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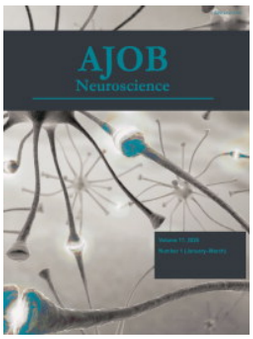

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additional appeal to the importance of gratitude and respect for those involved in military service also diminishes the moral significance of harm coming specifically from disenhancement. To the extent harm ensues in the wake of military service, state beneficence, gratitude, and respect weave a safety net that should meet that harm regardless of its origin.

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Must Care Be Earned? The Normalization of Sacrifice in Post-Disenhancement Ethics

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Tubig and Gilbert (2026) rightly gesture toward the broader relevance of post-disenhancement care ethics beyond military contexts, yet they do not fully engage the tensions this gesture reveals. They ground their argument about care for (hypothetical) neurotechnology-disenhanced U.S. service members in two potentially contradictory claims: 1) that the U.S. military has an obligation to provide long-term medical care for soldiers who have "compromise[d] their bodily and mental integrity in the service of a state's sociopolitical goal;" and 2) that "institutions responsible for creating new states of embodied agency are also responsible for managing the harms that could result when those states are removed." While the latter principle appears to offer hope to present-day civilian neurotechnology recipients (including explantees) who face device obsolescence, abandonment, malfunction, and/or removal (Gilbert, Ienca, and Cook 2023; Black et al. 2025; Bottorff 2025), the former reinforces a persistent barrier to care access: the expectation that care must be earned.

Assessing speculative matters is not a passive act, nor are its effects limited to the future; the ways we imagine—or fail to imagine—help normalize and entrench our everyday realities, making their socially-constructed contours appear inevitable and unchangeable even when they are not (Haraway 2016; Benjamin 2019). Framing care in the context of neurotechnology as something to be earned thus not only disregards the ongoing struggles of disabled civilian implantees and explantees to access adequate support, but also risks further legitimizing those struggles. Any meaningful assertion of care needs for neurotechnology recipients must directly challenge the broader moral logics of care scarcity.

Decoupling care from duty carries additional significance: even those who have, in principle, "earned" care are not guaranteed to receive it in practice. This reality is reflected in the experiences of veterans who

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are ostensibly entitled to care yet remain unable to access it (Kerfoot 2024). If Tubig and Gilbert's principal aim is to ensure that disenhancement would be unequivocally recognized as a medical issue demanding long-term care, then arguably the most urgent task of speculation is anticipating how a disenhanced service member might prove—or fail to prove—that a care need stems from a PIAAAS-related harm. Such evidentiary demands would seemingly mirror those already faced by disabled veterans seeking recognition of injury in contexts such as traumatic brain injury, chronic pain, or post-traumatic stress disorder (see for instance: Buckwalter 2025). Ultimately, any ethical framework that renders care conditional simultaneously articulates the terms of its own exemption.

The very framing of PIAAAS suggests an intriguing crossroads: it signals long-overdue recognition of harms that are under-attended to and less readily measurable; yet it could suggest an underlying *expectation* that technology inherently alters or alienates the self. If neuroethicists seek to bring attention to the former—under-recognized or invalidated experiences of harm—without sensationalizing the latter, then we must confront how challenging it *already* is to secure adequate care for such conditions (Zickerman 2024).

The goal of amending or mitigating sacrifice through long-term care might seem like an insistence on reciprocity, but to what end? In other words: in this envisioned future, what kinds of problems might the provision of long-term care to disenhanced soldiers solve vs fail to solve? It's challenging to envision a near-future U.S. military *uninterested* in providing such care, if only to better study its own experimentation—or more cynically still: to limit public recognition of any adverse effects. Any scenario in which militarized disenhancement were to have already transcended from valued experiment to an utterly mundane phenomenon untethered from aftercare would be a profoundly bleak future—and to glimpse such a reality and target long-term disenhancement care seems almost like solving the wrong problem. Perhaps the most pressing question, then, isn't whether disenhancement creates new forms of harm that deserve care, or even how to ensure accountability for such care needs; instead, it may be, *When is long-term care not enough?* Indeed, as disability studies scholars Puar (2017) and Wool (2015) have demonstrated, aftercare itself is not ethically or politically "neutral"—it can serve to normalize, rather than contest, treating a population as disposable. It is striking then that Tubig and Gilbert leave the normalization of sacrifice itself unexamined: in preparing for new forms of harm to service members, we are invited to imagine long-term care that enables it to proceed rather than to ask how it might instead serve as an impetus to halt neurotech-enhanced soldiering altogether.

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