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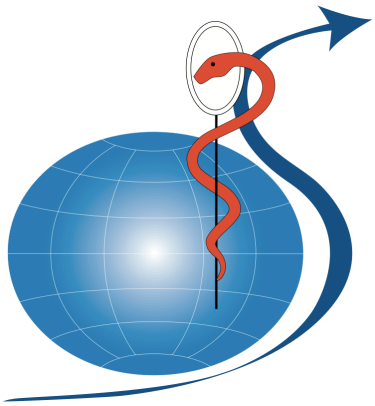
10th ICMM Workshop on Military Medical Ethics

Medical Rules of Eligibility and Medical Care under Resource Scarcity

26-28 April 2021 | Online Workshop via zoom

Hosted from Zurich, Switzerland



Patronage

Major General (ret.) Geert Laire, MD (ICMM Secretary General)
Major General Andreas Stettbacher, MD (Surgeon General, Swiss Armed Forces)
Prof. Dr. phil. Peter Schaber (Professor of Applied Ethics, University of Zurich)

Scientific Coordination

Dr. phil. Daniel Messelken
ZH Center for Military Medical Ethics

Lt Col David Winkler, MD, PhD
ICMM Center of Reference
for Education on IHL and Ethics

Workshop Organization

Swiss Armed Forces,
Medical Services Directorate

ICMM Centre of Reference for Education on International Humanitarian Law and Ethics

ZH Center for Military Medical Ethics

Scientific Coordination

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Idea of the workshop series

The idea of the *ICMM Conference Series on Military Medical Ethics and IHL* is to bring people from different backgrounds together, to share their experience and expertise on specific problems or ethical issues with the aim of discussing how to (re)act in future comparable situations. Speakers and participants have their expertise and experience in the fields of military, international humanitarian law, and philosophy, both from academia and practice. The conference itself gives large room for plenary and informal discussions. The plenary lectures shall be published.

Chatham House Rule

The whole workshop shall be held under the "Chatham House Rule" to encourage open discussions among the participants and the sharing of information.
This rule reads as follows:

> *When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed.*

The Chatham House Rule originated at Chatham House and it is now used throughout the world as an aid to free discussion. Meetings do not have to take place at Chatham House, or be organized by Chatham House, to be held under the Rule. Meetings, events and discussions held at Chatham House are normally conducted 'on the record' with the Rule occasionally invoked at the speaker's request.

SIWF Accreditation

The MME workshop has been accredited by the Swiss Institute for Postgraduate and Further Education in Medicine (SIWF / ISFM) with max. 12 Credit Points. Participants will receive a certificate and can check with their national institutions if the credit points are accepted by them..

Monday 26 April 2021

All times are given in CEST = UTC+2

Session I

14:00 – 18:00 (CEST/ UTC+2) **Chair: Johan Crouse / Daniel Messelken/ David Winkler**

14:00 – 14:15

Welcome	*Swiss Surgeon General and ICMM Chairman*	MG Andreas Stettbacher
	ICMM Secretary General	MG (ret) Geert Laire
Introduction to the Workshop		D. Winkler/ D. Messelken

14:15 – 15:00

The Military (Medical) Operational Planning Process – cradle of ethical challenges? — Bart Demuynck

Mini-Break

15:00 – 15:45

Ethical and Legal Basis for the Standards of Triage Used in the Russian Military Medical Service — Ivan Kholikov

30 Minutes Break

16:15 – 17:00

Interoperability: Ethical Challenges in En Route Care — Sarah Huffman

Mini-Break

17:00– 17:45

The Responsibility for Collateral Harm and the Second Rule of Eligibility — Michael L. Gross

17:45 – 18:00

Wrap-Up Day one – Plenary Discussion

Tuesday 27 April 2021

All times are given in CEST = UTC+2

Session II

14:00 – 18:00 (CEST/ UTC+2) **Chair: Eléonore Carrot/ Pamela Ermuth / Andreas Wildi**

14:00 – 15:00

Reconsidering triage: a panel presentation giving	*Simon Horne*
ethical, historical and medical perspectives	*Robert James*
on planning for mass casualty events in military and civilian settings	*Heather Draper*

Mini-Break

15:00 – 15:45

Medical Rules of Eligibility: A Comparative Analysis	Sheena Eagan
	Joanne Clifford
	Paul Eagan

