Virtual Mentor
American Medical Association Journal of Ethics
October 2007, Volume 9, Number 10: 718-721.

History of Medicine
From Medical Neutrality to Medical Immunity
Michael L. Gross, PhD

To what extent are physicians neutral in war? After all, the job of any army medical corps is to maintain the fitness of the armed forces and to return the wounded to duty so they can fight again. Military surgeons, medics, and nurses support armies in the most fundamental way and insure their fighting capability. In what way, then, are they neutral?

Answering this question depends upon whether we understand neutrality to mean "impartiality" or "immunity." These are very different meanings, and only the second speaks to the neutrality of medical personnel as we know it today. "Impartiality" means "objective" and reflects the imperative to provide medical care without preference for one side or another. At one time, this was true. Medical workers who took the field as civilian volunteers in the early days of the Red Cross or Quakers who volunteered for the British Army in World War I tended to the wounded of both sides without distinguishing between them. This is not true, however, of modern-day military medicine. Here medical personnel augment military capabilities. This point is often lost on pacifists who agree to military service on condition that they be assigned to medical duties. Manuals for conscientious objectors, therefore, find it necessary to warn against such naivete:

> …some men are actually inducted into the medical service thinking that medics are instruments of mercy apart from the Army and its primary objectives. This erroneous conclusion can lead to serious personal difficulties. True, the medics save lives and ease suffering, sometimes in a manner which takes real heroism. But the medic is a soldier, and the ultimate objective of medics is to win battles [1].

Nevertheless, medical personnel are different from other battlefield actors. Although they are not neutral in the sense of being impartial, medical workers do retain a large measure of immunity or protection. Their immunity from harm is one of the most enduring conventions of modern war. In the early modern period, there were several ad hoc agreements to protect medical personnel and to repatriate them if captured. But quality medical care did not become a feature of modern war until the mid-19th century [2]. Prior to this time, the wounded often found themselves abandoned when the fighting ended. Those who made it to an aid station received abysmal care, and the mortally wounded were shunted aside to die alone and unattended. These were the horrors that Henry Dunant witnessed at the battle of Solferino, Italy, that brought

him to lead an international effort to found the Red Cross in 1859. Red Cross volunteer nurses were not soldiers, but civilians. They were not beholden to any army or nation, and were neutral by definition. As such, they could not enter the battlefield without a guarantee of protection from the warring parties. This volunteer nursing effort was the basis for the First Geneva Conference in 1863 [3].

By 1868, the Geneva accords had firmly established the conventions of medical neutrality. Nonmilitary medical personnel required immunity because they were, in fact, neutral, unarmed, and incidental to the war. Their immunity stemmed from their prior, objective neutrality, not from the medical task they performed. Nuns tending religious needs enjoyed the same protection as nurses caring for the wounded. The fact that some served a medical function did not, in and of itself, accord protection. Yet as volunteer medical personnel continued to work closely with, and under the direction of, "official medical personnel," that is, military surgeons, the two required and eventually came to enjoy identical protection. Neutrality passed seamlessly from nursing volunteers to military surgeons. As a result, the latter acquired a measure of objective neutrality, and we began to think of military medical workers as somehow incidental to war and "above the fray." By the 20th century, volunteer medical personnel largely disappeared as modern armies expanded their medical corps significantly. The volunteers were gone, but the principle of medical neutrality they initiated remained behind and intact.

Immunity, a Matter of Convention

From this brief history, it is important to see that immunity is a matter of convention or agreement; it is not a moral imperative linked to the practice of medicine or religion. That is, there is nothing about the practice of medicine that morally compels anyone to protect surgeons and nurses on the battlefield. As a military asset, they are vulnerable to death and injury. There is no compelling moral reason to distinguish between a doctor and a tank driver except for the fact that the sides *agree* to protect medical personnel. They do so out of mutual self-interest in the same way they agree not to harm one another's political leaders. In the latter instance, large armies fear anarchy should their top political echelon suddenly be wiped out. Anarchy would devastate the ability of either side to wage war, and, because both sides are equally vulnerable to its threat, it is mutually advantageous to protect one another's leaders. The same is true for medical care. Modern military organizations fear that, without their medical corps, they would not be able to maintain their fighting force. Since either side can easily respond in kind should the other target medical personnel, there are good reasons to protect them.

