

**Is Medical Ethics in Armed Conflict Identical  
to Medical Ethics in Times of Peace?**



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By

Janet Kelly

**CAMBRIDGE**  
**SCHOLARS**  

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**P U B L I S H I N G**

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by Janet Kelly

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**To  
Mum and Dad**



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## ABSTRACT

This book challenges The World Medical Association's (WMA) International Code of Ethics statement in 2004, which declared that **'medical ethics in armed conflict is identical to medical ethics in times of peace'**. This is achieved by examining the professional, ethical, and legal conflicts in British Military healthcare practice that occur in three distinct military environments. These are (i) the battlefield, (ii) the operational environment and (iii) the non-operational environment. As this conflict is exacerbated by, the need to achieve Operational Effectiveness, this book also explores the dual loyalty conflict that Military Health Care Professionals (MHCPs) encounter between following military orders and professional codes of practice.

The method used to challenge the WMAs statement and explore these conflicts is by real-life problem-solving vignettes, which mirror actual ethical and professional conflicts and dilemmas that may occur in the three environments. The areas of law analysed similarly reflect the difficulties that MHCPs face when caring for the sick and wounded in violent locations when under attack. In particular, the book questions whether it is right for a MHCP to owe their patients a duty of care in hostile environments. This leads onto to questioning if any MHCP could be protected by combat immunity where no duty of care is owed to fellow soldiers in the battlefield.

The book also questions whether the standard of care should be variable in hostile environments. It also explores the dual loyalty conflict of a wounded senior officer refusing treatment from a junior officer. In addition, it examines the difficulties of a doctor maintaining patient confidentiality when a soldier refuses treatment for a psychological injury but wishes to redeploy to the battlefield.

The book successfully challenges the WMAs statement. It also concludes by suggesting that neither a military-focused approach nor a professional healthcare-focused approach towards military healthcare is the best way to solve the dual loyalty conflict.

# CHAPTER ONE

## PREAMBLE

This first chapter briefly outlines the aim of the book and outlines the contents of each chapter. In 2004, The World Medical Association's International Code of Ethics (WMA 2004; Hallgarth, 2007) claimed that **'medical ethics in armed conflict is identical to medical ethics in times of peace'**, thus suggesting that the patients' clinical needs in war remain sacrosanct, above all other considerations (Annas, 2008). This book aims to challenge the WMA's statement and assert that medical ethics in British Military Healthcare Practice, as encountered by Military Healthcare Professionals (MHCPs) on the battlefield and in the operational environment, is *not* identical. This is underpinned by arguments, which demonstrate that medical ethics are constrained and questionable under existing ethical, professional, and legal parameters. Therefore, new professional regulatory solutions to solve these ethical conflicts are required.

## Summary of Chapters

**Chapters 2, 3, 4 and 5** details the main themes of the book in order to set the context. This is to aid an understanding of the concept of military healthcare in the battlefield, operational environment and non-operational environment in which MHCPs serve. Chapters 3 and 4 further explain the historical background and importance of international, humanitarian and military law and discipline to the present day and its relationship with civil law and healthcare professional regulations.

Chapter 5 continues by highlighting the complexities of solving ethical and professional dilemmas in diverse military environments (Tschudin, 2002). It highlights the paucity of existing research on the ethical and professional complexities of MHCPs caring for the sick and wounded in war (Vetter, 2007; Robinson 2007 and Fleischmann, 2006). The chapter does, however, critically analyse one specific quantitative study by Verweij, Hofhuis and Soeters (2007), which was conducted to emphasise how the Dutch Military view the ethical and moral training of its military personnel. This paper arose in an attempt to avoid a repetition of events

that involved Dutch troops when Serbian soldiers allegedly murdered Bosnian Muslims during the Balkan Wars in the 1990's. The significance of this study is that it highlights the complexities of ethical decision making in challenging military environments. In addition, chapter 5 illustrates a study by Boyd, Himmelstie, Lasser, McCormick, Bor, Cutrona and Woolhandler (2007) conducted at selected universities across the United States, that examined how much knowledge and understanding medical students had about military medical ethics and the Geneva Conventions'. As a result of these two studies, this chapter indicates that both a *military-focused* approach and a *professional healthcare-focused* approach could, perhaps, be used to solve the difficulties that a MHCP might face when having to follow both military orders and professional codes of conduct in diverse military environments.

**Chapter 6** explains the rationale for using vignettes to Address Military Clinical Ethical Issues. It explains that real-life vignettes based on the experiences of military nurses with problem-solving questions to give 'recognisable snapshots' of events that require legal analysis to solve their outcomes (Schofield, 2009 at pg. 1109) were uniquely used in three distinct military environments: the **battlefield**, the **operational environment**, and the **non-operational environment**. These were then critically analysed by legal methodology. Legal methodology involved (i) Identification of the legal area and relevant legal issues. This was medical law and included issues such as refusal of treatment, confidentiality and mental capacity, (ii) the use of relevant legal authority by case law and statutory authority and then, (iii) giving the legal advice. Legal methodology was enhanced by using Howe's (2003) three role-specific military ethical model. These consisted of a **military role-specific ethic** where MHCPs would follow military orders above everything else. This ethic follows a *military-focused* approach. A **medical role-specific ethic**, which follows a *professional-healthcare focused* approach and where MHCPs would follow professional codes of practice and put their patients first (Howe, 2003 at pp. 333-334). Finally, the third role is a **discretionary role-specific ethic** where the MHCPs use some discretion in deciding when and whether the needs of the military are absolute (Howe, 2003 at p.335).

