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| RESEARCH ARTICLE

Oaths and Orders: Navigating Wartime Medical Neutrality in Deanna Germain's *Reaching Past the Wire: A Nurse at Abu Ghraib*

Sara A. Alzahrani
Associate Professor of American Studies, Department of English, College of Languages and Translation, University of Jeddah, Jeddah, Saudi Arabia
Corresponding Author: Sara A. Alzahrani, **E-mail**: salzahrani@uj.edu.sa

| ABSTRACT
This paper examines the ethical tension confronting the healthcare workers stationed at Abu Ghraib Prison, where the principles of humanitarian care dissolved under the pressure of state-sanctioned violence, preexisting structural violence and the intense scrutiny of the international public gaze. Focusing on Major Deanna Germain's memoir, *Reaching Past the Wire: A Nurse at Abu Ghraib*, the study offers a critical account of the challenges of maintaining medical neutrality in the context of a morally degraded prison where complicity and care coexist. Most of the scholarly literature that concerns itself with questions of medical neutrality during wartime has largely documented the ethical transgressions of healthcare providers, with far less scholarship attending to the experience of those who attempted to maintain a commitment to medical ethics under intense pressure. I draw on Virginia Held's "ethics of care" to argue that Germain's memoir testifies to a nurse's effort to fashion an ethical self in a prison context that works to deconstruct such a caring self. The memoir complicates the image of Abu Ghraib as merely a site of institutionalized abuse by offering a counternarrative in which care, agency, and medical ethics persist, however tenuously. Read in this way, the study contributes to a nuanced understanding of medical accountability and the potential for compassionate practice within the frame of institutionalized violence.

| KEYWORDS
medical neutrality, Deanna Germain, Reaching Past the Wire, ethics of care, Virginia Held, war nurses, Abu Ghraib, Iraq War

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1. Introduction

> As the allegations and pictures continued to be publicized, we started fearing retaliation. We were afraid that the world might not even care. What a demoralizing time for us.
> —Deanna Germain's *Reaching Past the Wire: A Nurse at Abu Ghraib* (2007)

Major Deanna Germain, a U.S. Army Reserve nurse stationed at Abu Ghraib, provides, in her memoir *Reaching Past the Wire* (2007), a cogent testament to the disjuncture between the lived-realities of the nurses on the ground and the mediated depictions of the Abu Ghraib scandal that, once released into the public domain, were immediately decontextualized and repackaged for consumption as headlines and titillating images. Germain, serving within the prison's walls without the comfort and distance of an outside perspective, was left to process a far more complex and morally disturbing reality in which duty, humanity, and violence were inextricably and unnervingly entangled. In the above quote, Germain's anxiety pertains less to the threat of physical harm—the immediate and visceral danger of insurgents, or a violent response from the Iraqi civilians—and more to the inner turmoil of having to reconcile herself to the institutional breakdown of the scandal in all its moral public disintegration (p.71). In her experience of witnessing such external and internal collapse, Germain felt compelled to reckon not only with the breakdown of

institutional integrity in regard to the Abu Ghraib scandal, but more acutely with the more deeply personal reckoning that comes with having to care within an uncaring system.

Major Deanna Germain's concerns are firmly situated in a much larger discourse of the moral collapse of the medical profession in the context of war and imprisonment. The existing literature has documented the ways in which wars give rise to conditions in which healthcare professionals are brought into practices that subordinated medical ethics and human rights to security imperatives, contributing to violations of both international humanitarian law and professional medical ethics (Lifton, 2004; Clark, 2006; Cuerda-Galindo & Lopez-Muñoz, 2021; Annas & Crosby, 2019). The prevailing scholarly consensus underscores a disturbing trend of ethical violations and moral failures that characterized the actions of U.S. medical personnel during the Abu Ghraib scandal, but less attention has been paid to physicians and nurses who remained committed to the tenets of professional and ethical commitments. This has led to a dearth of scholarship on those medical personnel who—despite being embedded within a carceral context that subverted the principles of medical professionalism and ethics—were able to resist participating in the institutional violence of Abu Ghraib.

