Professional ethics in military medical teams: A clash of oaths?

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Introduction

Military healthcare professionals answer to two masters – the professional bodies of their chosen healthcare speciality, and the 'profession of arms'. Both might involve an oath or professional obligations – for example, the Hippocratic oath for doctors, and an oath of allegiance to Queen and State for military personnel; in other words, to follow orders. While it is acknowledged that both military and civilian healthcare practitioners can be exposed to dual loyalty conflicts, from long experience the desperation of deciding which to prioritise in the dynamic environment of a combat zone stands in stark contrast to decisions made in the civilian context. Having served as a military nurse in combat zones for over two years of my career I have seen, first-hand, ethical decision-making in its most brutal, visceral form in and around many treatment bays and operating tables in Kosovo, Iraq and Afghanistan. There are ethical and moral tensions and constraints at play in these complex situations which military healthcare professionals (MCHP) face daily.

These difficult ethical decisions in the military operational context can result in disparity of care being delivered. This is shown to be e.g., for reasons of scarce resources, overwhelming numbers of casualties of varying degrees of complexity presenting over a short space of time, or extreme battlefield conditions. This can give rise to two-tiered care, providing optimum healthcare to own-force coalition troops but relegating local nationals and allied forces to their (often) poor quality and ill-equipped local health service for care. The medical rules of eligibility, a politically approved list of criteria which limits admissions into the military treatment facility, can also be morally problematic for MHCPs; especially when treatment facilities remain empty in the face of great need in the areas surrounding it. Further ethical breaches in medical care may occur on the battlefield depending on how close to the fighting MHCPs are.

Being a pragmatic front-line healthcare professional and firmly rooted in the reality of ethics 'at the sharp end' of combat care delivery, rather than a full-time academic limited to academic debate without experience of the sights, sounds and smells of war, I was interested to see how other nurses experienced these tensions; and their thoughts on the personal character attributes and virtues which operationally experienced military nurses believe makes someone a moral, upstanding professional. Accordingly, I undertook a PhD study to explore their thoughts. I also explored what they thought constituted a reliable 'moral compass', which guided their decisions in this operational context.

Ethics in the deployed environment

The World Medical Association (WMA, 2022) asserts in the first line of its 'Regulations in Times of Armed Conflict and Other Situations of Violence' that medical ethics in times of armed conflict is *identical* to medical ethics in times of peace. It is my intention to demonstrate in this paper that the deployed environment has significant potential to alter MHCPs' ethical paradigms and decision-making when compared with the civilian context due to the tensions and constraints described above. MHCPs face ethically difficult situations in the course of every operational deployment. The ethical thinking behind the decisions they make and the way they act is not always readily apparent, nor when directly challenged are they always able to describe or accurately rationalise it. This is because, as Lindseth and Norberg (2004, p. 145) state, 'humans live and act out of their morals, i.e., internalised norms, values and

attitudes without necessarily knowing about them'. Further, as Vollmar (2003, p. 741) states, 'exigencies of battle pose unique challenges incomparable to the civilian context because of the scale of the threats to life, unpredictability and levels of violence'. Taking nurses as an example, and in order to set the scene, it is necessary to briefly discuss the different values and standards to which civilian healthcare practitioners (HCP) and MHCPs are held.

Character and values of nurses

Nurses are held to the same standards of (largely consequence-driven) ethics which apply to the whole of the population, e.g., 'act in this way, in accordance with these rules, or you will go to jail'. However, nurses are also held to a 'higher tier' of ethics than the rest of the population. They must make ethical decisions on behalf of the vulnerable patients they serve, keeping within an additional professional set of rules promising different adverse consequences for breaches, instead of just for themselves. Additionally, many people view nurses as moral role models in society (Porter, 2012). They are bound to maintain good character through adhering to the 'not negotiable or discretionary' values set out in their Code of Professional Standards (NMC, 2015), which are regularly updated through patient and public consultation and expectations. The literature is replete with examples of the values or virtues which should typify a nurse's character. History provides an interesting trail of change in this regard.