Using legal sources from the common law and statutes, **chapter 7** introduces the first vignette that concerns the law concerning a MHCP owing a duty of care to a patient. Similarly, chapters 7 and 8 present a legal literature review of the law concerning Crown Immunity and the doctrine of combat immunity. By the use of problem-solving vignettes which, according to Hughes and Huby (2000) are useful tools to simulate

real life situations and examine difficult complex concepts in context, **chapters 6 to 12** highlight realistic ethical, professional and legal difficulties which can occur in hostile and non-hostile military environments. In view of the author's first hand experiences, **chapter 7** explains that military healthcare in the battlefield environment is distinctly different to civilian healthcare, even in an emergency and thus a question emerges: 'Should a duty of care apply to Military Healthcare Professionals in this environment?' The chapter explains that although MHCPs have a legal and professional obligation to care for the wounded on the battlefield, this obligation can contradict the following of military orders, causing a dual loyalty conflict. As further discussed in this chapter, soldiers are part of a 'fighting force' so that they are fit to fight the enemy and win the battle. They are thus seen as being more of a commodity rather than individuals with distinct healthcare needs. Such distinct differences in wartime can override normal peacetime professional ethics to the extent that the duty of care owed by MHCPs to their patients on the battlefield can be constrained and questionable under existing ethical and legal parameters.

Following a legal literature review of combat immunity, **chapter 9** extends the discussion of a duty of care owed by MHCPs to their patients on the battlefield being problematic under existing ethical and legal parameters. It does this by explaining that the combatant soldier on the battlefield remains protected from any claim in negligence by the doctrine of *combat immunity* for any negligent act or omission they may make when fighting. In other words, the combatant soldier *does not* owe a fellow soldier a duty of care on the battlefield, as the duty of care is non-justiciable. However, the non-combatant MHCP, although sometimes operating in the same hostile circumstances as the fighting soldier, is currently unlikely to benefit from combat immunity for any negligent act or omission that they make on the battlefield, as they continue to owe their patient a duty of care. The chapter, therefore, considers if the MHCP could ever be protected by combat immunity. It then further considers if a unique and a modified form of immunity, namely *Military Healthcare Battlefield Immunity*, could be a viable and exclusive doctrine to protect MHCPs against a claim by a patient for an alleged negligent act or omission. The chapter demonstrates that it is unlikely that a MHCP could enjoy combat immunity due to their non-combatant status. Instead, the chapter proposes that this unique form of immunity may be viable, but *only* in rare circumstances and to a much lesser degree than combat immunity.

**Chapter 10** explains that the battlefield is a hostile environment for MHCPs. The chapter considers whether the current standard of care on

the battlefield is sufficiently viable to protect the Ministry of Defence (MoD) against a claim of a breach of a duty of care for any negligent act or omission by a MHCP. In addition, as MHCPs have both legal and professional obligations to care for the wounded on the battlefield, as well as an obligation to follow military orders, the chapter considers the effect that dual loyalty conflict has when giving emergency care and treatment in this environment. The chapter concludes that the law is sufficiently viable to protect the MoD and that dual loyalty conflict does not unduly influence healthcare professionals, as decisions are made quickly, thus giving the MHCP little time to consider this dual role conflict issue.

In contrast to chapters 7, 9 and 10, which consider ethical, professional, and legal conflicts on the *battlefield*, **chapter 11** considers ethical, professional, and legal conflicts in an *operational* environment. It explores the law concerning consent and refusal of medical treatment where the capacity of a patient soldier is questionable. This is discussed in the context of dual loyalty conflict, where the patient soldier, who is a senior military officer, refuses life-saving treatment and gives a military order to a healthcare professional not to give him treatment. This chapter concludes by suggesting that, ordinarily, it is unlawful and unethical to exert any undue influence over a patient in persuading them to accept medical treatment. However, in an operational environment, where the MHCP and the patient's safety may be at risk from enemy attack, it is understandable that some undue influence may be exerted by the MHCP on their patient.

**Chapter 12** considers ethical, professional, and legal conflicts in a *non-operational* environment. It explains that military doctors have a legal and professional obligation to maintain patient soldier confidentiality and allow a competent patient soldier to refuse consent to medical treatment. However, this obligation can be inconsistent with following military orders, causing a dual loyalty conflict. This can become more problematic when the military doctor believes he has a professional duty to disclose confidential medical information to a senior military officer in the public interest, so that an unfit soldier can be prevented from deploying on an operational tour. The chapter concludes by suggesting that dual loyalty conflict in the context of a *non-operational* vignette is best managed via a discretionary ethic-role. This then allows independent clinical judgment, whilst at the same time minimising harm and conflict to a Commanding Officer as an interested third party.