30 Minutes Break

16:15 – 17:00

Ethical justifications for preferential treatment provisions?	Daniel Messelken

Mini-Break

17:00 – 17:45

Morally Responsible Triage in Crisis and War	Stephen Woodside

17:45 – 18:00

Wrap-Up Day Two – Plenary Discussion

Wednesday 28 April 2021

All times are given in CEST = UTC+2

Session III

14:00 – 18:00 (CEST/ UTC+2) **Chair: Bernard Koch/ Daniel Messelken/ Peter Schaber**

14:00 – 14:45

Ethical challenges triggered by medical rules of eligibility and triage: The way-out — Narender Singh

Mini-Break

14:45 – 15:30

Fairness in military care: Might a hybrid concept of equity be the answer? — Frederic Gilbert

30 Minutes Break

16:00 – 16:45

The Phenomenon of Allocation: Military Pathways in the Light of Biomedical Ethical Principles — Dirk Fischer

Mini-Break

16:45 – 17:30

Facing Death: An Ethical Exploration of Thanatophobia in Combat Casualty Care — Erika Ann Jeschke

17:30 – 18:00

Concluding Plenary Discussion

Closing Remarks	*ICMM Chairman of the Scientific Council*	MG (ret) Humbert Boisseaux
	Swiss Surgeon General and ICMM Chairman	MG Andreas Stettbacher

Abstracts and Bio Notes (in alphabetical order)

Bart Demuynck – *The Military (Medical) Operational Planning Process - Cradle of Ethical Challenges?*

Abstract

Sources of ethical challenges such as medical rules of Eligibility and who to care for in situations of resource scarcity can be very often found within the initial and final operational planning process. It is therefore relevant and important to understand how a military operation is planned, which steps there are in the process and when the seeds for later on ethical challenges in the field can be sown. Once this awareness acquired, one can hope and try to prevent some situations of resource scarcity or ethical challenges related to the MRE. This presentation will explain how military planning is done, will discover the "hot" moments in the process where with particular attention, ethical challenges can be partially or completely prevented.

Biographical Note

Colonel **Bart Demuynck** (BEL) started to introduce Ethical-Deontology-Loac-Leadership elements in the medical officers' course when he took over the command of the Belgian Medical Centre of competences (CCMed) in 2010.
He also attended and presented courses, lectures and workshops on the military medical ethical dilemmas theme in BEL Defense and ICMM community. Bart is the pilot of a multidisciplinary workgroup responsible for further implementation of MME matters into education and training. He served in 2006 and 2008/2009 in the UNIFIL missions and recently in the Operation Inherent Resolve against IS.
He combines his current position of Change Manager at the Belgian Medical Component and Head of the International Relations Office / PAO with the preparation of the ICMM World Congress 2021 to be held in Brussels and is still involved in MME thematic courses in the Belgian Medical Component.

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Sheena Eagan, Joanne Clifford, Paul Eagan – *Medical Rules of Eligibility: A Comparative Analysis*

Abstract

Despite International Humanitarian Law/Law of Armed Conflict (IHL/LoAC) requiring that medical care be provided without distinction, the realities of armed conflict have complicated the universal rule. Specifically, resource scarcity within the context of armed conflict has led to policy and practice that seem to contradict the foundational concept of non-discrimination. Simply put—sometimes health care providers cannot provide care to everyone, necessitating distinction between patient groups based not only upon medical need, but also military necessity, and patient identity (compatriot, ally, enemy, civilian, etc.). Policies defining an individual's eligibility and the level of medical care that they will receive from deployed medical treatment facilities are often called medical rules of eligibility or more. NATO Allied Joint Publication (AJP) 4.10: Allied Joint Doctrine for Medical Support was approved by the nations in the Military Committee Medical Standardization Board, and officially promulgated in September 2019. This doctrine states that the development of MRoE, "should be guided by operational requirements as well as by ethical and legal principles and ensure, that health service support capabilities can provide appropriate treatment and care when it is needed." This doctrine joins others in offering seemingly contradictory and confusing guidance to military healthcare providers, rendering full understanding and adherence challenging. The proposed presentation will offer comparative analysis of established policy on this topic: focusing on the Canadian Armed Forces (CAF), the United States Department of Defense (DoD), and recent NATO doctrine. This comparison will establish an overview of how these eligibility decisions are formalized into policy across military contexts, while highlighting recurring ethical issues.