In the early days of vocational nursing, in Nightingale's era, personal attributes required to take the 'Nightingale Pledge' (Gretter, 2006) were Godliness, purity, faithfulness, loyalty and a commitment to 'aid the physician' (Begley, 2010), evoking a chaste, subservient 'don't think for yourself and don't speak up' religion-based culture. Other attributes demanded over the next 50 years included obedience, stoicism, endurance, servility, modesty and humility (Gareshce, 1944; Denesford and Everett, 1946; Way, 1962). This demonstrates that nurses in those days were expected to follow a code of etiquette rather than a code of ethics. There was a drive to professionalise nursing after the 1950s, and an increasing reduction in thinking of nursing as a 'calling' over the next 30 years or so (Fowler, 1984). The two most commonly defined characteristics of a profession are that it must (i) self-regulate, and (ii) provide a service to others (Wilkenfeld and Durmis, 2022). Taking these characteristics into account, nursing can now clearly be defined as a profession rather than a vocation or a 'calling'.

Crossan et al. (2013) suggest that values and virtues evolve as important underpinnings to character, which supports Begley's (2010) claims that the character attributes and virtues required of 'the good nurse' in the modern era have evolved and can now be distilled into three core categories - *intellectual / practical* (e.g. theoretical and practical wisdom, cleverness, discernment and judgement) *dispositional* (e.g. tolerance, kindness, compassion and empathy) and *moral* (e.g. integrity, moral courage, fidelity and honesty). There are reports which variously describe integrity (Mitchell, 2015), truth-telling (Hodkinson, 2008) and courage (Lindh et al., 2010) as core virtues for nurses. A study by Kristjansson et al. (2017) reported that nurses identified kindness, honesty, fairness, appreciation of beauty, zest and prudence as their most important character strengths. These personal qualities of nurses such as kindness and honesty, with the implicit addition of trustworthiness and patience, are also typically understood as moral virtues in the Aristotelian sense (Armstrong, 2006).

The participants in my PhD study also listed honesty, openness, reliability, emotional intelligence (which they say mitigates against those 'cold, calculated resource allocation decisions' made out of context), moral courage and confidence as key character attributes for a 'good military nurse'. Interestingly, they also regarded the role of experience as critical to developing those character attributes they regarded most positively. Further, they felt that

the more senior an individual got, the better they would be able to exercise their 'internal moral compass' in an ethical dilemma (due to their accrued experience) and be better prepared to act as a moral or ethical guide for subordinates. For example, one participant (P006), an Officer, said, 'If I thought something was ethically wrong, that internal compass would cause me so much dissonance, and anxiety, and problems, that I had to do something about it'.

It is interesting that nurses have identified the character strength of prudence in themselves, as this is one of Aristotle's intellectual virtues, sometimes called practical wisdom or phronesis. In the virtue ethics philosophy phronesis allows for the application of reason and judgement in ethical decision-making, allowing context to take central place, as legal and professional rules and frameworks alone will not always be sufficient in this process (Hodkinson, 2008). MacIntyre (2007) says that phronesis is the intellectual virtue without which none of the virtues of character can be exercised. I take this to mean that the application of prudence, or phronesis, allows a practitioner to navigate Aristotle's 'golden mean' (or 'happy medium') through the pitfalls of excesses and deficits of character which may interrupt at various points their lifelong journey to *eudaimonia*, or 'ultimate human flourishing' – allowing a HCP to become the virtuous professional. If we accept that the self-identified values (or virtues) of nurses are central to the profession of nursing, like Kristjansson et al. (2017), it seems to me that in addition to the traditional deontological, consequentialist and principlist ethical approaches normally encountered in nurse education, there is also a strong case for teaching a virtue ethics philosophy in nurse education to help prepare undergraduate and postgraduate nurses to flourish into the best nurses they can be. This would also need to be related to practice through case-based learning in order to help develop the character that nurses have grown to that point, through primary and secondary sources and early careers, to an ever higher professional level.