Seeking to engage with this gap, this paper examines the ways in which the tension between the narrative of care and the narrative of complicity—and their subsequent, present coexistence—has influenced the Abu Ghraib legacy. Recognizing the limitations in working with a small number of personal accounts from medical personnel publicly willing to associate themselves with Abu Ghraib, this paper anchors its analysis solely in Major Deanna Germain's memoir *Reaching Past the Wire: A Nurse at Abu Ghraib*. A close reading of Germain's memoir will be conducted to uncover the nuances of human action and ethical agency that could coexist even within a system of institutional collapse and humanitarian crisis. Using Virginia Held's "ethics of care" as the point of departure, this paper argues that in Germain's narrative, one observes a continuous process of ethical negotiation in which Germain found herself navigating the tension between institutional demands and her own individual sense of professional duty, until eventually arriving at a decision to care in a way that, to some extent, subverted the dehumanization of Abu Ghraib. By bringing to the fore this under-explored counternarrative of care and ethical decision-making in the Abu Ghraib scandal, the present paper aims to complexify the existing discourse around Abu Ghraib, which is often presented as a monolithic narrative of abuse and moral failure. By so doing, the paper contributes to a more nuanced understanding of how acts of care can become a form of quiet, interpersonal resistance and humanization in spaces of structural violence and moral erosion.

2. Literature Review

On the front lines of the battlefield as well as the front of healthcare, military medical professionals are in charge of providing care in situations where ethical conceptions of medical professionalism—neutrality, impartiality, and humanity—are constantly disrupted by the on-the-ground realities of war. Unlike civilian healthcare, military contexts involve a more direct and pressing moral compromise in which front-line physicians and nurses face acute tensions between their loyalties to institutional hierarchies, their nation's military objectives, and competing health priorities and humanitarian crises. This review covers literature on medical neutrality in the military setting, analyzing medical ethics as constantly being put under pressure and being compromised in zones of conflict.

A nuanced exploration of the foundational principle of medical neutrality reveals a doctrine situated at the intersection of international humanitarian law, human rights discourse, and medical ethics. In her critical entry "Medical Neutrality," in *Humanitarianism: Keywords*, Lauren Carruth (2020) gives a history and an overview of the concept of medical neutrality as both an international legal imperative and moral ideal. Citing legal and historical precedents set by the Geneva Conventions and other normative sources and documents like the Hippocratic Oath, Carruth's argued that medical neutrality can be conceptualized as not only a duty to do no harm but a more active practice of monitoring, speaking out, and working to protect the neutrality, safety, and accessibility of health care in zones of conflict and crisis. She further clarified that the three interrelated principles that make up the concept of medical neutrality are protection/non-interference which requires the protection of medical infrastructure and personnel from attack; impartial care, the ethical duty to care for all regardless of political or military considerations, and civilian protection, the active protection of civilians by parties to conflict (p. 128). Collectively, these principles show how medical neutrality is more than just abstaining from the logic and violence of war but require active ethical and moral commitment.

Nonetheless, even as medical neutrality is considered a standard ethical and legal principle, a robust body of theoretical work has interrogated the ethical struggles of medical practice in the military, where institutional loyalty and military requirements work against traditional medical neutrality. In his introductory chapter, "Physicians at War: The Dual-Loyalties Challenge," Fritz Allhoff (2008) provided a compelling framework for understanding the ethical tensions that arise when medical professionals operate within military structures. Situating the physician squarely between the Hippocratic obligation to care and the institutional obligation to obey, Allhoff foregrounded the dual-loyalty dilemma as a central challenge in military medical ethics. He pointed out that while civilian medicine is oriented by the primacy of the patient's well-being, physicians under military command, due to their placement within an apparatus of hierarchy, are routinely required to engage in actions which benefit operational or strategic ends at the expense of the care of individual patients. This tension is particularly clear in war or in detention centers, where military doctors are often required to facilitate interrogations, to treat soldiers first rather than civilians or prisoners, or even to deny care in certain operational circumstances. In a similar vein, Michael L. Gross (2014) in *Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War* argued against the taken-for-granted idea that medicine must remain the same in both peace and war,

suggesting to the contrary that the moral conduct of medicine changes in wartime, because the practice of medicine is in war oriented not just to the individual patient, but to the needs of the military and national security. Gross located his argument in the long-standing tension between medical neutrality and military necessity which is particularly salient in the conduct of asymmetric warfare, counterinsurgency, and counterterrorism (p. 60). Both Allhoff and Gross revealed a profound instability in the ethics of medicine under military command. But in the end their arguments also make clear that there is a more fundamental paradox, one in which the effort to fit medical ethics into the logics of war normalizes precisely the violations of medical neutrality those logics are designed to prevent.