**Chapters 13 and 14** suggests that professional codes of practice by the General Medical Council and the Nursing Midwifery Council are not a sufficient solution to the existing and emerging ethical and professional

conflicts that occur in the battlefield and operational environments. It further suggests that ‘medical ethics in armed conflict is *not* identical to medical ethics in times of peace’. In doing so, chapters 13 and 14 critically analyse each vignette from a *military-focused* approach and a *professional healthcare-focused* approach and concludes that neither of these approaches to military medical ethics is appropriate. This is due to the difficulty in determining whether the military duty to follow military orders or the medical duty to follow professional codes of practice should override one another. Chapters 13 and 14 further suggest that both of these approaches contradict with the principles of healthcare ethics, thus potentially compromising patient care. In addition, as explained in chapter 5, they also contradict with achieving Operational Effectiveness and thus could potentially compromise a set military mission. **Chapter 15** concludes the book by recommending that new professional regulatory solutions by the General Medical Council and the Nursing Midwifery Council may be required to help solve ethical conflicts in the diverse and harsh military environments in which MHCP serve. This final chapter highlights some limitations and boundaries of the book, but also its uniqueness and originality.

In conclusion, this book, therefore, successfully highlights that medical ethics in armed conflict is *not identical* to medical ethics in times of peace. This is primarily due to MHCPs providing healthcare in more controlling, distinct and hostile environments compared to civilian healthcare professionals. Furthermore, it is also due to MHCPs having a dual loyalty conflict between following military orders and professional codes of practice. It suggests that, although dual loyalty conflict can exist in other areas of healthcare apart from the military, the conflict is less problematic than it is in a military environment. This is because the duty to follow military orders can be incompatible with the duty to follow professional clinical codes of practice.

# CHAPTER TWO

## CONTEXTUAL BACKGROUND

### Introduction

These next three chapters highlight the main themes of the book to aid an understanding of the concept of military healthcare in the diverse environments in which Military Healthcare Professionals (MHCPs) operate and serve. This chapter draws attention to the organisational and cultural differences between civilian and military personnel and the military's relationship with civil law and healthcare professional regulations. The following chapter gives a review of international and humanitarian law followed by chapter 4, which gives an historical review of military law and the importance of military discipline, which is a core value for the British Armed Forces and is a fundamental requirement towards achieving Operational Effectiveness. Chapter 5 highlights two studies on the moral and ethical judgment of individuals in a military context.

### Civil and Military Values

Regarding civil and military values, there are significant differences regarding (i) the physical environment and (ii) the context of where care is given. It is also clear that there is some distinction regarding the philosophy of care, which is discussed next from a *military philosophical perspective* and a *National Health Service philosophical perspective*.

#### ***Military philosophical perspective***

From a military philosophical perspective, the British Army perceives that wherever a service person is serving, military law and discipline must underpin Operational Effectiveness (Soldier Management, 2004). In other words, Operational Effectiveness, which is examined in more detail in chapters 7, 10, 13 and 14, is the British Army's ultimate and primary objective. The implication of this for MHCPs within the environment they



serve, means that to achieve Operational Effectiveness, they must be ready and prepared to give treatment and healthcare to military personnel who are about to deploy, or who are already deployed, in any military operation (Delivering Our Armed Forces' Healthcare Needs, 2007). Present examples of such deployments are those formerly in Iraq and now in Afghanistan. When not deployed on operations or military exercises, Operational Effectiveness is achieved in other ways. This is by regular military training at military bases, acquisition of new knowledge and maintenance of clinical skills within a primary care location, such as a General Practitioner's surgery, a medical centre or via a secondary care establishment such as at a Military Defence Hospital Unit (Queen's Regulation, 1975, section 5.181).

Nonetheless, it is reasonable to suggest that switching between a battlefield, an operational environment and a non-operational environment, and having to maintain Operational Effectiveness constantly is challenging both physically and psychologically (Gross, 2006). Smith and Arthur (1992) remark that there is an expectation by Commanding Officers that MHCPs can easily switch and adapt to delivering the unique healthcare requirements provided by service personnel from that of a peacetime environment to that of a war zone. Anything that compromises or challenges that ability undermines the successful functioning of the army in achieving its given mission (Soldier Management, 2004). To adapt efficiently and effectively to that change of environment, all military service personnel must, therefore, demonstrate individual fitness. This is currently achieved by successfully passing Military Annual Training Tests (Queen's Regulations, 1975), which is necessary and essential to ensure that Operational Effectiveness is sustained. However, as explained in the next section, outside a military environment, Operational Effectiveness is, perhaps, not a consideration or issue that front line civilian personnel in the NHS are preoccupied with, as it rather different in a NHS context.

### ***National Health Service philosophical perspective***

The Darzi Report in 2008 highlighted the need for the NHS to provide high quality patient care that prevents illness, as well as treating illness (High Quality Care For All, 2008). In addition, a strong emphasis was placed on the need to encourage people to live healthier lives, to raise standards of care by empowering patients and professionals and also by providing the most effective diagnostics and subsequent treatments to detect diseases earlier (High Quality Care For All, 2008). The legal mandate for this was originally via the National Health Service Acts of

1977 and 2006 and more recently, the Health and Social Care Act 2012. Clearly, despite the expected political changes ahead, the function and aim of the NHS is *not* to support the British Armed Forces in achieving Operational Effectiveness, although it may be sympathetic to that cause.