Biographical Notes

Sheena M. Eagan is an Assistant Professor of Bioethics with Brody School of Medicine at East Carolina University. Dr. Eagan holds a PhD in the medical humanities as well as a Master of Public Health. Her research and teaching have focused on medical ethics and the history of medicine, with a sub-specialized focus on military medicine.
Dr. Eagan is co-director of ECU's Veteran to Scholar Bootcamp, an NEH funded program. She is also the creator and president of the American Society of Bioethics and Humanities group for Military, Humanitarian and Disaster Medicine and serves as a bioethicist for the CDMRP (Congressionally Directed Medical Research Program).

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Joanne Clifford is a Senior Analyst in the Defence Ethics Programme, within the Department of National Defence (Canada). A former Bioscience officer in the Canadian Armed Forces, Joanne holds an MA in Ethics and a Master of Public Health. She is a PhD candidate at Carleton University in their Ethics and Public Affairs doctoral program.

Dirk Fischer – *The Phenomenon of Allocation: Military Pathways in the Light of Biomedical Ethical Principles*

Abstract

Today a great number of medical ethical challenges in a military context result from allocational problems. The phenomenon of allocation is far more than a limitation of material and/or personal re-source. Particularly in times of war, the decisions based on allocational problems have serious consequences on the soldier's self-realization as a moral subject and under special circumstances may lead to moral injury. Whether allocation has to be based on medical necessity alone, or must consider military necessity primarily, seems to be a crucial question in this context. The usage of the four principles of biomedical ethics somehow does not suffice to take reasonable ethical decisions here. This is true for autonomy, beneficence and non-maleficence, as it is particularly for justice. Besides medical needs, cultural, social and political aspects influence the medical decision-making process as much as military needs. This is true for both, the medical treatment of the military personnel and the civil population. How far the usage of classical principles can lead in situations bearing serious military medical ethical challenges, will be discussed based on infield experiences of the Bundeswehr Medical Service.

Biographical Note

Dr. med. Dr. theol. **Dirk Fischer**, Teaching and Research Unit for Military Medical Ethics, Bundeswehr Medical Academy Medical doctor, philosopher and theologian. Doctor of medical history, doctor of moral theology, medical ethics consultant in the medical service of the Bundeswehr, head of the Teaching and Research Unit for Military Medical Ethic at the Bundeswehr Medical Academy Munich.

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Frederic Gilbert – *Fairness in military care: Might a hybrid concept of equity be the answer?*

Abstract

Applying equity to health care is difficult; it is especially challenging when applied to cases that involve urgent military medicine care under resource scarcity. Part of the difficulty centers on the concept of equity itself. It is not clear what the best concept of equity applicable to medical care would be, or that there should be only one, or the same ones, across all levels of military health care provision at which resource allocation occurs. Despite the fact that equity is a key concern in health care, it may be that there is no single theory of justice that would be most justified for military physicians to use. This paper examines whether a hybrid position that draws upon a number of theories of equity might be both theoretically robust and applicable in practice. After briefly introducing the discussion, we outline four major philosophical definitions of equity - 1) Egalitarianism, 2) Prioritarianism, 3) Desertism, and 4) Sufficientism- and examine each as applied independently of the others. We then report empirical findings suggesting that a practice-based hybrid concept of equity is used by physicians within the practice of micro-allocation. We finally examine how robust such hybrid views are by exploring their theoretical weakness and strengths. Our findings will shed lights on ethical justifications and reasoning which should guide medical rules for military and humanitarian health care providers.

Biographical Note

At the of writing this bio, I am a Senior Lecturer in Ethics, affiliated with the Ethics, Policy & Public Engagement program of the ARC Australian Centre of Excellence for Electromaterials Science (ACES), located at UTas, Australia. I am concomitantly an Ethics Consultant for the Centre for Neurotechnology, for which I conduct research at the University of Washington, in Seattle, USA. I have published over 65 publications in neuroethics, bioethics and applied ethics.

