Ethical Implications of Military Medicine in Large Scale Combat Operations

by Jon Butler

Introduction

Even before the days of Hammurabi (c. 1792-1750 BC) and Hippocrates (c. 460-375 BC), the activities of fighting and healing were intuitively related. As warring factions developed more effective battlefield treatments, the two guilds became inseparable, establishing military medicine. While operational treatments have always encountered ethical challenges, large-scale warfare brings competing values to the forefront due to the high number of casualties anticipated in comparison with the limited resources available. The well-known process of triage reveals ethical questions associated with principle and professionalism. Triage demonstrates that military objectives and medical responses in war can compete and even conflict with each other, bringing about ethical dilemmas and moral injury. Military leaders must be aware of these friction points to ensure the best practices of both, minimize internal conflicts, and maximize victory on the battlefield.

Triage

Army doctrine describes triage as "the process of sorting casualties based on need for treatment, evacuation, and available resources."[1] Profound existential questions come up, such as "Who lives? Who dies? Who decides?"[2] Triage is the systematic approach to try and answer those questions, given the wartime context in which they are asked.[3] Often using the acronym DIME (Diplomatic, Informational, Military, and Economic), the categories for triage are as follows:

Category	Description
Immediate	Patients requiring immediate care to save life, limb, or eyesight
Delayed	Patients who, after emergency treatment, incur little additional risk by delaying further treatment
Minimal / Ambulatory	Those who require limited treatment and can be rapidly returned to duty
Expectant	Patients so critically injured that only complicated and prolonged treatment will improve the chances of survival
Source: FM 4-02 Army Health System	

There is a fundamental shift currently taking place between traditional concepts of triage, used during the last 80 years or more, and one that takes into consideration a future LSCO environment. Both methods are concerned with scarce resources, but contestation in multiple domains, as anticipated in future LSCO, necessitates a modified approach. Recent attempts to wrestle with the changing battlefield argue for a prioritization change. Instead of the immediate casualties (as currently defined) receiving first care, those soldiers who may be *returned to duty the quickest* would be prioritized in LSCO.[4] Sometimes known as "situational triage," "reverse triage," or "tactical triage," it considers operational priorities and the harshest realities of limited resources.[5] As such, it is Tactical Combat Casualty Care (TCCC) writ large, returning fire *en masse*.[6] Strategically, the focus is on winning the war in the fastest possible manner as the best way to heal the greatest number of people. It represents the ethical conflict of patient survivability vs. strategic objective, and battlefield triage favors an instrumental

approach over the clinical ethics found in civilian practice. In and of itself, this is a conflict with the Kantian notion of people as ends vs. instrumental means.[7] It translates at the everyday level to the question of people vs. mission, often resolved rhetorically as "mission first, people always."[8]

Triage decisions are ethical decisions that involve judgment calls by personnel who may be undertrained in the task. Even well-trained individuals and organizations will likely struggle internally, due to the very nature of triage and the weight of the decisions that impact survivability.[9] Bobier and Hurst go so far as to say that military triage is a "moral tragedy" incurring cost to participants by the very nature of what it is.[10] Given the challenges of triage on the battlefield, especially in a LSCO environment, the situation forces us to think about how we might mitigate moral distress and moral injury associated with the task. To do so effectively, it is essential to explore key dimensions at work behind the looming changes to prioritization. As triage encapsulates the ethical dilemma during LSCO, principle and professionalism emerge as two key areas of ethical friction between military and medicine, even as they seek to work together for the accomplishment of goals.

Nonmaleficence – The Practice of Preventing Harm

The Hippocratic writings with its famous Oath, established the concept of "do no harm."[11] It has withstood the test of time, enshrined in popular vocabulary and articulated as "nonmaleficence" in the standard principles of biomedical ethics.[12] Military healthcare professionals from surgeon to medic understand that there is a moral obligation to take care of patients and not make things worse by their actions. The fundamental shift from traditional triage to situational triage, described earlier, strikes at the core of who a medical professional is…their identity. In other words, to ask a medical professional to help those who would be classified as ambulatory at the expense of a patient who is immediate may cause irreparable harm and even death. Patients who are enemy combatants further test the physician's rule to do no harm in a resource-constrained environment.

Triage is a question of distributive justice.[13] One significant problem for military medical personnel is that situational triage appears to be at odds with international humanitarian law (IHL) in its distribution of treatment and unintentional harm.[14] In other words, if IHL seems to favor medical necessity, situational triage favors the mission.[15] Of note here is that the international rules on this topic are a "bundle of contradictions," that allows for mission centric thinking in certain places.[16] What is clear is that operational goals are always to be carried out as humanely as possible under the principles of *jus in bello* and the law of armed conflict (LOAC).[17] Yet wars are not directly driven by humanitarianism per se. Operational prioritization of casualty care means first treating service members who can get back in the fight, and this is justifiable under the of the rule of salvage during times of war as the "ultimate goal of triage."[18]

Dual Loyalty – Professionalism in Conflict

Military medical professionals take two oaths with competing values and tensions. This is the concept of dual loyalty, and it is unavoidable in military medicine. Sidel and Levy argue that such a predicament causes more harm than good and significant changes need to be made.[19] While they articulate some very real dilemmas and considerations in the service of military medicine, their path forward seems unrealistic and far from helpful. Sidel and Levy reach the conclusion that military medicine is incompatible, and physicians simply should not serve in the uniformed military.[20] Yet given their life-saving work for hundreds, if not thousands of years, the combination of combat mission and patient care are better than any realistic alternative. No neutral force would have the level of integration, training, and trust with command to enable a type of pacificist entity to replace them completely.

Nevertheless, the clash is real. The two professions ask different questions and are concerned with distinct outcomes. The principles of biomedical ethics are at times curtailed in military medicine, even though they are not abandoned wholesale.[21] This is a significant friction point revealed in triage, as mission takes priority over patient autonomy. There are many instances of leadership taking advantage of these curtailments and experimenting upon soldiers with novel drugs.[22] Drawing the line between which ethical principles apply and when can lead to abuses, and both military and medical leadership need to be cautious and protective of the four principles of biomedical ethics, even as they are bound by a mission-first prioritization.

In the background of situational triage is the foundation of just warfare, both *jus ad bellum* and *jus in bello*. A just cause in war sets the groundwork for just behavior in war. It is therefore more justifiable to invoke situational triage if both the cause and conduct in LSCO are following the just war principles. Medical personnel who are called to not only bend bioethical principles and conduct situational triage in favor of an unjust war are put in an incredible difficult position. Clear medical rules of engagement (MEDROE), moral treatment of civilians on the battlefield, medical aid for enemy prisoners of war, and a whole host of other actions impact military medical personnel. The Geneva Conventions afford protected status for uniformed healthcare professionals. Violation of LOAC and just war principles by military units can create a downward spiral of moral drift and increase moral injury following combat.[23]

Conclusion

Today's preparation for large-scale combat operations (LSCO) includes consideration of medical functions as part of the war effort.[24] Carrying out those functions is understandably complex and brings with them unique ethical challenges. The juxtaposition of *taking* life and *saving* life exposes competing values in the fog of war, seen most clearly through the process of triage. In a large-scale conflict, physical fighting is not the only battle that takes place as wrestling over right actions is always close at hand in military medicine. Wartime triage reveals the dilemmas of nonmaleficence and dual loyalty through its rationing of healthcare. Military leaders must pay attention to their medical personnel with an appreciation for these unique challenges. They are often acutely aware of these ethical challenges in their daily delivery of medical care. Sustaining military medical personnel is perhaps the most important way to conserve fighting strength and balance mission with people.[25]

Endnotes

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