Clearly, the core ideology and beliefs of either a *military philosophical perspective* or a *National Health Service philosophical perspective* are significantly different from each other, yet it is apparent that the military personnel who work within this structure are subject to *both* military and civilian laws that govern this core NHS ideology.

In addition and as discussed in the next chapter, military personnel including MHCPs *must* also follow International Law, which main aim is to manage relations between states during war and peace as stipulated by the International Committee of the Red Cross (The Joint Service Manual of the Law of Armed Conflict, 2004 at para 1.1). As explained in the next chapter, the implications of International Committee of the Red Cross parameters for the MHCP therefore, is that it reinforces the need for the MHCP to have an understanding of how military healthcare practice and professional codes of practice, must be compatible with several facets of law i.e. international, domestic and military law (Lamp, 2011).

# CHAPTER THREE

## INTERNATIONAL LAW

Military personnel including Military Healthcare Professional (MHCPs) *must* also follow International Law, which main aim is to manage relations between states during war and peace (The Joint Service Manual of the Law of Armed Conflict, 2004 at para 1.1). Whilst international and humanitarian law is not explicitly addressed in the vignettes apart from in chapter 9, it is abundantly clear that, international law places obligations on states to act within defined humanitarian parameters as stipulated by the International Committee of the Red Cross (ICRC) within their own country, and to commence any legal action against personnel through their domestic courts when these parameters are breached (Orakhelashvili, 2006; Akander and Sangeete, 2010). Thus, it is clear that the ICRC is the ‘guardian’ of humanitarian law and is a major player in the protection of the sick and wounded in war (Ratner, 2011). This is clearly highlighted in the vignette in chapter 9 when the MHCP believes he is protecting his wounded patient by firing at the enemy. The implications of ICRC parameters for the MHCP therefore, is that it reinforces the need for the MHCP to have an understanding of how military healthcare practice and professional codes of practice, must be compatible with several facets of law i.e. international, domestic and military law (Lamp, 2011).

### **Historical Background of Humanitarian Law**

The earliest form of humanitarian law stems as far back as 3000 BC in Africa and Ancient Greece to protect victims of war and control how war was conducted in relation to the use of weapons and proportionality (Sassòli et al, 2011). There is also evidence of humanitarian law from the Saracens in the Middle Ages during the Crusades when they followed the principles laid down in the Koran and allowed the lives of the civilians living in Jerusalem at that time, to be saved from attack and certain death (Detter, 2000; Algassee, 1977). Following this, there was little intervention on the conduct of warfare against armed forces and civilians until the 19<sup>th</sup> century when during the American Civil War (1861-1865), President

Lincoln successfully codified the behaviour of Union forces via the Lieber Code (Rogers, 2004). Shortly afterwards, the St Petersburg Declaration of 1868 gave greater clarity on the prohibition of certain weapons in war (Schindler and Toman, 1988). In modern humanitarian law, however, the protection of the wounded, civilians and property (the law of property is not discussed in this book) arises principally from the 'Law of Geneva' through the Geneva Conventions and the 'Law of Hague' through the Hague Conventions of 1899 and 1907.

Humanitarian law has two distinct branches, these are, the '**Law of Geneva**' and the '**Law of Hague**' (International Humanitarian Law, 2002). The Law of Hague commonly known as the Hague Conventions are two international agreements (referred to as Treaties) that were negotiated and agreed between States at international peace conferences at The Hague in the Netherlands. The First Hague Conference was in 1899 and the Second Hague Conference in 1907. The Law of Hague refers to the 'rights and obligations of belligerents in the conduct of military operations' or as Bugnion (1995) remarks more succinctly, how nation's conduct war on each other. For example, following the atomic bomb attacks on the Japanese cities on Hiroshima and Nagasaki that ended the Second World War, an ICRC delegate, Fritz Bilfinger, sent a telegram stating the following:

"Visited Hiroshima thirtieth, conditions appalling stop city wiped out, eighty percent all hospitals destroyed or seriously damaged; inspected..." (Bugnion, 1995).

Following this observation on Hiroshima, the ICRC strongly encouraged all states to ban the use of nuclear weapons and any type or weapons that caused the devastating destruction on the two Japanese cities and their peoples. As suggested by Reisman and Stevick (1998), whilst collateral damage during war is unavoidable, it is essential that lawful primary targets be clearly defined to establish boundaries of what can and cannot be attacked. These two authors further remarked that the use of weapons is neither lawful nor unlawful but must be used in the specific context that they were defined for, so that they can separate between combatants and non-combatants. Thus, when targeting a military establishment the principle of proportionality needs to be taken into account (Fenrick, 2001). Although the differentiation between combatants and non-combatants is explored in detail in chapter 9, the use of weapons by non-combatants clearly has implications for MHCPs as they are bound to respect international and humanitarian law as well as national and military law (Bianchi, 2007).

