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Ethical decision-making of military nurses during war and humanitarian crises

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Abstract

Background: The unfamiliar situations and complex environments encountered in evolving combat and humanitarian operations, combined with advances in practice, means that deployed military nurses are increasingly likely to become more involved in, or lead, ethical decision-making in military treatment facilities.

Aim: How do United Kingdom military nurses experience ethical decision-making on combat and humanitarian deployments? Question: What are the experiences of military nurses regarding ethical decision-making during war or humanitarian crisis?

Design: A qualitative, interpretive, 'Big Q' design analysed through reflexive thematic analysis was used.

Participants: Thirty United Kingdom military nurses with operational experience in combat or humanitarian missions, serving or retired, were purposively recruited.

Ethics: Ethical approval was obtained from both the Ministry of Defence Research Ethics Committee (1009/MODREC/19) and the University of Birmingham Research Ethics Committee (ERN_17-1414). All participants gave informed consent and interviews were anonymised.

Results: Two themes were developed: 'Doing the Right Thing', with one sub theme 'Professional Codes and Guidelines as Ethical Handrails', and 'The Deployed Context'.

Conclusion: The findings show how military nurses try and do the ethically right thing, but situational constraints are, perhaps, significantly different to non-military nursing making ethical decision-making especially complex. Relatedly, military nurses' attempts to manage the prioritisation of their sometimes-conflicting identities of being both a healthcare professional and military professional compound this complexity.

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Introduction

Nurses play 'a critical role in the continuum of care, often spending more time with patients than other healthcare professionals'[1](p.1), creating 'very diverse feelings when these are related to making decisions about ethical issues in patient care'.[2](p.1). It is essential that nurses are involved in ethical decision-making, which is 'interrelated with professional competency and autonomy, [making it] important to investigate [in] nurses'[3](p. 201).

Nurses 'still lack confidence in their ability to articulate their ethical concerns consistently and effectively'[4](p. 126). Although there is evidence about nurses' experience of ethical decision-making in the non-military context, there is much less so in the military context.

Background

In the deployed military context, 'most theory learned in nursing programs is "thrown out the window" when it collides with the reality of war'[5] (paragraph 4). Because of the context and conditions in which military nursing is practiced, that may, by military necessity, breach conventional professional values, ethical concerns are of particular importance.[5] Demands for nurses to be ever more deeply involved in ethical decision-making will increase, based on a modern healthcare climate of rapid change and growing complexity.[5] For military nurses, this includes the steadily evolving character of warfare, the continuous development of advanced front-line medical equipment, and life-saving techniques.

On deployment, situations often occur where casualty rates are overwhelming, and the military conditions are unclear or novel; with associated lack of precedent or experience from which to draw comparisons. Perhaps consequently, there has been a call for increased emphasis on education and awareness training in appropriate ethics and values in both undergraduate nursing and medical curricula, and in the Defence Medical Service, to improve critical thinking in this field.[6,7]

However, no consensus exists regarding the optimal method of transferring the theoretical skills learnt in formal education or pre-deployment training to apply to practical healthcare ethical decision-making in practice. There is also no consensus on how best to promote sound ethical practice of military nurses in both their peacetime and deployed practice environments. Although military nurses *ought* to act ethically in the same way as their peacetime practice, it does not always mean that they *can* on deployment. Military nurses are bound to follow orders from their Chain of Command, which may be non-medical, and which may clash with their professional guidelines or instincts.

There are papers about military nurses' experience in war and humanitarian disaster operations, but they are almost all focused on military nurses from outside the United Kingdom. They also focus on issues of training or clinical practice, or were anti-war, rather than ethical issues.[8]

Aim

The research aimed to explore the lived experience of serving and retired UK military nurses in relation to the ethical decision-making they were involved in, or observed, during their operational deployed service.

Research question

What are the experiences of military nurses regarding ethical decision-making during war or humanitarian crisis?

Material and methods

Design

This qualitative study is based on a phenomenologically orientated approach with Reflexive Thematic Analysis.[9,10] Using a phenomenological orientation in qualitative research allows for '*lived*-experience' as the integration of the physical, cognitive and cultural, avoiding scientism (but not science) and the resultant problems for the reality of ethics, and emphasising meaning by the first-person active engagement in the world gaining something like van Manen's pathic knowledge.[9] The ontological understanding is critical realist and the epistemology contextualist emphasising the participants interpretation of reality and the ways they know. Reflexive Thematic Analysis allowed for development of shared and contextual meanings and provided guidance on interpretation in a reflexive and flexible manner, on a large data set, that could address the research question.[10]

Recruitment and sampling

Participants were recruited via an email sent on the researcher's behalf to all serving and retired military nurses through respective Service Associations, by gatekeepers. Emails were sent without reference to the researcher's rank or position in Defence Nursing to help reduce perception of rank coercion by seniority.