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Michael L. Gross – *The Responsibility for Collateral Harm and the Second Rule of Eligibility*

Abstract

According British and American formulations of the rules of medical eligibility, local civilians qualified for care in Coalition facilities in Iraq and Afghanistan if a. Their injuries pose an imminent threat to "life, limb and eyesight" and b. Their injuries are the direct result of Coalition military action. This presentation questions the moral logic of the second rule and asks the following question: Why do civilian victims of collateral harm enjoy a special right to medical care that other, more seriously sick or injured local civilians, do not enjoy? The answer is: They do not. Victims of collateral do not enjoy any special rights to medical care. There is little in law or ethics that dictates moral or legal liability for causing collateral harm. Collateral harm, properly understood, is permissible harm as long as it meets conditions of necessity, distinction and proportionality. Permissible harm is non-compensable whether with money or medicine. More generally, the US and other nations specifically disallow claims resulting combat operations. Nevertheless, there are two instances when medical care is justified. First, when required as the result of criminal or negligent behavior. Second, there are pragmatic grounds for offering medical care to the collaterally wounded if it quells resentment and engenders support for Coalition troops and the local government. This justifies the rules of medical eligibility by turning to military necessity, not moral liability or fault. It also rewrites the rule to mean that local civilians enjoy the right to medical care if it offers Coalition forces a military advantage. This may justify treatment for some victims of collateral harm but also justifies medical care for anyone, say the children of local warlords, who offer significant support for counter insurgency operations.

Biographical Note

Michael L. Gross is Professor of Political Science at the University of Haifa. His publications include Bioethics and Armed Conflict (MIT Press 2006), The Ethics of Insurgency (CUP 2015) and an edited volume, Military Medical Ethics in the 21st Century (with Don Carrick, Routledge 2013). He has published on military medical ethics, distributive justice and veteran care in the American Journal of Bioethics, The Cambridge Quarterly and the Hastings Center Report. Activities include workshops on battlefield ethics, medicine and national security for the Dutch Ministry of Defense, The US Army Medical Department, the Defence Medical Services (UK), The US Naval Academy, the International Committee of Military Medicine and the Medical Corps and National Security College of the Israel Defense Forces.

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Simon Horne / Robert James/ Heather Draper – *Reconsidering triage: a panel presentation giving ethical, historical and medical perspectives on planning for mass casualty events in military and civilian settings*

Abstract

Planning for military medical support has to encompass a number of different scenarios, one of which is the prospect of peer-on-peer conflicts with the potential to generate hundreds or thousands of casualties very quickly. In these circumstances, it is likely that the demand for care will outmatch the resource available. This will necessitate not only robust and stringent prioritisation of patients, but consideration of what care should be delivered and by whom, and indeed what injuries are unsurvivable in that setting. Using examples from the UK National Health Service and process improvement programmes, we will review what can happen to healthcare systems under intense strain and demonstrate how current triage systems will only exacerbate this problem in the context of a mass casualty incident. Having demonstrated that attempts to deliver 'gold standard' care will fail, we will argue that a recognised, evidence-based and planned 'silver standard' could be better than ad hoc care at both the individual patient and system levels. Describing early concepts arising from this re-evaluation of major incident management, we will identify ethical and other issues and opportunities that will need to be explored in order to ensure that patients (military and civilian) get the best care possible in these extreme circumstances. In particular, we will focus on how triage can support flow through functional areas both within and without facilities, rather than simply prioritising patients for interventions that may not be feasible, or at least not in time to deliver meaningful benefit. In addition, prioritising flow out of a facility will prevent it from being totally overwhelmed.

The success of the response will depend in part on the effective utilisation all available personnel and a recognition that 'silver standard' care will in many cases depend upon the best of what 'low skill/tech' solutions can offer. In the First World War, it was the equivalent of first responders (the specialist stretcher bearers) who, in addition to the

control of haemorrhage and other trauma management measures, made decisions about futility and palliative care for their patients. These skills and insights were not recognised or valued in the post-war setting, and opportunities to consolidate their place in the medical curriculum were missed. Historical accounts, in which these first responders describe their work, remain the most significant source for future curriculum design for peer-on-peer conflict.
By drawing on historical and ethical insights and combining military and civilian medical expertise this panel will offer an account of triage and mass casualty planning that is applicable for civilian, military and humanitarian contexts.