A different body of work has placed the violation of medical neutrality in a long historical perspective, thus highlighting the fact that these acts are not exclusively associated with recent history. Cuerda-Galindo and López-Muñoz (2021) in "The Role of Doctors in Torture: From Middle Age to Abu Ghraib", presented a historical overview of the involvement of medical practitioners in torture, illustrating the different ways in which they have been used in different periods of time. The authors began by explaining that the use of physicians for the purposes of torture began during the Middle Ages, when doctors and other health practitioners were forced to serve their rulers to obtain information by all means possible. They also observed that during this period, doctors were used to supervise and assist with torture during the Inquisition and other religious tribunals, in an ironic twist where these individuals were used to keep the victims alive long enough for torturers to get their confessions. Cuerda-Galindo and López-Muñoz concluded that these examples from the Middle Ages were not isolated events, but rather the first instance of a trend, where doctors are used to the benefit of systems of control, confession, or punishment, rather than health.

Other scholars have argued that the conditions of contemporary warfare have heightened the vulnerability of medical neutrality, rendering violations not only more frequent but increasingly facilitated by the structural dynamics of modern conflict. Carruth (2020) argued that the nature of wars in recent decades encourages violations of medical neutrality as civilians, medical facilities and medical personnel are deliberately targeted in such conflicts. As she observed, access to medical supplies is often controlled by parties to conflict, compelling medical providers to collaborate with the very actors who compromise their neutrality. This dynamic creates an entangled web of structural constraints that foreclose avenues for justice, leaving both medical personnel and civilians without meaningful recourse. In a related vein, the militarization of medical roles is not confined to contemporary wars but, as Darius Rejali (2007) suggests, operates in tandem with the very structures of modern democracy. In his book *Torture and Democracy*, Rejali examined the evolution of torture practices, including so-called "clean" or "stealth" torture techniques used by democratic regimes. In the context of U.S. detention practices, he brought light on how medical professionals—especially physicians and psychologists—were enlisted to advise interrogators, particularly in CIA black sites, to monitor and modulate pain to avoid death while still extracting information. Carruth and Rejali revealed complementary dimensions of the erosion of medical neutrality underscoring that violations arise not only from battlefield conditions but from the political architecture that sustains them.

There are many studies that demonstrate the ways in which medical neutrality has been repeatedly violated in different contexts throughout time. In his book *The Nazi Doctors: Medical Killing and the Psychology of Genocide*, Robert Jay Lifton (1986) provided an in-depth analysis of the involvement of German physicians in the Holocaust. His concept of the "doubling" of the self—whereby doctors maintained a divided moral consciousness that allowed them to perform acts of healing in some contexts and acts of killing in others—remains a powerful analytical framework for understanding the erosion of ethical boundaries under authoritarian and militarized systems (p. 6). Lifton's analysis underscored the dangers of moral disengagement within medical practice, particularly when state ideologies and professional identities become entangled. Another example of the literature examined the involvement of military medical personnel in torture programs, particularly within post-9/11 U.S. counterterrorism operations. Annas & Crosby (2019) critically assessed U.S. military medical ethics in the War on Terror, contending that the War on Terror created an environment where human rights principles were routinely subordinated to perceived national security imperatives. They argued that medical professionals became entangled in interrogation and detention practices that violated both domestic and international ethical codes, such as the Geneva Conventions and the American Medical Association's Code of Medical Ethics.

A significant strand of literature positioned Abu Ghraib as a pivotal site where the failures of medical neutrality become starkly visible, particularly in relation to the media involvement and ethical dilemmas of military medical personnel. Robert Jay Lifton (2004) argued that some military and intelligence-affiliated medical staff have failed to report evidence of torture, despite encountering detainees with injuries that clearly resulted from abusive treatment. In addition to passivity, Lifton revealed that physicians in detention facilities have provided interrogators with prisoners' medical records, which were subsequently used to exploit the physical or psychological vulnerabilities of detainees during interrogations. Moreover, medical personnel contributed to the delaying or falsifying of death certificates of detainees who were killed because of torture. Peter A. Clark (2006) maintained that the lack of documented cases of military medical personnel formally reporting abuses prior to the Army's investigation in January 2004 contributed to a broader erosion of medical neutrality. Christian Enemark (2008) further critiqued the ethical implications of triage protocols, wherein treatment is allocated not purely on the basis of clinical urgency, but according to strategic military priorities—a practice that subordinates patient welfare to operational calculus. His analysis reveals how the convergence of medicine, military objectives, and coercive practices results in a form of ethical drift in which physicians become desensitized to the erosion of professional standards.