Purposive sampling[11] of active or retired military nurses from all three Military Services occurred within the Defence Medical Services and Service Associations. The inclusion criteria required at least one experience of combat or humanitarian deployment in a clinical role to be selected for the study. The sample size was justified by the need for a range of nurses in, service, rank and age in order to obtain rich data as well the requirement of the Military Research Ethics Committee. No participants withdrew.

Participants

Of the thirty participants 17 were male and 13 female. Some had more operational experience than others and there were a range of nursing specialities including Advanced Nurse Practitioners. No further demographics are provided to maintain confidentiality due to the nature of the subject, its military focus, and the integrated working environment of the population concerned.

Data collection

Data was collected using twenty-nine online and one face to face (due to the Covid pandemic) semi-structured interviews. Field notes of non-verbal cues were taken during the interviews with participants in their home setting. The recorded interviews allowed the option of repeated viewing to confirm the accuracy of the field notes. Each interview began with a reminder of the topic of the study and an open question: '*In this study, I am interested in your experience of ethical or moral decisions made, observed or witnessed in your nursing practice during your service, particularly on operational tour. Can you tell me about this?'* When needed, prompts were provided such as: '*Can you give me examples of what you mean, and what it meant for you?*'[12]

The mean duration of interviews was sixty minutes ranging from forty-seven to 90 minutes. All participants consented to being audio recorded and twenty-nine were video recorded using software. The researcher did not wear military uniform during the interviews.

Data analysis

Data analysis followed a recognised fifteen step process of Reflexive Thematic Analysis.[10] Early interviews were transcribed manually, and later interviews were transcribed using Quirkos software (a computer assisted qualitative data analysis tool). Transcripts were all repeatedly checked alongside the audio and visual recording to ensure accuracy, aiding familiarisation with and exploration of the data. Open coding allowed for the researcher's interpretive engagement with the data to allow development and refinement of themes. Reflexivity throughout this process helped ensure the researcher kept focused on participant's experience 'as lived' and reduce (but not eliminate) influence from theory and the researcher's preconceptions. This is perhaps akin to 'bracketing' of the natural attitude in philosophical phenomenology.

The researcher himself has a common background with participants and thus has some insight into the ethical decision-making they have experienced at strategic and operational levels as well as in day-to-day practice. This can assist with interpretation of meaning within the data as well as connection between the 'object' of the experience of ethical decision-making and the experience itself (akin, perhaps to 'phenomenological reduction').[9] Reflexive thematic analysis allowed the researcher to give needed depth of interpretation using his emic position.[10] Reflexivity occurred in thought and notes taken as well as discussion with (not verification by) doctoral supervisors about the transcripts, codes and themes.

Ethics

The study was approved by both the Ministry of Defence Research Ethics Committee (1009/MODREC/19) and the University of Birmingham Research Ethics Committee (ERN_17-1414). All participants consented and were informed they were free to leave the study at any point without giving a reason. No participants withdrew. An explanatory document detailing the arrangements for the claim and payment of no-fault compensation to participants, if required, was provided in accordance with MODREC policy.

The researcher completing the interviews is himself a military nurse. However, any potential for coercion and rank bias was minimised by the voluntary nature of the study and the recruitment method above. Positions of gender (male researcher) and power (senior officer in the military) were always borne in mind.

It was recognised this study covers a potentially sensitive topic and could raise new concerns from past experiences. However, no participants had just returned from deployment at the time of interview and many stated that they were keen to share their experiences. If participants showed signs of distress or upset, they were informed that the interview could be paused or cancelled if they wished. Participants were also informed that they could access military support services or non-military services such as their General Practitioner at any time, should they wish.

Findings

There were two themes and one sub-theme. The first theme, 'Doing the right thing', focuses on how participants conceptualise their place in and make ethical decisions within the context of military nursing. It has a sub-theme 'Professional codes and guidelines as ethical handrails' which reflects participants' thoughts on the utility of professional codes and guidelines in ethical decision-making. The second theme, 'The deployed context', is because everything participants discussed around the nature of ethical decision-making in the deployed space was very context dependent.