Military values and standards

Nurses in the military are held not only to the first two 'tiers' of ethics and healthcare ethics as described above, but also to an even higher tier of 'military healthcare ethics' (Bricknell et al., 2022) which applies only to MHCPs, including nurses. According to Kelly (2013), this is because there are several differences between civilian and military values in terms of the physical environment and the context of where care is given. The regulations that govern and drive MHCPs are also different, from a philosophical standpoint. Fundamentally underpinning the conduct of MHCPs (at all times, and regardless of location) are not only the professional obligations detailed by the NMC Code (2015), like their civilian peers, but also discipline[1] and military law.[2] These are in force to drive the imperative that the MHCP remains operationally effective. In needing all service personnel to remain operationally effective (by law and by the armed forces values and standards framework) the armed forces recognises that this means Service personnel will *by necessity* have different values and standards from general society (and their civilian HCP peers). Core army values, some of which could also arguably be called virtues, include courage, discipline, respect for others, integrity, loyalty, and selfless commitment. They are intended to 'inspire good character as the basis for virtuous intention and action'. (Walker et al., 2021) There are clearly some overlapping values with those described above for nurses.

[1] BRd 2 – The Queen's Regulations for the Royal Navy (2013); Queen's Regulations for the Army (1975); The Queen's Regulations for the Royal Air Force (1999)

[2] The Armed Forces Act 2011 (continuing the Armed Forces Act 2006)

Values in other Services differ slightly, for example the Royal Marines separate the Commando *values* of excellence, integrity, self-discipline and humility from the Commando *qualities* of courage, determination, unselfishness and cheerfulness (RMC, 2022). Many of these could also be read as virtues. The main point is that if individuals fail to keep to these values and standards, operational effectiveness (OE) suffers and military goals may not be achieved (MOD, 2008). This has connotations for both those deployed on combat operations (maintaining OE by doing their jobs well and treating troops effectively to return them to the front line) and those achieving OE through developing or maintaining their clinical skills in a National Health Service (NHS) facility (MOD, 2007).

In contrast, the NHS focus is clearly not identical to *military* operational effectiveness, despite the military's reliance on the NHS to deliver MHCPs' peacetime training and clinical skills maintenance. The Darzi Report (NHS, 2008) shaped NHS direction, and in the process defined NHS operational effectiveness as 'providing high-quality care in tandem with targeted health promotion'. This is driven by a clear legal mandate[3,4]. This difference of perspective highlights the fact that while MHCPs even in peacetime are subject to both military and NHS ideologies and laws, civilian HCP are only ever restricted to NHS concerns.

Military necessity

When the MHCP deploys to a conflict area out with the NHS, those ideological concerns cease to influence their practice. They are instead replaced with concerns of military necessity, which serve to complicate matters. Here, the mantra instilled into every Armed Forces medical recruit of 'soldier first, MHCP second' gains prominence. For instance, MHCPs may generally take their personal code of ethics into armed conflict and employ it to determine their patients' medical needs. However as Gross and Carrick (2013) say, in the battle for priority in dual loyalty conflict, 'military commanders decide when and how to serve [those needs] consistent with military necessity and the prosecution of the [conflict]'. Collen et al. (2013) explain that this is because military necessity is often paramount (to the military at least), particularly when mission success is at stake.

Military healthcare ethics

Academically, military healthcare ethics (use of the term military medical ethics is falling out of favour, as it is argued to be too 'doctor-centric' and fails to take account of other healthcare professions) is a hybrid field of study which fails to fit neatly into either of the two parent disciplines upon which it is founded - healthcare ethics and military ethics. Bioethicists have tended to steer away from the subset of military healthcare ethics, leaving it underrepresented in academic circles (Sokol, 2012). Military healthcare ethics encompasses the practical application of ethics by MHCPs to dilemmas in deployed military clinical environments in which patients may be friendly or 'enemy' personnel, or civilians affected by military operations. This takes place against a backdrop of the ethical tensions and constraints mentioned above which have been observed to induce alterations to MHCPs' established ethical approaches to care.