Biographical Notes

Lt Col **Simon Horne** is an Emergency Medicine Physician with research interests in Major Incident management and triage. His deployments include Iraq and Afghanistan, as the medical director of the UK Military Ebola treatment unit in Sierra Leone and also with the UN to South Sudan. He ran the UK Medical Civil-Military training course and has established a Military Global Emergency Medicine Fellowship in collaboration with the Royal College of Emergency Medicine. He is the research lead for the Academic Department for Defence Healthcare Engagement, with ongoing projects in Pakistan and Kenya.
Wing Commander **Robert James** is a Consultant in Emergency Medicine and Pre-Hospital Emergency Medicine. Having trained in London, Cambridge and the South West of the UK he now works at Derriford Hospital, the Major Trauma Centre for the South West Peninsula, and with Devon Air Ambulance. He is an Honorary Lecturer in Military Emergency Medicine for the Academic Department of Military Emergency Medicine and in Pre-Hospital, Retrieval and Transfer Medicine for the University of Plymouth. His research interests include the resuscitation of bleeding trauma patients, a subject on which he has published both papers and book chapters, and triage in major incidents.
Professor **Heather Draper** is Chair of Bioethics in Warwick Medical School, University of Warwick. She has published widely in bioethics, including on issues related to military medical ethics.
Personal webpage: https://warwick.ac.uk/fac/sci/med/staff/h_draper/
Military medical ethics project page: https://warwick.ac.uk/fac/sci/med/research/hscience/sssh/ethics/milmed/
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Sarah Huffman – *Interoperability: Ethical Challenges in En Route Care*

Abstract

In 2012, the surgeon generals of the United States, Australia, Canada, New Zealand, and Great Britain signed an international proclamation of understanding to promote cooperation and interoperability of air evacuation assets, which includes military medical personnel working side by side in a shared En Route Care environment. The ability of international medical services to work effectively together is critical to achieving allied tactical, operational, and strategic objectives, especially as the focus moves from limited contingency operations to potential large-scale combat operations (LSCOs) with prolonged field care. While AE personnel and Critical Care Air Transport (CCAT) teams played key roles in the high survivability of injuries in Iraq and Afghanistan, access to these high- demand, low-supply assets may be limited in LSCO. Current LSCO considerations for ERC include having fewer forward medical and evacuation resources making reliance on nearby Allied AE assets with integrated international teams and non-US equipment an urgent concern to manage anticipated combat casualties. While allied aircrafts are similar overall, medical equipment and procedures vary making clinical interoperability a challenge to the effective integration of US/Allied medical teams working in the AE environment and sharing evacuation aircraft. Improving combat casualty care within the US/allied shared ERC environment requires collaborative coordination of medical care to ensure and improve optimal combat casualty care during future contingencies. This presentation will provide an experience briefing related to the ethical challenges of coordinating care with coalition partners in a resource constrained environment. Using a case study to illustrate difficulties in coordinating combat casualty care, I show that communication and collaboration skills emerge as a central ethical concern.

Biographical Note

Lieutenant Colonel **Sarah L. Huffman** is Director of the 88th Medical Group Clinical Investigations Program, Wright-Patterson Air Force Base, Ohio. She is responsible for the execution of clinical research at the Air Force's second largest Medical Center, supporting 11 General Health Science Education programs with 180 Medical, Dental, Nursing,

and Biological Science Corps trainees. Additionally, she provides guidance and expertise in compliance, regulation, design, implementation, and management of research protocols and evidence-based care initiatives. Lieutenant Colonel Huffman's current research efforts include nutrition in Critical Care Air Transport patients, Team Coordination in Critical Care Air Transport personnel, Resilience in Combat Casualty Care Providers, Military Ethics, and Operating Room Communication. As the first dual nurse scientist, she collaborates between the 88th Medical Group and the 711th Human Performance Wing, Warfighter Optimization Division, Center for Clinical Inquiry bridging the gap between science, technology, and patient care.

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Erika 'Ann' Jeschke – *Facing Death: An Ethical Exploration of Thanatophobia in Combat Casualty Care*

Abstract

Over the past two decades, the ability to deliver advanced medical care on and off the battlefield along with a rapid casualty evacuation platform has allowed for unprecedented survival rates exceeding 90%. While laudable, these medical achievements have also set up a casualty management paradigm in which medical decision-making singularly focuses on life-saving care. Confronting near-peer adversaries in large scale combat operations (LSCO) on a multi-domain battlefield will make casualty management frighteningly more complex by introducing major infrastructural, personnel, and resource constraints. When considering the high number of casualties expected in LSCO alongside enormous limitations in medical resource and resupply capability, the current casualty management paradigm will not be sustainable. The resource constrained environment in LSCO will shift medical decision-making away from a singular focus on life-saving care to triage, which hinges on the ability to determine futile medical interventions—a skill that has been lost in the past two generation of combat casualty care providers. As such, a broad ethical challenge that arises in preparation for LSCO is the need to set new expectations concerning dying and death. However, medical decision-making focused on death and dying has not been explicitly addressed in military medical training, research, or policy. Relying on a body of literature known as terror management theory (TMT), I am going to argue that preparing combat casualty care providers to face dying and death is necessary to engage in effective and ethical triage. Familiarizing combat casualty care providers with dying and death will not only reduce the potential for cognitive overwhelm that could lead to mission failure, but also groupthink and rigid adherence to authoritarian leadership that could lead to medical crimes of war.