The ‘Law of Geneva’, was inspired by a Geneva businessman, Henry Dunant at the battle of Solferino, in northern Italy between French, Italian and Austrian forces in 1859. Dunant was concerned about the lack of care for the wounded soldiers on the battlefield that were left to die without any treatment or care (Sassòli et al, 2011). As a consequence of his experiences, he published a book, *A Memory of Solferino* with recommendations on how to care for the sick and wounded in war that was quickly endorsed by other countries. This resulted in a small committee being created, which was the inauguration of the modern ICRC. Thus, the First Geneva Convention was written and implemented by countries in 1864. Presently, the Geneva Conventions comprise of four treaties, which are commonly known as the ‘Geneva Conventions of 1947’ or the ‘Geneva Conventions’; they also include three Additional Protocols (Rogers, 2004), which have been updated throughout the years to meet the demands of modern warfare in protecting the wounded and sick in war. The Geneva Conventions and the Hague Conventions were merged together by the adoption of Protocols I and II in 1977.

The importance of the Geneva Conventions has recently been re-affirmed in two documents by the ICRC; ‘*Health Care in Danger*’ (ICRC, 2011) and ‘*How Does Law Protect in War?*’ (Sassòli et al, 2011) where it reiterated that protective emblems such as wearing the Red Cross, Red Crescent or Red Crystal must be respected by all sides and that all military personnel including MHCPs must follow the international and humanitarian law. As explored in chapter 9, both these documents have stated the importance of distinguishing between combatants and non-combatants and that health facilities and personnel will lose their protection if they engage in harmful acts against the enemy that are not, for their own, or their patients’ protections. Thus, the ICRC is clear about what the role of all MHCPs involves, this is, they must have an understanding of the importance of humanitarian law and the Law of Armed Conflict.

### **International and humanitarian law within the context of the vignettes**

Although this book explores *British* military healthcare practice, the essential features of humanitarian law are nonetheless, clearly acknowledged, and entrenched implicitly within the vignettes and in particular, more explicitly in chapter 9, which critically explores the legitimacy of a non-combatant MHCP firing at the enemy when under attack. In addition, the Geneva Conventions Act 1957 and more recently the Geneva Conventions

(Amendments) Act 1995 ratifies the Geneva Conventions into United Kingdom law. Section 1 of this 1957 Act also states that any violation of the Geneva Conventions will be punishable via either a civil court or a court martial for military personnel and may involve a custodial sentence pending the severity of the crime. The 1957 Act is now strengthened by the Armed Forces Act 2006, which allows Commanding Officers to deal more readily with offences committed whilst on operations. The 2006 Act also confirms British military law's compatibility with international and humanitarian law. For example, schedule 2, section 12 (t) of the Armed Forces Act 2006, directly refers to section 1 of the Geneva Conventions Act 1957 thereby reinforcing the United Kingdom's commitment to conforming to the Geneva Conventions and its Additional Protocols.

Regarding chapter 9 of this book, Chapter 3, Article 19 of the First Geneva Convention (the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field) refers to 'Medical Units and Establishments' and states that 'mobile medical units' such as military medical vehicles or military personnel travelling in light armoured tactical vehicles where their Red Cross insignia is clearly visible, may not in any 'circumstances', be attacked. In addition, Chapter 5, Article 35 of the same convention also states that medical transport vehicles when escorting the sick and wounded to medical establishments must not be attacked. Further, Chapter 7, Article 40 of the First Geneva Convention also refers directly to the 'Distinctive Emblem' i.e. the Red Cross that all personnel must legally wear on their upper left arm. The position of the protective emblem is further enhanced in Protocol III, which is the Third Protocol additional to the Geneva Conventions of 1949 relating to the Adoption of an Additional Distinctive Emblem (Protocol III). Accordingly, in each vignette, all military personnel wear this distinctive insignia i.e. the Red Cross apart from chapter 12 as this vignette is not based in a theatre of war and therefore there is no legal requirement for any medical personnel to wear this emblem at this time.

In chapter 9 of the book, the battlefield vignette also explains that the MHCP is wearing an upper left armband with a Red Cross on it that denotes his protected medical status as stated above. In Chapter 3, Article 24 of the First Geneva Convention under 'protected persons' the phrase, 'medical personnel proper', further categories doctors and nurses as personal who give direct care to the wounded. Thus, all of the MHCPs in the vignettes are 'medical personnel proper'. As further explained in chapter 9, the wearing of a Red Cross armband denotes that the enemy *must not* fire at him. Equally, it also signifies that medical personnel must not fire at the enemy, *unless*; it is for the protection of their patient's or

their own life. Nonetheless, as the vignette explains, the enemy are firing at him and consequently, the MHCP fires back. In the context of this vignette, because the wearing of a protective emblem directly relates to the First Geneva Convention and the use of the protective Red Cross emblem on a white background, it is therefore important to explicitly mention the key principles of international law via the Geneva Conventions. In addition, chapter 9 also mentions that British combatants are firing back at the enemy. By way of Protocol I (Protocol Additional to the Geneva Conventions of 1949 relating to the Protection of Victims of International Armed Conflicts), section 3 on 'Combatants and Prisoners of War', Article 43 (2) (Protocol I), combatants are defined as being personnel who are legitimately permitted to engage in hostilities against the enemy. In chapter 9 therefore, it is clear that the combatant soldiers are legally allowed to fire at the enemy when under attack. Accordingly, it is therefore essential and relevant to critically analyse the differences between combatants and non-combatants regarding the consequences of their actions when under fire and the contrasting actions that they are lawfully permitted to undertake when under the rules and regulations of international law.