Dual loyalty conflict

Despite the popular public view of MHCPs as 'angels of mercy', who exist solely to relieve suffering on the field of battle, the truth is a little more complex. Gross (2008, p. 1) states that MHCPs are in fact an 'integral part of their nation's war-making machine'. In being so, their

[3] National Health Service Act 2006

[4] Health and Social Care Act 2012

primary role as doctor, nurse or other health professional is subject to pressures and influence from out with the healthcare field. In essence, the MHCP answers to two masters. The British Medical Association (BMA) acknowledges that 'doctors in the armed forces can *at times*[5] be required to balance conflicting, and sometimes irreconcilable obligations or loyalties'. I emphasise *at times*, because once it has been established that military necessity no longer has primacy over medical or ethical decision-making, any dual loyalty conflict experienced by the MHCP is largely resolved and the individual practitioner can revert to whatever peace time model or code of personal ethics that they normally employ. However, the concept of dual loyalty and those instances where professional conflict occurs warrant further exploration.

Dual loyalty conflict and the HCP in peacetime

HCPs and MHCPs working within the NHS often face dual loyalty conflict, albeit usually not between two professions. Dual loyalty conflict involves ethical conflict between two external accountabilities, which are generally irreconcilable. This typically does not involve personal gain. HCPs may for example encounter patients who implore them not to inform their family of their deteriorating or terminal condition, or a family or next of kin who insist that the HCP does not inform the patient of significant 'bad news' e.g., their imminent health decline. This will involve deciding which loyalty takes precedence, if a solution acceptable to all parties cannot be found. It may also be that HCPs need to decide on limited resource allocation amongst their patients, whether it is an expensive surgical procedure or an emerging revolutionary treatment, with risk measured against benefit for both the patient and taxpayers. However, in theory at least, they should be free to follow their own national professional association guidelines and professional codes of ethics - which 'generally mandate complete loyalty to patients' (London et al., 2006, p. 382) without undue impedance from organs of State. There is no shortage of dual loyalty conflict in peacetime healthcare. However, having stated that, it appears relatively easy to manage in practice as the individual practitioner ultimately weighs, justifies and decides the issue for themselves, without being subject to the 'big and decisive hammer of military necessity' (Gross and Carrick, 2013).

Dual loyalty conflict and the MHCP in military action

MHCPs, as described earlier, have two distinct and separate professional identities – as 'a member of both their healthcare profession, and the profession of arms' (Chamberlin, 2013). According to Madden and Carter (2003, p. 271), the profession of arms is tasked with 'defending members of a society by becoming directly involved with activities leading to the wounding or death of others'. Professional, civil and criminal controls have long been in place to prevent civilian HCPs from being involved in such activities. The term used in the literature for MHCPs is often 'physician-soldier'. Interestingly, authors with military experience tend to use the term 'soldier-physician', echoing the importance of the 'military first, profession second' mindset the military demands. This term in itself expresses the duality of professions, embodies a clear delineation between HCP and serviceperson (even implying mutual exclusivity) and represents an ironic categorisation of the MHCP given that many authors mean it as an oxymoron. For example, Schwartz (2007, p. 715) believes that the professional roles of HCP and soldier are so fundamentally different that he questions how anyone can think that serving concurrently in both professions is ethically possible, and comments that 'perhaps to do so is even reproachable'. Parrish (1972) is of the opinion that

[5] My emphasis added.

a HCP absolutely cannot be a soldier as well, because the two professions have entirely different values.

To ensure that MHCPs are in no doubt, the Oath they swear upon enlistment in the armed forces (similar in Armies across the world) is to pledge loyalty to the head of State in the first instance (the King in the UK), to *obey the orders*[6] of the Officers appointed over them, and to defend their countries and territories. On the other hand, in its various forms, the Oath that many HCPs still swear when qualifying (albeit without the force of law) boils down to working solely in the interests of their patients and giving preference to that relationship (Olsthoorn et al., 2013). It is attempting to adhere to these two different ethics that is likely to cause conflicting loyalties for the MHCP. The WMA statement that medical ethics in times of armed conflict is identical to medical ethics in times of peace continues to state that 'standard ethical norms apply'. Further, it states that the MHCP must give the required care impartially, and that 'if, in performing their professional duty, [MHCPs] have conflicting loyalties; their primary obligation is to their patients'. This implies that there should be no difference in the treatment of own forces and local civilians or host nation forces.