Biographical Note

E. Ann Jeschke, Ph.D. is a military medical ethicist. In 2015, Dr. Jeschke defended her dissertation on post-war reintegration. This multi-disciplinary research critiqued the over-reliance on modern notions of trauma to explain the phenomenon of resilience and reintegration in combat veterans. Dr. Jeschke's work heavily relies on the use of anthropological methods to articulate culturally sensitive concerns in the ethics of force health protection. She is broadly interested in understanding the virtue of caring as the center of gravity for military medical providers on the battlefield. Dr. Jeschke is particularly interested in exploring the human costs of war by looking at how exposure to death, dying and disfigurement impacts the provision of combat casualty care. Currently, her research explores grief processing after catastrophic injury to identify and articulate contemporary modes of ritual lament that might serve as an antidote to performance degradation and support readiness, retention, resilience and reintegration.

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Ivan Kholikov – *Ethical and Legal Basis for the Standards of Triage Used in the Russian Military Medical Service*

Abstract

The norms of International Humanitarian Law (IHL) oblige military medical personnel to provide medical assistance to all victims of armed conflicts without any distinction. Legal norms normally derive from ethical rules, which in case of military medical activity, are often reflected in various manuals, rules and procedures adopted both on national and international levels. Moreover, a moral code of common values known as the Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies was elaborated by the ICRC five years ago. This document aims to ensure the safety and protection of health care workers as well as patients in situations of armed disputes, and was endorsed

by a number of international organizations, including the ICMM. Later the UN Security Council unanimously adopted Resolution S/RES/2286 on Health Care in Armed Conflict reaffirming principles of international human rights and humanitarian law that provide health services immunity from attack and demanding that states and all parties to armed conflict comply with their provisions. The resolution reaffirms also that health workers should never be punished for following their ethical obligations to provide care, no matter the identity or affiliation of the patient. The obligations of the Russian Federation under IHL are reflected in the standards of triage used in the Russian military medical service. In order to comply with both ethical and legal requirements during the triage it is important to use the most objective criteria to assess the severity of the injury on every stage of medical evacuation. Such assessment is a cornerstone of the triage. While many foreign colleagues approach this problem using morphological, functional, etiological criteria or a combination thereof, in Russia it is more common to use descriptive categories where the complexity of the injury is a stable category and complexity of the condition of the injured is a dynamic one.

Biographical Note

Colonel (ret.) **Ivan Kholikov** is a graduate of Military University, Moscow. He participated in such international campaigns as United Nations Mission in Angola – 1996, Multinational Operation in Kosovo – 2001 and United Nations Mission in Chad – 2009. In 2014 he was in charge of the Russian military Ebola response team in the Guinea Republic. Having completed 24 years in the military he retired in March 2016 from activeduty service being decorated with a number of awards and medals for the distinguished service. Currently he is a Professor of the Chair of International and European Law at the Institute of Legislation and Comparative Law under the Government of the Russian Federation. Professor Kholikov is a Doctor of Law, author of numerous publications on international and military law, peacekeeping and international cooperation. He is a faculty member of the International Committee of Military Medicine (ICMM) at the Law of Armed Conflict (LOAC) courses and also holds the position of Legal Advisor to the Secretary General of ICMM.

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Daniel Messelken – *Triage and ethical justifications for preferential treatment provisions?*

Abstract

In emergency situations and when medical resources are sufficient, doctors are expected to prioritize and treat patients according to medical criteria only. This is the case in civilian settings (peacetime) but also during conflict (according to IHL) and in other emergency situations (according to widely accepted ethical principles).

In MASSCAL situations and when medical resources become insufficient, patient selection and prioritization may change. Rules of triage are applied with the aim of saving the largest number possible under the circumstances: collective health outweighs individual health. Still, according to the standard ethical principles, non-medical criteria should not influence the doctors' decision of who will be treated. (One notable exception is that other health care personnel may be prioritized in triage situation if and only if they can then help saving a bigger number of other patients.) In reality however, doctors may often feel that they cannot simply ignore all non-medical criteria, or they may even be asked to take non-medical criteria into account. For example, they may feel a desire to prioritize relatives over strangers in civilian settings or they may be ordered to treat comrades first and enemy combatants later in a conflict setting. In military contexts, so-called medical rules of eligibility even provide explicit rules that include non-medical criteria. This paper recapitulates ethical justifications of triage and provides arguments if and under what circumstances it may ever be ethically acceptable to prioritize patients according to non-medical criteria.