Similarly, in chapter 10, as this battlefield vignette also involves a MHCP giving care and treatment to a wounded soldier when under enemy fire, the requirements of international law and the Geneva Conventions are clearly relevant in the same context as in chapter 9. This is, that the enemy *must not* fire at any medical personnel when they are treating a wounded soldier. For instance, Chapter 2, Article 12 of the First Geneva Convention (the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field) refers to the wounded and sick and medical personnel treating them. In this section, it clearly states that the wounded and medical personnel treating them *must not* be fired upon by the enemy. However, unlike chapter 9, in chapter 10, the importance of international law and the Geneva Conventions is implicitly applied. This is to avoid repetition from the previous chapter, but also, in contrast to chapter 9, where the importance of international law and the Geneva Conventions cannot be overlooked and must be unequivocally addressed, it is to highlight that the main focus of chapter 10, is to examine the *standard of care* in the battlefield and whether there is a *dual loyalty conflict* between following military orders or professional codes of practice in the context of the vignette. Accordingly, although important, the aim of chapter 10 is *not* to explore the relevance of international law in this context.

In the same way, the aim and focus of the operational vignette in chapter 11 is to explore dual loyalty conflict when a senior military officer

*refuses* life-saving medical treatment from a junior MHCP and when the senior officer's *capacity* to consent is questionable due to their injury. In this vignette, although international law will clearly apply because of the vignette indicating that the injury is sustained within enemy and hostile territory, the purpose of the vignette is *not* to discuss international law. Instead, the aim of the vignette in chapter 11, is to critically discuss professional requirements as required by professional bodies such as the General Medical Council (GMC) and the Nursing Midwifery Council (NMC) on *capacity to consent* and allowing a competent patient to *refuse life-saving treatment*. In the context of the vignette, this is when the patient is being given treatment in a hostile and dangerous environment and when the MHCPs life is at risk. However, if international law were the focus of the discussion, then Part II, Article 21 of Protocol I, would apply, as 'medical vehicles' such as the medical helicopter carrying the emergency surgical team in chapter 11, must not be attacked. Further, Part II, Article 11 (5) of Protocol I, similarly would be relevant as this concerns refusal of treatment and any act or omission that endangers the physical health of another person; however, clearly this discussion would be outside the scope of professional guidance and requirements from either the GMC or NMC.

In contrast, the non-operational vignette of chapter 12 is based in a United Kingdom environment and is therefore outside the theatre of war. This vignette involves *refusal of treatment* and *confidentiality* of a soldier suffering from a psychological injury. Accordingly, the implications of international law and the Geneva Conventions are less significant in this environment and context compared to the other vignettes in more hostile situations. However, as in chapter 11 if the psychological injury did occur in a battlefield or operational environment then Part 2, Article 11 (1) and (4) of Protocol I would apply as this concerns the care and treatment for the mental health of wounded personnel.

In not openly mentioning or having the main focus of analysis throughout each vignette on international and humanitarian law and the Geneva Conventions, this book *does not*, in any way whatsoever, diminish or dismiss the extreme importance and practical relevance of this area of law. On the contrary, because this area of law is so important, as already discussed, chapter 9 explores separately international law within the context of a realistic vignette. This is before the book discusses the next battlefield vignette and the operational and non-operational vignettes in the subsequent chapters. This allows the remaining vignettes to explore the areas of medical law discussed above, in the context of British military law and its compatibility with professional codes of practice and *not*



international law or the specific criteria mentioned in the four Treaties of the Geneva Conventions and the 'Additional Protocols'.

More specifically, the main focus of the book is *not* about international and humanitarian law. Instead, and as mentioned in chapter 1, its emphasis is to (i) challenge the World Medical Association's claim that medical ethics during armed conflict is *identical* to medical ethics in times of peace in the context of British Military Healthcare Practice, (ii) to discuss British Military law in conjunction with professional codes of practice from either the General Medical Council or Nursing Midwifery Council and (iii) to explore the dual loyalty conflict between either following military law or professional codes practice. Clearly, if the context of each vignette were more directed towards exploring international and humanitarian law and the Geneva Conventions, then the book would quite evidently not address or challenge the WMA's statement. However, as mentioned above, this does not mean that the book has relegated international law in favour of domestic, civil, and military law or dismissed its significance. On the contrary, international law clearly *does* merit attention and exploration within a military discourse. However, this should only be done where appropriate and in this book, a thorough examination of international law, would detract from the main aim and purpose of it and would be outside the scope of this work. Accordingly, this area of law is best dealt with in a separate book.

However, notwithstanding the above, in addition to the legal requirement of having to follow international and humanitarian law, as discussed in the next chapter, military law also makes it imperative to obey and follow military orders without question and acquire military discipline. Using real life vignettes, this book, therefore, considers how this can cause ethical and professional constraints between either following professional codes of practice or following military orders to achieve Operational Effectiveness, and whether the World Medical Association's statement that **'medical ethics in armed conflict is identical to medical ethics in times of peace'** can be successfully challenged (WMA 2004; Hallgarth, 2007).