As Borow (2010, p. 172) points out, medical ethics in peace time is not identical to medical ethics during war for two reasons: 'First, the hallmark principles that drive bioethical decision-making in ordinary clinical settings are largely absent, and second, the principles of contemporary just war may simply override bioethical concerns.' This is alluding to the principal focus of military medicine in conflict - that of 'salvage medicine'. This involves returning as many soldiers as possible to combat as its guiding principle and is not concerned with treating purely by medical need alone; in spite of the dictates of the Geneva Conventions (ICRC, 1995). This is a prime example of dual loyalty conflict caused by military necessity. On the occasions that a conflict between medical and State interests occur (as decided by the military commanders on the ground), they can often cause individual MHCPs to 'forcibly' violate tenets of their personally held code of ethics (as previously discussed, putting the patients' interests first) or other ideals.

Gross (2006) tells us that 'war thus transforms medical ethics'. The situations civilian HCPs encounter are typically vastly different to the situations MHCPs regularly find themselves in. Civilian HCPs can generally put the interests of their patients above all else, unfettered by the shackles of State interest, whereas MHCPs cannot always guarantee to act 'in the interests of [every] patient without incurring more risks to themselves and to their colleagues' (Olsthoorn et al., 2013). MHCPs in a war zone are affected by their environment, facing equal risks to their non-medical military colleagues. In addition, Nehaus (2011) reflects that 'the effects of working with constant fatigue and dealing constantly with horrific injuries contributes to compassion fatigue'. From personal experience, working on patients while under enemy fire is also a challenge.

Chamberlin (2013) says that the 'internal morality of *medicine* demands patient-centred consequentialism, driven by beneficence and non-maleficence'. This means that HCPs are ethically obligated at all times to act as advocates for their vulnerable patients and do their best to cure them, or at least alleviate suffering to the best of their abilities. However, she then goes on to state that the 'internal morality of the *military* demands the protection of the nation, service to your fellow soldier, and an obligation to a 'mission-first mentality'. Practising a healthcare profession whilst prioritising their roles as soldiers is a fine line MHCPs have had to learn to walk over the last few big conflicts. Chamberlin (2013)

[6] *My emphasis added*: this Oath is exactly the same as the one sworn by non-medical military personnel, but which creates no dual loyalty issues for them.

concludes that it is ‘a morally problematic predicament, and a unique feature of the moral landscape of military medicine’.

Clinical triage and scarce resource allocation

Conventional emergency department triage (both civilian and military) typically involves a nurse or other qualified HCP screening patients prior to any treatment decisions being taken. This is to allow them to *sort* the patient into the correct treatment pathway and timeline, based on the principle of greatest clinical need, or *those most severely ill or injured will be seen quickest*. This is the prevailing system of clinical triage in both routine peacetime and deployed military environments.

In practice, civilian and military casualty triage and management differ little in both routine home and deployed military environments, even up to the point of multiple and mass casualty situations. The approach only differs drastically in the military paradigm when vital military goals or objectives (as dictated by military commanders), which I take primarily to mean winning battles (as generally speaking if you win enough battles, you will win the war), are in dire jeopardy through dwindling force strength or a dire shortage of medical resources.

Mass casualties and disaster medicine - Battlefield triage

When faced with many casualties over a short space of time, the standard clinical triage methods will be insufficient to cope. Treatment facilities and resources are then quickly overwhelmed by the sheer numbers encountered in military medicine. The first deviation from the *treat solely by urgency of clinical need* dictum can be seen here. Casualties in armed conflict, as in civilian disaster (natural or otherwise), often occur in multiples and an established framework for prioritising them for treatment is essential (Nicholson-Roberts and Berry, 2012, p. 187).

Now the response begins to take on distinctly utilitarian characteristics. If the military were to maintain an entirely ‘treat by medical need alone’ ethos in the face of overwhelming casualties, they would quickly become ineffective; whilst eminently salvageable casualties would undoubtedly perish in the face of dogged pursuance of medical futility on casualties beyond saving. This is not to say that an NHS hospital would not instigate a mass casualty protocol which prioritises its resources, but the *thresholds* to prompt that protocol are vastly different from those of a deployed military medical treatment facility’s (MTF).