Biographical Note

Dr. phil. **Daniel Messelken** is heading the Zurich Centre for Military Medical Ethics (CMME) at Zurich University on behalf of Centre of Competence for Military and Disaster Medicine of the Swiss Armed Forces. The CMME conducts research and training in the field of military medical ethics, in partnership with the medical services of the Swiss Armed Forces and the Center of Reference for Education on IHL and Ethics of the International Committee of Military Medicine (ICMM). After his studies in philosophy and political science (Leipzig, Paris), D. Messelken gained his doctorate in philosophy from Leipzig University in 2010. Since 2012, he is a member of the Board of Directors of the International Society for Military Ethics in Europe (EuroISME). His research interests include military medical ethics, military ethics, disaster bioethics, and applied ethics.

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Narender Singh – *Ethical challenges triggered by medical rules of eligibility and triage: The way-out*

Abstract

All military conflicts and disasters are constraints on military medical care, as there are more casualties than medical echelon can handle. To overcome these constraints of limited resources and to provide medical care military medical team resort to triage. In triage most fatally wounded are given least medical care and eventually left to die. This basic philosophy of triage is totally against the medical rules of eligibility that all lives are to be saved with all possible means despite of any cast, color, creed, condition and nationality. Selection in triage put a very big ethical challenge on medics dealing in triage and medical care. In future military conflicts, more and more lethal weapons will be used. This will cause more and more seriously wounded casualties leading to bigger ethical challenge. To break this vicious cycle of triage for serious casualties leading to their death we must strict to philosophy of saving all lives at all costs in future. We military medical team must follow our medical philosophy of "each life is important and must be saved till it's last breath". In implementing this philosophy limitation of available resources can be overcome by better selection and transfer of casualties for medical care. Our approach should be to increase capacity of our tertiary care hospitals and transfer these very seriously wounded cases there through fastest means. In order to execute this approach, we must improve our transfer system to save all wounded persons. Our approach should inculcate more precise level of care according to resources scarcity. This paper attempt to change military medicine philosophy from survival of most fit casualties to survival of all casualties including most fatal one in resources constrain environment. Author emphasis that life of all to be saved even if it is financially costing more, it's worth saving.

Biographical Note

Narender Singh has done his masters in rehabilitation (prosthodontics) from Armed Forces medical college, Pune, India. He has won best prize in poster and paper presentation in national conferences. He has also presented papers international conferences on military medicine. His two papers got selected in regional conference on military medicine (Pan Asia Pacific). He has keen interest in military warfare, military medicine, rehabilitation of maxillo facial region, military medical ethics. He wants to contribute to military medicine for betterment of combatants, medics and mankind.

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Stephen Woodside – *Morally Responsible Triage in Crisis and War*

Abstract

IHL mandates that all wounded in war, no matter which party they belong to, shall receive aid in accordance with their medical condition, and that “[t]here shall be no distinction among them founded on any grounds other than medical ones.” This principle of impartiality is endorsed by various other military and civilian institutions to include the ICRC, the US DoD, and the American Medical Association. In this essay, I argue that this principle of impartiality is morally problematic, both in domestic crises and in war. I argue that in some cases, we ought, morally speaking, to discriminate regarding our treatment of casualties for reasons beyond their medical condition. More specifically, I argue that in these cases, we ought to discriminate, at least partly, based on their moral responsibility for their current predicament. I make this argument in two stages. In the first stage, I point out that the principle of impartiality is morally silent in forced-choice cases—those in which two or more people require similar aid, but we cannot treat them all. At most, the principle tells us that we have no moral reason to save one over the others—we ought to flip a coin to decide. I then argue that this is an implausible implication of the principle of impartiality, as we do have good moral reason in many of these cases to choose. I argue that this reason is a comparative assessment of the casualties’ moral responsibility for their medical situation. In arguing for this claim, I attempt to show its plausibility in a range of domestic crisis cases, and then extend its application to relevantly similar cases in armed conflict. I conclude by discussing the practicality of my moral conclusion for our current practice of medical aid in domestic crises and war.