The existing body of literature converges on a serious consensus: the maintenance of medical neutrality in contexts of armed conflict and coercive detention is fraught with profound, often insurmountable, ethical and institutional challenges. Frequently portrayed as an aspirational construct, medical neutrality is revealed as acutely vulnerable to erosion under the weight of military imperatives and political pressures. This paper does not seek to undermine this critical consensus, nor to deny the structural forces that compromise ethical integrity in war. Rather, it contends that the presence of systemic challenges does not render the pursuit of medical neutrality futile. To discard the principle altogether as an unattainable myth is to risk abandoning one of the final ethical anchors in spaces where humanitarian values are already under threat. Instead, medical neutrality must be understood not only as a legal or professional obligation, but as a moral stance that requires active reinforcement, even—especially—when conditions are most hostile to its preservation. Through the close reading of a singular yet illuminating narrative—that of Major Deanna Germain, a nurse stationed at Abu Ghraib—this study explores how professional integrity can endure amid institutional decay, and how individual ethical agency may serve as a countercurrent to the normalization of complicity. Germain's account offers a rare embodiment of resistance—a living testament to the possibility of upholding humanitarian values in the most dehumanizing of environments.

3. Theoretical Framework

Ethics of care, since its emergence as a critical intervention in moral development theory, has evolved significantly beyond its early formulations in the work of Carol Gilligan and her critique of Lawrence Kohlberg's moral reasoning (Held, 2006, p. 27). It extends into global humanitarian contexts and challenges universalist ethical assumptions by offering a grounded, relational, and often radical perspective that reveals the unequal distribution of care labor, the hierarchies determining who is deemed worthy of care, and the exclusionary structures embedded in institutions and policies (Held, 2006, p. 9). Virginia Held finds the strength of the theory resides in its panoramic moral orientation that is grounded in the specificity of context, relationships, and lived experience. This interpretive flexibility is not a weakness, but a defining feature that prefers to be sensitive to the complexities of modern human life. The following section comprises an attempt to identify some key assumptions that occur in the various formulations of care ethics.

At its core, ethics of care are rooted in the realities of human dependence. It is neither autonomous nor independent. Instead, it takes as its starting point the experiences and practices of interdependence between human beings and thus contrasts sharply with the universalism of other moral theories. The ethics of care, in many of its expressions, starts with the assumption that human life emerges with care relationships of various kinds; for example, those between children and parents or adult carers, patients and doctors, or families and communities. Dependence, vulnerability and asymmetry are features of these care relations that are not accidental but central. The ethics of care thus seeks to expose the dependence of all human beings (children, the sick, the frail, the elderly, etc.) on the care of others, and how this care is so often invisible to moral theories that privilege the independent and autonomous moral agent. A central assumption, therefore, of the ethics of care is that most human beings need care from others at some stage in their lives and that this is not a contingent or temporary fact but a necessary and constitutive feature of what it means to be human. Rather than beginning with the individual, the abstract or hypothetical universal subject, the ethics of care focuses on the interdependence of human beings. Autonomy, far from being antithetical to care, is enabled by it. Autonomy is, from this perspective, predicated on prior caring relationships, and to focus exclusively on the former, on human independence, is to misunderstand how, morally speaking, human beings are enabled to be autonomous in the first place. A care-ethical perspective rejects, therefore, impartialist claims to reason and universality that underwrite many moral theories. Held claims, rather, that the moral point of view is premised on attention and concern for others, which in turn is dependent on human relationships of interdependence. Care theorists thus seek to re-conceptualize morality as the perception and consideration of the needs of others in such relationships, making care, rather than justice or autonomy, the basis for human well-being and for morally informed reflection (Held, 2006).

Ethics of care offers a radical revaluation of emotion, not as a threat to moral reasoning but as integral to it. Emotions, in the rationalist moral theories, have long been cast as antithetical to the ideals of objectivity and impartiality, often relegated to the realm of the irrational and deemed incompatible with the principled administration of justice. Drawing from feminist philosophical traditions, Held's care ethics asserts that emotions such as empathy, compassion, attentiveness, and responsiveness are not merely supplementary to ethical deliberation but constitutive of it. These moral emotions function not to subvert reason but to guide, temper, and enrich it, enabling a form of ethical discernment that is sensitive to context, relationality, and the lived realities of those affected by moral decisions (Held, p. 10).

Held underscores the importance of distinguishing between care as a general disposition or as conceived within virtue ethics—as a character trait or an inclination or readiness to assist others—and care as a form of labor, which requires active, ongoing attentiveness to the needs, autonomy, and particularity of the other (p. 19). This distinction is crucial, as it shifts the moral weight from abstract benevolence to the ethical labor of sustained engagement, that is both materially necessary and morally significant. Within the framework of care ethics, the moral orientation of the caregiver defies the binary opposition between egoism and altruism that often structures traditional ethical paradigms (Held, pp. 34-35, p. 54). This means that the well-being of a caring relation is not reducible to the welfare of one party alone but must be understood as a dynamic of reciprocity in which self and

others are co-constitutive shared space in which care is enacted, sustained, and made meaningful. Care, in this sense, is not about self-sacrifice or self-loss, but about sustaining the mutual flourishing of a concrete relationship.