This arrangement holds up well (and has held up well) until one side withdraws from the agreement. But if medical neutrality is grounded in agreement, there is nothing morally wrong with attacking military surgeons if the sides agree otherwise or if one side refuses to sign on. This may occur when there is no longer an incentive to protect one another's medical personnel. This problem is acute in asymmetrical warfare in the Middle East. Following a vicious wave of terror attacks against

Israelis in February 2002, for example, the Israeli Defense Forces systematically entered Palestinian cities to destroy terrorist infrastructures.

The fighting in some areas was fierce, and troops sometimes fired on ambulances and killed medical personnel. In response to charges of violating medical neutrality, Israel drew attention to guerrilla practices of booby-trapping the wounded, using ambulances to transport terrorists and war materiel, and taking refuge in hospitals. Two arguments characterize the debate. One reaches to the conventional and reciprocal nature of medical immunity and suggests that, once one side violates the convention, the other side is no longer bound to respect it. The other argument accepts the overwhelming importance of medical immunity but argues that military necessity may override medical neutrality in those exceptional cases when innocent civilians are threatened by terror attacks.

These are relatively new arguments because each side now weighs the costs and benefits of violating immunity in a way that conventional adversaries could not. In conventional war, the risk of violating medical immunity was great, as were the benefits of respecting it. In asymmetrical warfare, this is not necessarily the case. Guerrillas will complain when ambulances are stopped and hospitals searched for suspected terrorists, but the benefits of using an ambulance or hospital for military purposes often outweigh the cost. Equally, the stronger power has nothing to fear from attacking medical installations except, perhaps, the condemnation of the international community. But violations of neutrality by guerrilla fighters, often for the purpose of conducting terrorist attacks, blunt public opinion. Many will see the logic, for example, of stopping, searching, and even attacking ambulances. Once one ambulance is used to transport arms or terrorists, what are the chances another will used in the same way? Human rights activists call on Israel to show restraint because the probability is not high. In fact, most ambulances *are* utilized for their intended purpose. Israeli responses echo rational choice: under uncertainty, the odds of abuse are even. And, if the odds are even and the potential harm to a single patient in an ambulance pales beside the potential harm posed by terrorism, then utility demands stopping each and every one. Palestinians complain that harm accumulates to their detriment; Israelis fear that the next ambulance may be a car bomb.

In this environment, civilians and wounded suffer as medical care is disrupted in precisely the way the Red Cross hoped to prevent. Here we see how clear, traditional guidelines are upended by insurgency warfare, creating acute dilemmas for commanders in the field and international law. Whether and how the international community will deal with the problem remains to be seen. The rules of warfare are changing rapidly as asymmetrical, guerrilla war replaces conventional warfare between nation-states. Time-honored conventions that include the protection of medical personnel, torture-free interrogation, the ban on assassination, and the prohibition of chemical weapons are all facing difficult challenges.

References

1. Tatum A. *Handbook for Conscientious Objectors.* 10th ed. Philadelphia, PA: Central Committee for Conscientious Objectors; 1970:87-88.
2. Gross ML. Neutrality. In: Gross ML. *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War*. Cambridge, MA: MIT Press; 2006:175-210.
3. International Relief Committee for Injured Combatants. Resolutions of the Geneva International Conference. Geneva, Switzerland. October 26-29, 1863. http://www.icrc.org/ihl.nsf/FULL/115?OpenDocument. Accessed August 29, 2007.

Michael L. Gross, PhD, is chair of the Department of International Relations at the University of Haifa in Israel. His recent publications include *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* (MIT Press, 2006).

Related in VM

Maintaining Medical Neutrality in Conflict Zones, October 2007