Theme 1: Doing the right thing. Most participants described ethical decision-making as a carefully considered process holding patients at the centre of nurses' thoughts. In a military hierarchy, decision-making responsibility increases with rank, yet senior-ranked participants never lost sight of the patients at the end of each decision. Many used the phrase 'doing the right thing for the patient', or a variation thereof, including having the right motive and always acting in the patient's best interests. However, there was ethical tension with the latter aspect as evidenced in theme two. There was some difficulty in expressing the subjective nature of ethical decision-making and the idea that making ethical decisions was objective:

> What it means to me personally would be making a decision that is in the best interests of the patient. […] It's doing the right thing, at the right time, for the right reason (P030). P020, however, also implies it is objective in that '[In] ethical decision-making...you've got to ensure that you are doing the right thing'.

She is ultimately clear, however, that she feels ethical decision-making is a contextual and subjective endeavour; being influenced by 'time, person, and place' and 'because my moral compass may be entirely different to yours' (P020).

Often in the military setting, ethical decisions were made from a third person perspective, those in higher rank or by, for example, doctors. In such cases, having an explanation of the decision-making was found helpful by military nurses:

> As a nurse, quite often you feel forgotten about, especially you know, that input to a decision of whether it's the right or wrong decision at the time. In the military, working with such small teams, it's even more key to sort of understand why decisions are made, and for what reasons (P025).

Trying to be impartial in ethical decision-making was experienced as difficult to achieve, with military nurses trying to hide their feelings about 'the enemy' when acting:

> Even though you wouldn't tell it in my body language, my brain is thinking, you know, 'You bastard!' But ethically…you treat everyone the same (P027).

Most, but not all, participants agreed that their experiences of clinical decision-making blurred with ethical decision-making:

> All clinical decisions should have a degree of ethical input, I would hope (P008).

The sub theme picked up on these experiences of clinical and ethical decision-making.

Sub-theme Codes and guidelines as an ethical handrail

Many participants agreed that written codes and guidelines have their place in nursing, although some viewed them as punitive measures. P010 states that in relation to ethical practice in nursing:

> I think you have to have some sort of framework, or a handrail for people to give guidance, because otherwise if you've got no boundaries, and you've got no framework, and you've got whatever...chaos will ensue. And patients die.

One nurse was quite emphatic about how she felt as to the professional code of nursing in the UK:

> …But the values and standards and your Trust and whatever that tells you you should be nice to people and…[tuts] all of these things I actually think are a little bit […] obvious, and they're telling…they're saying things that

> everybody should be anyway. But I suppose not everybody is moral and upstanding and looks after their patients and doesn't want to be horrible and doesn't want to bully people (P001).

Military nurses on deployment all agreed that they were there to do the right thing for all patients though there were voiced concerns about trying to act impartially to friends and foe alike when, sometimes, their feelings or emotions did not match their actions. The notion that ethical decision-making is both subjective and objective was raised by participants but not in a way that was explicit as to the theoretical issues surrounding it being more about what they felt. Generally, nurses of all ranks felt the (UK) professional code of conduct was of help in providing guidance or at least a framework as to how a nurse ought to act.

It was clear that the particular situations for ethical decision-making made such application hard particularly the nature of 'dual loyalty' to both the profession and to the military and this is the subject of the second theme.

Theme 2: The deployed context influences the ethical decision-making of military nurses. The experiences shared by all participants, which sometimes caused tension with the idea of doing the best for the individual patient, were centred around the context of war and humanitarian crisis:

> You know, you're being shot at, you can't hear a lot of things, your decision-making…you don't always have enough people to do what you want to do. You haven't got the equipment, you haven't got the peace, you haven't got that calmer environment. And you have to make big decisions... (P027)

The World Medical Association's statement on the identical nature of ethical decision-making in both peacetime and times of war and conflict was almost universally criticised:

> Oh gosh, you know now I'm thinking more deeply about it, and I'm thinking well, [the ethical decision-making] should be identical. It should be, but if it were identical, then I wouldn't have a history of these examples that I've given you. Do you see what I mean? It would be the same. Yes, and that's what we all strive for, that's what we want. [But] my history demonstrates it hasn't been (P028).