Held firmly situates the ethics of care within a feminist intellectual tradition, arguing that any articulation of care divorced from feminist commitments is conceptually and politically incoherent. As she asserts, "no ethic of care that is not feminist is entitled to call itself an ethic of care"—a bold statement that underscores the inseparability of care from the structural conditions that shape who gives care, who receives it, and under what terms (p. 66). Care ethics from this viewpoint is a challenge to the dichotomy between public and private that has long been entrenched in Western political and moral philosophy (p. 36). Mainstream ethical and political theories have traditionally treated care as private (domestic, feminized, and invisible) and justice, reason, and citizenship as public (and vice versa in some ways). Held, however, does not want to make care, the work that has most frequently been done by women, racialized people and the economically marginalized, invisible to ethics or politics but rather central to democracy, citizenship and social justice. Thus, in Held's framework, the ethics of care is a critical, feminist reorientation of ethics itself, aimed at redressing both the conceptual erasure and material exploitation of care in patriarchal societies.

On the whole, ethics of care should be understood not as a fleeting emotion, innate virtue, or private motive, but as a structured practice—or more precisely, a cluster of interrelated practices and values—that are enacted, embodied, and historically situated. The ethics of care has deep resonance in nursing: as an ethic of service, sacrifice, and relationship, care lingers at the thresholds between the intimate and the institutional, the personal and the political, binding the caregiver to the patient in a relationship that is as much about solidarity as it is about service. In war zones or detention centers, military nurses do not only treat bodies in need of repair but people in distress whose injuries may include fear, trauma, and grief. Nurses are called upon to navigate loyalties to institutional structures, commitment to their patients' well-being, and recognition of their own vulnerability, moral injury, and emotional exhaustion. In these contexts, nurses do not only practice their professional roles, but enact a form of moral witnessing, wherein care is both a labor of the body and a quiet, resolute act of defiance against the erosion of dignity.

4. Analysis

Nurse Deanne Germaine's professional career as a military nurse extends beyond the clinical boundaries of military medicine to encompass the historical dimensions of America's encounters with war, trauma, and collective memory. It is a journey that takes her from the strict, antiseptic wards of Fort Gordon to the ruined courtyard of Saddam Hussein's former prison, a journey that reflects an unbroken professional, psychological and moral engagement with the complexities of war. Germaine's early service in 1971 at Fort Gordon situates her within a critical historical moment—the closing phase of the Vietnam War—when the physical and psychological repercussions of combat were acutely visible within the military medical system. Her assignment in the Intermediate Care Ward, devoted to amputation follow-up, pain management, and rehabilitation, positioned her simultaneously as a witness to and an agent of recovery amid the profound human cost of warfare (Germain, p. 59). The description of the ward, in her own words, as "clean and well-organized" extends beyond a statement of clinical efficiency to convey a moral and aesthetic response to violence, an assertion of order and compassion against the disintegration wrought by war. Within this space, the act of healing emerges not merely as a medical possibility but as a disciplined, humane endeavor to restore dignity to the wounded body and spirit.

The memoir shifts dramatically as Germaine's later assignment takes her to Cellblock F—ominously renamed the Shadows—a setting whose very name evokes the lingering presence of death, memory, and violence that survive political collapse (pp. 53-54)). Her movement from the orderly wards of Fort Gordon to this haunted space marks a descent from the clarity of medical practice into the moral and psychological turbulence of post-9/11 warfare. Once a site of Saddam Hussein's brutality and now under American control, the prison embodies a troubling continuity of power in which systems of domination persist beneath changing hands of power. It is in this atmosphere of simmering tension that Germaine's decades-long history of humanitarian work takes on a darker and more disturbing hue: as a caretaker, she has been a nurturer and, in a sense, a collaborator of suffering, caught in a liminal space where care and culpability, past and present, converge in a gray zone of ethical ambiguity.