This is because there are many options open to an NHS hospital to support it during mass casualty incidents (such as a good road network, casualty diversion protocols, huge reserves of consumables and a staff cascade call-out system) which are not available to a deployed MTF. These must rely on the staff it has in place, the fixed number of treatment areas and consumables it holds (including operating tables) with an unreliable resupply line, and the degree of physical and mental degradation suffered by MHCPs over a protracted period with no hope of a fresh team to take over. Therefore, the casualty numbers are much smaller for a typical MTF to trigger a mass casualty incident and enact its scarce resource allocation protocol.

Extreme conditions

This state of battlefield conditions has rarely been seen in modern conflicts, principally due to the move away from State-on-State confrontation and into anti-insurgent, guerrilla and terrorist warfare. The reason that it has attracted much commentary is because of the nature of and motive driving the ‘salvage medicine’ triage model used, which Adams (2008) refers to as ‘triage reversal’. If a defending battalion were in imminent danger of being overrun and

losing the battle which was critical to the defenders' war effort, this would constitute extreme conditions due to the dangerously depleted fighting force. The situation would prompt military commanders to order their MHCPs in these desperate conditions to reverse their triage methodology, to treat the most lightly wounded troops who require the least treatment time and resources, so that they can be recycled to the battlefield as quickly as possible (Beam, 2003, p. 381). This is to ensure that critical manning on the front line, and therefore maximum force strength, will be preserved.

The ethical dilemma created by triage reversal is difficult to resolve. This is because the treatment rights of not only those most seriously wounded who would die regardless of receiving extensive medical treatment are curtailed, but also those of seriously wounded patients who would be expected to live if urgent surgery is performed. Neither of these groups is able to return to the fight, and their rights are subjugated in favour of the walking wounded receiving priority treatment so that they can quickly be returned to the fighting. In essence, the lives of the seriously wounded soldiers have been trumped by military necessity. As this 'extreme conditions' model of salvage medicine deviates so far from the conventional ethical view of treatment priority guided solely by clinical urgency, ethicists and international organisations are likely to be firmly opposed to it.

However, I support the view of Adams (2008) when he states that it is 'both warranted and morally required on the grounds that military commanders have fiduciary obligations [to their State] to win battles'. He is of the opinion that MHCPs and their *soldier-patients* do not necessarily enter into a normal *patient-physician* relationship, as would be found in civilian life, whereby the doctor would owe a fiduciary obligation only to their patients as they may have sworn to do in their professional oaths. Instead, I conclude that the State *trusts* that the MHCP will obey the lawful orders of their military commanders over concerns of patient management, thus altering the focus of the MHCP's fiduciary obligation to the State, through his military commander. This, Adams states, allows for triage reversal should the chain of command so require it.

Murdock and Jenkins (2010) state that this extreme conditions model clearly has no analogous civilian experience as a system of triage prioritisation, even in mass casualty situations. Therefore, civilian HCPs may believe the theory to be morally repugnant. I believe I have shown that the extreme battlefield conditions model is ethically different from civilian peace time models. Armed conflict certainly prompts altered ethical paradigms in this situation.

Two-tiered care

Any deployed MTF has limited patient holding capability due to predicted operational tempo. They, by necessity, must feed their patients out to a definitive care facility. Coalition troops are evacuated back to their own countries, to a similar or slightly better standard of care. Host nation allies and local national civilians must be discharged to the care of their own Armed Forces and State hospitals respectively for definitive care, which often provide a significantly lower standard of care than in the MTF. Towards the forward edge of the battle area at smaller facilities, emergency life, limb, and eyesight saving interventions may be undertaken. However, wherever possible patients will be delivered to local facilities, even if these do not meet UK standards of care. Here, the problem of providing a higher standard of healthcare in initial management in a UK MTF becomes evident when giving way to a second (lower) tier of healthcare standards.