Dual loyalty, the military's deployed medical rules of eligibility, and scarce resource allocation affected military nurses' experiences of ethical decision-making:

> … you know, you'd be a nurse on shift, and you wear your Red Cross. But then when you come off shift, you've got to go and do your guard duty, and you take your Red Cross off – 'I am the Guard Commander for this sanger!' [Pause]. But you know, I suppose I think now, the ethical question is, are you a soldier first or a nurse first? And I was just like... 'I'm a soldier-nurse. Don't ask me to separate the two!' [Laughs] (P004).

> …you try walking down to that gate and turning a family away'. You know, this is not the NHS [National Health service (UK)] out in [that country]. People knew it [that logically, the medical rules of eligibility were necessary]. But knowing it and living it, I think, were two different things (P003).

One participant, (P027), presented an especially harrowing account of her experience during war time that made the researcher especially aware of the need for reflexivity. Seeing her describe these raw experiences [in a video call] in a detached, unemotional, matter-of-fact way left the researcher feeling emotionally affected, recalling and reflecting on his similar experiences in the combat environment for a few days afterwards. During analysis, the transcript of her interview was read and re-read reflexively, watching

and listening to the video to carefully ensure her voice was captured accurately and not enmeshed with the researcher's own assumptions, beliefs and judgements due to his own experience.

Another participant, (P019), experienced and expressed her frustration with a non-medical Senior Officer overriding her professional and ethical decisions when trying to obtain support for a seriously wounded local Afghan boy:

> … Erm...there is...pressure from that hierarchy culture that you shouldn't challenge it. And I think that gets in the way for people, and it gives you that...awful situation of how do I best challenge this? Because I know I need to challenge it.

When talking about cultural issues in the places to which the UK has deployed in recent decades, one participant recalled the animosity of local national patients, regardless of their combatant or non-combatant status, towards female nurses:

> If we're talking about Iraqis, Afghanis, then obviously with the female side of things…a lot of spitting, not wanting the females looking after them. Erm...that was quite difficult, especially...I mean, I was a Chief [Petty Officer] at the time, but seeing the youngsters deal with that, um, could be a bit tricky...for them (P011).

Theme two highlights the crucial importance of context for ethical decision-making. Military nurses were working in environments that frequently required critical decision s to be made quickly and that could make doing the right thing difficult. As well as the environment, dual loyalty to the profession and to the military was felt to also make ethical decision-making particularly difficult as did the animosity expressed by local populace who were patients to the nurses of female gender.

Discussion

There is limited evidence of the phenomenological experience of military nurses delivering impartial care on operational deployment. Of the 25 papers included in a systematic review of nurses' experience of delivering care in war and conflict, none discussed experience of impartial care.[13] Most of this study's participants reported experiencing alarm, anger, or frustration with, or at least a strong emotional response to, challenges in impartial care delivery caused by the context of war and humanitarian crises. Thus, without relevant contextual experience, the literature confirms that these stressful conditions may lead to an alteration in nurses' normal ethical decision-making process.

According to the findings, explanation of ethical decisions is required. One consistent claim, based on participants experiences was that ethical decision-making can be improved through 'explanation-giving' as it gives nurses a voice in the process. Even though nurses may not be directly involved, by explaining how they have arrived at an ethical decision, the decision-makers can still give nurses a chance to contribute to the wider ethical debate *post hoc*. It gives them an opportunity to disagree, challenge, comment or ask questions, even if it does not change the final decision.[14] Explanatory *post hoc* debriefings of this nature may help reduce moral distress and improve resilience in ethically challenging situations, as well as improve patient outcomes.[15]

However, the opportunity to disagree is a contested issue for military nurses. Service personnel can exercise a reasonable, respectful challenge, or even practice 'intelligent disobedience'.[16,17] This ranges from questioning views and pointing out mistakes to lawfully refusing to follow orders which conflict with prevailing law, or which would require soldiers to breach legal or ethical rules to achieve. This is a part of military codes of conduct and international humanitarian law and is intended to ensure that soldiers act in accordance with the principles of humanity and justice. In the participants' experience, however, this is

difficult to achieve. The military context could make 'respectful challenge' somewhat hazardous to one's career. On one hand they have the obligations of their healthcare profession, on the other they have the obligations of their service as professional military personnel.[18] An 'oath' of loyalty in the military may take primacy in ethical decision-making, causing a dual loyalty conflict, which led to one participant in a US study calling the duality of a military nurse's role 'very cruel and unkind'.[19]