Germaine's view of the hospital and Abu Ghraib more generally, cast in a drab sepia tone, denotes an atmosphere drained of life and significance (p. 44). The drained palette suggests an existence reduced to endurance, where the physical decay of the setting mirrors the emotional and spiritual desolation of those within it. The description that "even God had abandoned" the prison transforms personal despair into a theological critique, indicting a world in which divine justice has been supplanted by bureaucratic and military authority (p. 57). The fragmentation she perceives, both spatial and existential, reflects the collapse of moral coherence under the weight of institutionalized violence. The wear on her body itself becomes evidence of the place's corrosive demands—marking her as both caregiver and casualty. In this context, Abu Ghraib transcends its role as a site of incarceration to become a totalizing environment of moral entrapment, one that involved all who inhabit it, blurring distinctions between healer and victim, authority and sufferer, until the very act of survival becomes an act of silent complicity.

After sketching the geography of the place, the memoir now re-centers on the scandal. For Germaine and her team of medics, the Abu Ghraib scandal shakes the very bases of their professional identity, as caregiving gets caught up in political controversy and suspicion. Torn in between two worlds, she is still dedicated to the ethical ideal of nursing while being weighed down by the symbolic load of her uniform and the systemic abuse it is made to stand for. Her initial defensiveness does not amount to excusing the horrors, which she unambiguously denounces, but to protecting her own moral standing in a situation of collective

suspicion. Subjected to the scrutiny of journalists, reporters, humanitarian observers, and the global public, Germaine experiences the collapse of professional privacy; the humanitarian labor, once intimate and redemptive, becomes exposed to external judgment (p. 71). It is shame, above all, that she feels in the aftermath of the scandal—a shame that goes beyond the personal to reflect a broader moral contamination within the American military.

The exposure of abuse forces Germaine and others within the military medical system into a profound process of ethical reckoning, compelling them to confront the precarious boundaries between service and harm. For those in her unit, a transformation has taken place; words, actions, and the way in which soldiers conduct themselves toward one another are now charged with ethical significance, and a collective sense of responsibility is born, not as the result of a mandate or command but as a result of moral awakening (p. 78). This sense of responsibility, combined with Germaine's ongoing work of care, is colored by a sharpened moral vigilance, borne of the knowledge of how easy it is for such machines of authority to twist the conscience, and a desire to be a part of a redemptive project to help set it right. This is care tempered by a desire to help bring about the rehabilitation of a system that has been compromised in moral terms.

In the chapters that follow the revelation of the scandal, the narrative begins to move in the direction of an account of acts of care, describing Germaine's care of Iraqi patients one by one. Her treatment of Bassem, an Iraqi patient, stands as one of the memoir's most profound meditations on moral ambiguity, professional ethics, and the fragile endurance of compassion within the machinery of war. Germain's recollection reveals the emotional and ethical complexity of caring for a patient whose status as both prisoner and possible combatant blurs the distinction between victim and perpetrator. Her uncertainty—whether Bassem was "innocent" or "involved in the fight"—captures the tension inherent in military medicine, where the obligation to heal collides with the pressures of political and moral judgment (p. 52). Yet rather than seeking to resolve this uncertainty, Germain adhered to the Geneva Conventions and to the professional codes governing medical neutrality to become a guiding principle that transcends regulation: a lived affirmation that care must not depend on identity, allegiance, or guilt. When she declares, "I gave each patient my best, no matter who he was," her words operate as both moral creed and quiet defiance—an insistence that the value of human life endures even amid institutionalized dehumanization (p. 53). In this light, Bassem's slow recuperation takes on emblematic significance; his survival is tantamount to the nurse's redemption as healer and as moral actor in an otherwise ethically bereft context. The gratification Germain takes from the knowledge of his recovery is dual: it is a vindication of her medical expertise, but it also amounts to the more meaningful reward of reaffirming Bassem's—and, by extension, her own—essential humanity in a setting where it is under siege. Her reflections on Bassem after his departure from the hospital—suggesting that care may also mean continuing to worry about another's fate long after their physical presence has vanished from the ward—bear traces of the nurse's lingering impulse to watch over those she has tended. Yet these reflections also testify to an enduring attachment, one that keeps care and compassion in view even in the absence of the body that once demanded them, transforming both into a form of moral memory.

The cumulative impact of the narratives of both the Marine and Mohammed is thus to shift Nurse Germaine's moral stance from one of visceral solidarity with her wounded soldier toward a vision of moral responsibility that is defined in universal terms by an expanded capacity for compassion. The arrival of the marine is met with a kind of choreographed liturgy of devotion and mourning: the caregivers' urgent coordination and emotional intensity reflect both professional reflex and existential fear: to save one American wounded soldier is to reaffirm their own humanity and to hold death at bay. The marine's suffering collapses the boundaries between clinical responsibility and personal identification; he becomes not merely a patient but a symbolic extension of the community's shared vulnerability and loyalty (p. 62). But that fragile moral unity is ruptured by the arrival of Mohammed, the wounded Iraqi detainee, suspected of having fired the shot at the Marine. His presence in the ward shatters the affective equilibrium, compelling Germaine and her colleagues to reckon with the unsettling reality of victim and suspected perpetrator coexisting within the same space of care. In this pivotal moment, Germaine is neither swept up in the crescendo of condemnation nor retreats into detached resignation; rather, she finds herself in an uncomfortable yet crucial interstice—the realm of ethical suspension, where judgment is suspended in favor of duty.