Biographical Note

Lieutenant Colonel **Steve Woodside** is an Academy Professor of Philosophy at the United States Military Academy, West Point, where he teaches various courses in introductory philosophy, ethics, logic, and philosophical methods. He earned his PhD in philosophy from Rutgers University in 2016 with a dissertation titled "Liability, Responsibility, and Ineffective Threats." He has presented at various conferences and published in the Journal of Military Ethics and the

Notre Dame Philosophical Review on topics related to his continuing research in the ethics of harming and war. Prior to his transition to academia, he served for 17 years as an aviation officer and UH-60 Blackhawk pilot, with an operational deployment to Bosnia-Herzegovina and two combat deployments to Iraq.

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Publications from previous workshops

Messelken, Daniel; Winkler, David (2020), editors. **Ethics of Medical Innovation, Experimentation, and Enhancement in Military and Humanitarian Contexts**. Springer. ISBN 978-3-030-36318-5

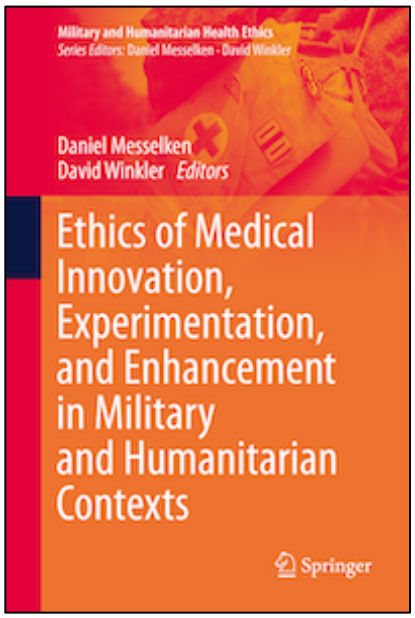
Messelken, Daniel; Winkler, David (2017), editors. **Ethical Challenges for Military Health Care Personnel: Dealing with Epidemics** (Proceedings of the 5th ICMM Workshop on Military Medical Ethics). Routledge. ISBN 978-1472480736

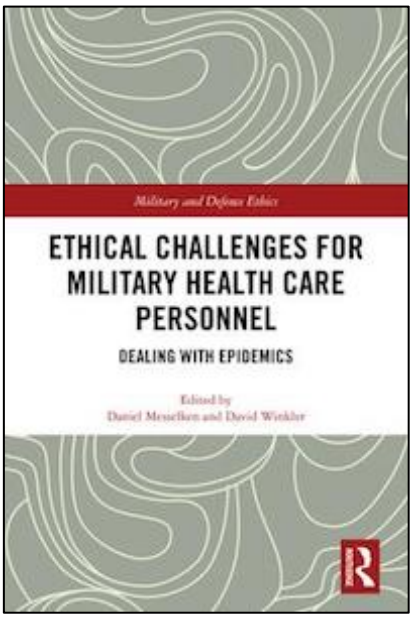
Messelken, Daniel; Winkler, David (2015), editors. **Proceedings of the 4th ICMM Workshop on Military Medical Ethics**. Bern, 2015. ISBN 978-3-905782-98-1

Messelken, Daniel; Baer, Hans U (2014), editors. **Proceedings of the 3rd ICMM Workshop on Military Medical Ethics**. Bern, 2014. ISBN 978-3-905782-97-4

Messelken, Daniel; Baer, Hans U (2013), editors. **Proceedings of the 2nd ICMM Workshop on Military Medical Ethics**. Bern, 2013. ISBN 978-3-905782-94-3

Available via → http://publications.melac.ch /





Practical Information

→ Registration is mandatory for all attendants. No participation is possible without registration and the zoom access links will only be distributed to admitted participants.

Please be aware that **places at the workshop are limited** as we want to keep the format of the workshop as close as possible to the previous years, which includes time and opportunity for discussions. These are only possible in a smaller group and we can therefore not accommodate more than 40 people in total (including the speakers and faculty members).
Participants will be selected with the aim of putting together a well-balanced group of speakers and participants to allow for productive discussions.

Criteria for selection will be:

- The motivation and previous knowledge/ expertise/ experience of applicants
- The function and institutional role of applicants
- Date the application is received
- The number of participants per country can be limited

Application form	https://apply.melac.ch (available from January 2021-March 2021)
Workshop fee	50 CHF to be payed via PayPal On justified request, the fee can be waived for participants from LIC and students.

Contact

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