Participants described being compelled by the chain of command to undertake combat-related duties while deployed as nurses. This is morally problematic because military nurses are operationally employed as non-combatants, entitled to wear the Red Cross symbol, as they fulfil a protected role governed by the Geneva Conventions. If a nurse chooses to remove the protections of their non-combatant role, as (P004) explicitly mentioned, they become a legitimate military target.[20] Practicing in a healthcare profession whilst prioritising their roles as soldiers is a fine line military nurses have had to tread over the last few big conflicts, being a morally problematic predicament, and a unique feature of the moral landscape of military healthcare.

War transforms healthcare ethics.[21] Military nurses, with their dual roles and obligations, cannot always guarantee to act in the best interest of every patient without incurring greater risks to themselves, their colleagues or their organisation.[22] Some think different ethical standards might apply to military nurses, believing that deployed nurses and other clinicians cannot be held to the same ethical standards as their non-military peers.[23] This is because there is a disparity in autonomy between the two, constraining ethical decision-making to the point that makes adherence to nursing professional codes and ethical guidelines challenging, or even at times inapplicable.[23]

The findings in this study suggest that written codes and guidelines etc. are generally important, and that some of those are even useful as a handrail to guide nurses through the ethical decision-making process in their practice. However, military nurses may be exposed to stressors they have never encountered before during their careers, and thus perhaps until one is in the situation, no amount of preparation can really prepare one for the actual specific context of war.

Additionally, the findings from this study show that while a few participants wanted to treat local civilians to the highest possible standards for as long as possible, to give them the best chance of survival, others were more pragmatic in thinking about the standard of healthcare the civilian would be returning to.

Scarce resource allocation includes lack of relevant specialist expertise or the ability to augment the healthcare team in busy periods. Thus, nursing care, staff resilience, and efficiency could degrade to the point of exhaustion in the short term or burnout over a longer period, leading to an unsafe care environment and poor outcomes for patients, particularly civilians.[24–26]

There was a great deal of discussion with participants about personal bias in altering what should be impartial ethical care decisions. The natural affinity of the military nurses with soldiers of their own nation over that of the allied or local forces, prisoners of war, captured persons or local national civilians on a deployment has been discussed in the literature.[27] Many of this study's participants commented that they felt a strong pull towards preferential treatment of their compatriots. It is a concept which complements the moral cohesion of the fighting force and forms the ethical foundation of the moral component of fighting power.[17] It also represents a form of motivation for 'own force' troops to risk their lives fighting at the front line. If soldiers had no realistic prospect of excellent medical care or were not confident of being prioritised for evacuation or treatment after injury, then the morale of the fighting force would collapse, and military objectives would be compromised.[17] The ethics of comradery holds that this prioritisation for treatment and reasonable expectation of it by own force troops is not only ethically justifiable, but an ethical obligation of the military healthcare apparatus. This is because there exists a natural inclination towards loyalty 'to one's own family, tribe or people over others'[28](p.59-60), which certainly includes fellow soldiers.

A report suggests that multiple studies show that US military nurses were unprepared to encounter the ethical challenges posed by cultural differences on deployment.[19] Participants of this study also encountered

difficulty in overcoming their habit of unconsciously applying their own (cultural) beliefs and mores to this kind of challenging situation.

Thus, military nurses' ethical decision-making during deployment raises particular situational concerns that make trying to do the morally right thing especially difficult. The accounts by military nurses of their lived experiences provides some insight into the social reality of such decision-making and may be useful to construct case studies to supplement pre-deployment ethical decision-making education and preparation for future nurses.

Limitations

The reliance on post hoc accounts, sometimes of many years ago, is a limitation to this study. The data analysis reflected what participants thought about ethical decision-making perhaps somewhat more than their phenomenological experiences of it.[12]

Conclusion

There are difficulties faced by military nurses in doing what they believe to be the right thing for their patients. This may have similarities in the context of their peacetime work in the United Kingdom National Health Service, but the difference in the degree of problems faced as a military nurse may be a significant one, even a difference in kind. Ethical case studies utilising real-world military nurses' experiences might be a useful addition to current ethical decision-making tools and processes in education.

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Author contributions

AB completed the data collection and all authors were involved in the analysis and discussion. RN and MC were also involved with supervision.

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For access to the original data please contact the first author.

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