In treating Mohammed under the same standards of care that govern the treatment of the marine, Germaine enacts the Geneva Conventions not as bureaucratic code but as moral conviction. Her self-directed questions and answers—"Did Mohammed shoot the young Marine? None of us will ever know. How did I feel about that? It didn't matter. We did our best for both of them"—articulates the culmination of this ethical evolution (p. 65). It is not neutrality born of detachment, but one forged through deliberate compassion, a recognition that the healer's responsibility must transcend political and emotional boundaries. Her response to Mohammed's final plea, "Am I going to die?"—the promise to pray for his wife and children—extends care beyond the body, offering spiritual recognition to a man otherwise defined by suspicion and enmity (p. 64). This act of grace underscores Germaine's moral maturation: where once care was an assertion of allegiance, it becomes an act of human solidarity. Also, the scene's spatial dynamics—the marine and Mohammed lying on opposite sides of a hospital curtain—is a powerful metaphor for the fragile ethical boundaries that define wartime caregiving. The curtain is at once division and bridge, symbolizing both the separation imposed by war and the moral permeability that allows compassion to pass through. The invocation of Indira Gandhi's maxim—"You cannot shake hands with a clenched fist"—encapsulates the moral stance of her medical practice: that healing requires the recognition that dignity restored to a single life affirms by necessity the moral possibility of all (p. 145).

Germaine's subsequent encounter with the young Iraqi detainee she names "Samson" gives way to a lived ethics—one grounded in presence, humility, and the courage to see the person beyond the uniform. In addressing the detainee not through accusation or detachment but through narrative and imagination, Germaine reclaims the symbolic power of storytelling as an instrument of care. Her invocation of the biblical Samson—once strong, now broken—transposes the man before her from the category of "enemy" to that of a complex human being marked by loss, endurance, and dignity (p. 146). Naming becomes re-humanization: restoring an identity to one of "them" that has been systemically depersonalized by the apparatus of war. The following dialogue, terse, stuttered, and intensely meaningful, shows how simple questions about family and jobs can subvert the strict power structure of military medicine. Within a system that discourages emotional proximity and prohibits personal inquiry under the Geneva Convention, Germaine's choice to engage personally constitutes a subtle but profound ethical intervention.

Nothing is more poignant than the moment when Germaine removes the "High Value Detainee" sign that a ward sergeant had placed above an Iraqi patient's bed, a seemingly small yet symbolically forceful gesture meant to protect the sanctity of the healing space from the contaminating logic of war (pp. 149-150). This act reveals the performative dimension of ethical practice. By refusing to allow labels to dictate the moral status of her patient, her removal of the sign becomes both corrective and declarative. As military medical care can easily be co-opted by systems of domination, individual moral agencies can challenge this through gestures that are modest in scale yet powerful in meaning. The hospital is a place of healing, not categorization, founded on the principle of human dignity, not strategic value. Germaine's memoir illustrates that care is not a one-way act of charity but a mutual moral transaction: in caring for her Iraqi patients with the professionalism and compassion of a nurse, their small acts of maternal reverence help her to re-bring softness and moral consciousness to a world bent on extinguishing both. She receives their deference not as submission but as recognition, allowing it to shape her care with greater intimacy. When the detainees call her "Maria"—a name imbued with spiritual associations of purity, mercy, and intercession—it evokes in her not triumph but quiet gratitude— "I felt honoured"—across lines of ideology and captivity (p. 166). It is not an episode of sentiment, but rather a reflection on the endurance of human compassion. By their names, gestures and shared moments, the nurse Germaine and the patients reassert aspects of their humanity, despite the inhumanity of war.