## CHAPTER FOUR

# MILITARY LAW AND DISCIPLINE

### Modern Military Law

Military law is entrenched via international obligations under military and humanitarian rules and regulations such as the Geneva Conventions of 1949 and Protocol 1 of 1977 (Rogers, 2004). Its aim is (i) to establish and maintain military discipline so that the underlying functional effectiveness of the military at all levels is not compromised and (ii), to ensure that the instructions and orders of the military commander can be achieved within any environment (Soldier Management, 2004). It is, as mentioned by Savitsky et al (2009), characterised by mobility and on 'mission readiness'.

Although it is a separate judicial system to civilian law, it is not exclusive from it; meaning that military personnel are equally subjected to the civilian law of any particular country wherever they are serving, including international law (Soldier Management, 2004). This means that, like any other employer, the military has a procedural system whereby it can discipline its employees if they fail to meet the required standards or fail to follow that which governs them. This also includes disciplining MHCPs for not obeying military orders. Therefore, as demonstrated in the real-life vignettes and unique to the military, is that they can discipline any soldier, irrespective of where they are serving, and whether the environment is hostile and violent from enemy attack. To aid this process, currently the British Army uses Army General and Administrative Instructions (AGAI) (1998). The AGAIs, however, do not give any guidance on whether the standard for disciplining MHCPs changes in line with the context of the situation and the hostile, challenging environments that the MHCP can work in when caring for wounded personnel. The AGAIs do not also give any guidance over which order takes precedence if conflict arises between obeying and following military orders or following professional codes of practice. Although no rationale is given for this, it may be because the Army *does not* identify and/or appreciate that such conflict could ever arise, as it may have assumed that whatever rank a person is, he/she will unquestionably obey a military order from a senior

officer. For example, as discussed in chapters 7 and 9 in a battlefield environment military orders could be for MHCPs to treat military personnel only and not civilians; contrasted with the non-operational environment to treat military and civilian casualties alike. This order may have adverse ethical, professional, and legal implications for a MHCP, which will be discussed further throughout the book. The complexity is self-evident when one has to consider that, to civilian healthcare professionals; not treating wounded civilians would be morally repugnant and contradict the entire underpinning principles of healthcare (Crowe, 1991). Moreover, feasibly and fundamentally, it contradicts the World Medical Association's philosophy, that 'medical ethics in armed conflict is *identical* to medical ethics in times of peace' (Hallgarth, 2007). Clearly, the military system appears to be more authoritarian than that to which civilian employees adhere and, as further discussed in the next paragraphs, this military system is re-enforced via military statutory authority.

### **Military Statutory Authority**

When medical and nursing services were recognised in a military capacity and became officially attached within their respective military framework, they became governed by military law and hence subject to stringent military discipline. These single service discipline Acts were the Army Act 1955, the Naval Discipline Act 1957, and the Royal Air Force Act 1955 (Explanatory Notes to Armed Forces Discipline Act 2000). However, it was recognised following the Strategic Defence Review in 1997, that military personnel from the three services often worked and were commanded by military personnel from a different armed service (Queen's Regulations 1975). It, therefore, seemed appropriate to have one Act to command all service personnel, irrespective of their service. These three discipline Acts, therefore, led to the creation of the Armed Forces Discipline Act 2000, which now exerts command over all military personnel in the British Armed Forces. Unique to MHCPs, however, is that they are also governed by their respective professional regulations, irrespective of the environment within which they are serving.

The Armed Forces Discipline Act 2000, modernised and updated the previous three single service Acts in relation to military discipline. In addition, it also reinforced and highlighted the need for military discipline and 'mission readiness' and a need for a separate military justice system rather than a reliance of civilian law alone. However, of importance is that this Act did not highlight whether the military duty flowing from the need for military discipline and following military orders takes a legal

precedence over professional codes of practice in the different environments in which a MHCP serves. In addition, this Act also did not take into consideration the effects of a dangerous environment and when a MHCP's life may be at risk when caring for an injured soldier.

More recently, the Army Act 1955, the Naval Discipline Act 1957 and the Royal Air Force Act 1955 were all repealed via the Armed Forces Act 2006, which received Royal Assent in November 2006. As recent conflicts in Iraq and Afghanistan have shown, the three services increasingly work closer together than ever before. The intention of this new Act is, therefore, to 'align discipline and command responsibilities' to create universal equity and fairness amongst the three services and create harmony with the Armed Forces Discipline Act 2000 (Armed Forces Act 2006). Like the Armed Forces Discipline Act 2000, however, it does not take into consideration the dual nature of the MHCP as subject to both professional codes of practice and military regulations in battlefield, operation, and non-operational environments. In the Armed Forces Act 2006, medical practitioners are only mentioned under the heading of Sentencing: Principles and Procedures (The Armed Forces Act 2006, part 9, chapter 1-2, and schedule 16). This involves assessing a soldier's fitness to stand trial or be imprisoned in a military correction centre and instructions what to do if a soldier is considered unfit to stand trial. Rubin (2002) asserts that even though the military law has undergone significant recent changes in becoming 'civilianised', the Armed Forces Act 2006 does not address the ethical dilemmas that MHCPs may face in battlefield, operation, and non-operational environments. Therefore, without clear military statutory authority or guidance from the GMC and the NMC for MHCPs when serving in these diverse environments, there may be tensions towards ensuring Operational Effectiveness and achieving military discipline.