Some examples of the problem of transferring patients from high to significantly lower standards of care include Kondro (2007), a Canadian paramedic working in Afghanistan.

They described the transfer of patients to local hospitals as tantamount to a death sentence. These hospitals had no ventilators, resuscitation equipment, laryngoscopes or monitoring devices and very few drugs. Patterson (2007) describes a doctor who was ordered not to intubate any Afghans in a mass casualty incident with burns >50%, as 'without a local burns unit, those patients would be doomed'. Conversely, they were told to do everything possible for Coalition troops.

The ethics of these situations would fill a large volume, complex as they are. Although it looks like a worst-case ethical scenario, these are the kind of events which typify the two-tiered care observed almost daily in modern conflicts. It is plain to see that some treatment decisions are made based on nationality, and in light of knowledge about the normally poor standard of host nation medical facilities. This situation, again, has no civilian equivalent that I am aware of; and is yet another clear sign of how medical ethics differs in times of armed conflict. The issue of whether moving patients to host nation medical facilities as soon as is practicable, or even commencing complex or high-tech treatment of a local national knowing that transfer to the local healthcare system is inevitable, is ethical - or morally – right, is ultimately irrelevant to the military medical apparatus. It is simply a matter of appropriate resource allocation, following orders and 'clearing the decks' for the next wave of casualties.

Impartiality, and the ethics of comradery

Gross and Carrick (2013) identify another challenge to the delivery of impartial care during armed conflict in addition to battlefield triage and two-tiered care - the ethics of comradery. They postulate the existence of special obligations related to ethics of care and comradery which may result in some MHCPs treating their own comrades first, regardless of medical need. Given my operational experience and service history, I can appreciate how this might be the case in practice. Although not studied extensively, this phenomenon of preferential treatment could well be replicable in armies across NATO. The results above are indicative of a strong obligation to provide their countrymen with the best possible treatment, at the earliest opportunity.

Gross and Carrick (2013) further argue that preferential care for family and friends is a fundamental moral obligation which may supersede impartial criteria for allocating medical care priority. Philosophers such as Simmons (1996) have long been aware of associative obligations that 'reflect the overwhelming moral importance of intense, interpersonal relations among members of a small, tightly woven and interdependent family or community that demand preferential care for those who are close'. This precisely describes an army platoon. Aside from social reasons for associative obligations, such as preserving friendship, Gross and Carrick (2013) also go on to speculate that there exists an 'ethics of care that transcends mutual aid and social utility and invokes unconditional duties that certain individuals owe one another by virtue of a special relationship between those who can provide life-sustaining care and those who need it'.

It is important to note that the operational effectiveness, as well as the survival, of the platoon may depend on preferential treatment over concerns of impartiality - particularly if resources are scarce. Gross and Carrick (2013) believe 'bonds of friendship dominate moral relationships and generate duties of care' that mandate this approach. Further, they highlight the 'moral primacy of the [perceived] special obligations of care amongst friends and comrades irrespective of the instrumental value of the group'.

Conclusion

In an ideal world, medical ethics for MHCPs during armed conflicts and other times of armed violence would be identical to peacetime, if we are talking about the application of their

normal ethical principles in their clinical practice. For some of the time, this is even achievable. However, many of the ethical issues described above appear to me to be unique to military deployed service, and I can find no civilian equivalent. Pragmatically, these circumstances necessarily force changes in MHCPs' approach to daily ethical decision-making in deployed MTFs from that which might be followed in the peacetime environment, with patient outcomes often being directly and detrimentally altered in the process. Medical ethics then, in times of armed conflict, is clearly not identical to medical ethics in times of peace for MHCPs.

The peculiar positions that MHCPs occupy as both healthcare professionals and military professionals, combined with their values and standards, their unique perspective and practical exposure to the circumstances outlined above, engenders a professional morality and a 'blended' professional ethics by which only the MHCP must live and navigate. The pressures and constraints of wartime healthcare practice influence their moral and ethical outlooks during operational deployment, and the tensions discussed above also contribute to this 'bump in the road' in their normal peacetime professional ethics. The contrast with their civilian practice, to me, could not be clearer.

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