The memory she relates involving "Grandpa" stands as one of the most revealing and affective moments in Germaine's memoir, distilling the text's central concern with the persistence of human connection after care. Grandpa's presence in the ward is initially bureaucratic—he is under investigation, his status uncertain, his past vague (p. 161). However, with time, the man is more than just a medical case; he is part of the ward's tenuous community. His subdued reaction to the news that he is being set free is not apathy towards the outside world but rather attachment to the dignity and respect he has known while in the care of Germaine. The fact that his first reaction to this news is the idea of having the nurse follow him home is not an insane delusion but an expression of gratitude and trust, of a desire to keep something stable in his life. In naming him "Grandpa," and in sustaining the roles he projected onto her—nurse, daughter, family—they all participated in a collective act of kindness. This story is not merely a charming detour in the memoir; it is a crystallization of genuine care ethics.

One of the memoir's most emotionally charged and ethically profound moments is when Germane escorts the Iraqi detainees Sael and Hashim to the ambulance where indifference—or even hostility—would be easier and more expected. What might have been a routine transfer—an anonymous procedural step in the vast machinery of detention and war—becomes, in Germaine's hands, a deeply human farewell. The detainees are not led out as prisoners; they are walked out as patients, as people. The physical vulnerability of Sael on his crutch, their blue hospital clothes, the quiet gratitude in their voices—all these details strip away the label of enemy and reveal two men who, despite whatever they may have done or been accused of, are suffering, fragile, and afraid. That she and Sergeant Pierce both cried and embraced the detainees while armed attendants looked on in disbelief, something sacred occurred (pp. 173-174). She symbolically hugs all those invisible in war—the displaced, the wounded, the silenced. In recognizing the personhood of Hashim and Sael, she reaffirms her own. In her words: the military "can make a good soldier out of a mother, but it can't take the good mother out of the soldier" (p. 174). This line reframes care as not incompatible with duty, but as a deeper kind of loyalty to the ideals that precede and outlast any war: mercy, dignity, humanity.

Germain's career as a caregiver to people in need represents the principles of care ethics that the good caregivers cannot be guided by either enlightened self-interest or an interest in humanity as an abstraction, but only by what is called relational embeddedness in care ethics, the state of being in which the good caregivers understand that their own flourishing in life is intimately bound up with that of the particular other people that they care for. In the case of Germain's care for the detainees, as with her caring for any other person, good care requires special knowledge, technical skill and virtuosity that she has achieved through practice, good judgment, intuition, her emotional and affective intelligence, and her capacity to establish and maintain rapport with those she is caring for.

Her retirement in September 2005 concludes a career shaped by service in the shadow of two wars in Vietnam and Iraq: wars framed by different ideologies but united by the human cost they exacted. In the Iraq War context, Germain is not merely a nurse but a figure of endurance, whose care work threads through the shifting contours of Iraq's recent history. Her journey charts a passage from the discipline of healing to the duty of witnessing, revealing the deep emotional and ethical weight military nurses quietly carry. In the sterile halls of Fort Gordon and the haunted corridors of the Shadows alike, Germaine stands as a quiet testament to the complexities of service—where care persists, even when hope hardly flickers.

5. Conclusion

This paper has analyzed Germain's account of care, and how it both approximates to—and ultimately breaks with—the ideal of medical neutrality. The memoir describes a subtle, albeit nevertheless decisive, shift away from the intransigence of neutrality in the direction of an ethic based on compassion, which puts "concrete human beings and their lives" before an abstract principle. Germain's personal evolution into this ethic is played out in a manner that is clear but not rushed, which avoids sensationalism as well as self-exculpation. At no point does her writing show elitism, distance, or insensitivity; instead, it is out of humility, moral receptivity, and a profoundly humanizing ethic of care that her nursing unfolds. In its implications, this break with neutrality highlights some of its own internal tensions and limitations. The memoir reveals that care, at least when lived in the ambiguity of human encounters, cannot be altogether consistent with neutrality. Germain refuses to treat her patients as medical cases or as mere interchangeable bodies; her attentiveness, affectivity, and moral response-ability reveal an ethical commitment to a relational understanding of care.

The move from neutrality to compassion in healthcare—especially so in military nursing and in zones of conflict—is wrought with ethical, emotional, and professional consequences. On the one hand, the break does not represent a dereliction of professionalism but rather illuminates the ethical boundaries of neutrality and how one cannot be completely neutral in the presence of others' suffering. On the other hand, this breaking with neutrality also intensifies the emotional and moral strain that is often imposed on nurses. For while compassion might bring deeper empathic understanding and a closer, more human relationship to care, it also necessarily entails greater vulnerability to burnout, moral injury, and mental illness as nurses take on the suffering and injustice of what is happening to those they care for. Future research can attend to nursing practice across different geopolitical landscapes and, in turn, show how the cultural, political, and military structures of these spaces enable and delimit the possibilities of neutrality and compassion in wartime care.

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