## **Military Discipline**

Napoleon Bonaparte stated, '*Il n'y a pas de victoire sans discipline*' meaning, victory cannot be achieved without discipline (Carney, 1996). Discipline is, therefore, the soul of any army, which only prevails and succeeds when soldiers are obedient to commands. Helvetius in Cramer (1921 at p. 774), in the eighteenth century, defined discipline as 'the art of inspiring soldiers with more fear for their own officers than they have for the enemy'. Other authors describe discipline as, '...the long-continued habit by which the very muscles of the soldier instinctively obey the command; even if his mind is too confused to attend, yet his muscles will

obey'(Murray, 1921). More recently, General Sir Mike Jackson (the retired former head of the British Armed Forces), in his autobiography, indicated that army discipline is ensuring 'immediate obedience when necessary' to any soldier or officer, irrespective of their specific role or their location (Jackson, 2007). More comprehensively, the British Army defines discipline as follows:

'Discipline is teaching, which makes a man do something which he would not, unless he had learnt that it was the right, the proper, and the expedient thing to do. At its best, it is instilled and maintained by pride in oneself, in one's unit, in one's profession; only at its worst by fear of punishment' (Field Marshall Sir William Slim, 1956).

Discipline is, therefore, the 'backbone' that promotes efficiency in the Army' (Soldier Management, 2004). This efficiency incorporates the army in peacetime and during war; at home in the United Kingdom and overseas and relies on teamwork, trust, loyalty and a set of values and standards for all those who are employed within it. It, therefore, applies to every British service person in the world, no matter what their specific role is, or whether that person is a MHCP with a dual responsibility to a professional body such as the GMC or the NMC. However, as the following quotation illustrates, before these collective values can be achieved, self-discipline needs to be acquired, which was described by Field Marshal The Viscount Montgomery of Alamein as:

'All of us have in our make-up good and bad points. Training in self-discipline consists in analysing a man's character and then in developing the good points whilst teaching him to hold in subjection the bad points. This leads on, automatically, to collective discipline, in which the outstanding factor is the subordination of self for the benefit of the community.' (Field-Marshal the Viscount Montgomery of Alamein, 1958).

This quotation indicates that not only self-discipline must be enforced, but also it must be enforced whatever the situation, for the collective benefit of all (Warbuton, 2006). It clearly, however, does not permit deviance and hence it would not allow a MHCP to decide to follow professional codes of practice or military orders. Thus, prioritising professional codes of practice over following military orders can cause conflict and become problematic, if not impossible, since a lack of self-discipline in the military is viewed as misconduct, and an offence according to the Armed Forces Act 2006, chapter 25, sections 2, 11, 12, and 13.

### ***Professional Regulation and its Conflict with Military Law***

All healthcare professionals have a duty to follow regulations from their respective professional bodies. This duty is also a legal one, since professional codes of practice are created via secondary legislation and statutory instruments. In addition, the National Institute for Health and Clinical Excellence, formerly known as the National Institute for Clinical Excellence (NICE), which is an independent organisation, guides all healthcare professionals in delivering care within an evidence-based framework, promoting health and preventing ill-health, irrespective of whether they are civilian or military healthcare professionals. Although they are more generalised than NICE guidelines, National Service Frameworks (NSFs), also have some effect on the way that patient care is delivered.

In contrast, and unlike civilian healthcare professionals, MHCPs are also regulated by military law via the Armed Forces Act 2006. The ethical and professional implications of such are explained in more detail in the vignettes. The potential problem for MHCPs in adhering to all elements of relevant military law, professional codes of practice, NICE guidelines, and NSFs is if any of them conflict with Operational Effectiveness. A number of examples concerning the management and prevention of self-harm serve to illustrate this point. For instance, NICE recommends that once a patient has deliberately injured him or herself, they should be treated ‘in an atmosphere of respect and understanding’ (NICE, 2004). Whilst this may be possible in a non-operational environment, such as the United Kingdom or in any Military Defence Hospital Unit and although on occasion a MHCP may have empathy towards a self-harm patient, generally it is difficult to imagine in a battlefield or operational environment that such respect and understanding would or could be accorded to that individual soldier by the majority of his or her colleagues, or by their Commanding Officer if it compromised Operational Effectiveness. Likewise, if a soldier were to refuse medical treatment, then according to the Armed Forces Act 2006, Part 1 (Offences), section 16 - Malingering (1) c, ‘A person subject to service law commits an offence if, to avoid service – by any act or omission he aggravates or prolongs any injury of his’. Refusing treatment is examined in detail in chapters 11 and 12. However, a soldier refusing treatment may be considered to deliberately and perhaps with premeditated intent, prevent himself from becoming fit to fight (Gross, 2006). It may, therefore, be considered as a military offence in accordance with the Armed Forces Act 2006.