanwhile, have to choose 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 may, for instance,

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[28] Neuhaus 2008.
[29] Bak 2010.
[30] Bak 2010.
[31] Leemans and Van Haeff 2009.
[32] Bak 2010.

use means available abundantly (e.g., bandage), or categorize wounds as threatening to life, limb, or eyesight while they are in fact not.

Reasons for taking a fairly lenient view are 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. The wish to keep in practice, and avoid inactivity, was also mentioned as reasons for taking a merciful view. [33]

5. Using Military Medical Capacity to Win Hearts and Minds

Peter A. Clark suggests that there is 'a need for guidelines to be established that assist military medical personnel in dealing with the issue of "dual loyalty"'.[34] As we have seen, such guidelines do already exist, at least as far as injured civilians are concerned – although medical professionals might wonder whether the present rules sufficiently take into account the interests of all parties involved. In recent years we have seen military personnel serving in a different capacity, though; not as medical personnel that should see to the medical needs of colleagues first, but taking part in projects that aim at building goodwill by providing medical care to the local population. Note, however, that such fairly humanitarian efforts are subject to dual loyalties too. They are often not undertaken as something worthwhile by itself, but as something that should contribute to the effectiveness of a particular mission.

The recent operations in Iraq and Afghanistan 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, for instance by using military medical capacity to improve healthcare for the local population.[35] This mainly takes place under the headings of Medical Civic Action Programs (MEDCAPs) and of medical engagement. MEDCAP is the generic term in NATO for the use of military medical capacity to provide healthcare to members of the local population in remote areas. A medical engagement is a medium or long-term medical assistance project *without* direct patient contact, such as the construction of a clinic

[33] Bak 2010.
[34] Clark 2006, p.571.
[35] Egnell 2010.

or the distribution of health-related 'consent-winning' items such as spectacles, shoes, or vitamins.

These MEDCAPs and medical engagements are the most visible military contributions to local healthcare, and they fit well into the classification of hearts and minds operations as 'a distinct category of tactical activities – separated from traditional military tasks'.[36] 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 health capability, and assist the Afghan government to deliver visible benefits. 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.

It is especially this combination of the aims of security for the troops and healthcare for the local population that may lead to tensions and dilemmas. A report on a US MEDCAP in Iraq in 2003 states that the aims of the undertaking 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.[37]

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 program differed 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 that the program 'violated basic ethical standards of medical care.'[38]

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[36] Egnell 2010.
[37] Malish, Scott and Rasheed 2006.
[38] Malish, Scott and Rasheed 2006.

Helping locals with an eye to furthering operational goals is 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 illustrate that military medical personnel do not always consider military effectiveness to be their sole or even primary interest. In this case they were 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 must be planned in conjunction with the provincial Director of Public Health (DPH), this unfortunately not always happens. Many MEDCAP and medical engagement activities are 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.[39] What is more, 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. And 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.[40]

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.[41] As soon as insurgents understand that a health intervention is designed for strategic purposes, health

[39] Alderman, Christensen and Crawford 2010.
[40] Rollins 2001.
[41] Rubenstein 2009; Rietjens and Bollen 2008.

facilities and workers will in all likelihood become a target[42], jeopardizing the safety of development projects and personnel in the vicinity.[43] 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.[44]

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.[45] 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. 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. A positive exception from the various medical engagements, which were focused on capacity building, undertaken in Uruzgan by Dutch military personnel. 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.[46]

Yet, it is mainly because of concerns such as those outlined above 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 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'.[47] 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

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[42] Ryan 2007.
[43] Rubenstein 2009.
[44] Egnell 2010.
[45] Rubenstein 2009.
[46] Rietjens et al. 2009.
[47] Petraeus 2010.

spite of how their own military medical personnel might feel about it, considerations of military effectiveness prevail in military medical ethics.

6. Conclusion

The dilemmas experienced by military medical personnel when they have to decide on the treatment of local nationals, the concerns regarding MED-CAPs, and General Petraeus's pragmatic response to those concerns, all illustrate that behind 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. These are the tensions the MASH novel (but the same goes for the movie and TV series) thrived on. Often, and in real life probably more often than in these fictional accounts, the interests of colleagues and the organization win through. The two examples in this chapter show that there are rules and policies to support the work of military medical personnel, 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. So, 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, and value systems are 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[48], 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 defense 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-defense to humanitarian interventions, military necessity may play less of a role in the future.[49]

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[48] Robinson 2007.
[49] Gross 2006, p.330.

Today, the combined forces of law, politics, an increased moral sensitivity, public opinion, and extensive media coverage require military personnel to take the interests of others, rather than just the organization and colleagues, into account.[50] Although military medical personnel as a result face questions and dilemmas they were not likely to encounter in earlier days, one might also wonder whether the development of a more encompassing military medical ethic that emphasizes loyalty to the professional ethic instead of to the organization is still too far-fetched at a time that many armed forces (sometimes even professing to be a 'force for good') consider the promotion of universal principles as their main ground for existence.

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