CHAPTER 12

Ethical Issues Encountered by Military Nurses During Wartime

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ABSTRACT

Military nurses encounter similar issues as civilian nurses in daily practice situations; however, wartime and humanitarian missions may bring unique and difficult ethical dilemmas. While nursing has the American Nurses Association code of ethics to provide a framework to guide ethical practice decisions, conflicts may arise from the unique aspects of nursing within a wartime environment. Understanding those conflicts occuring within the military wartime scenario can provide nurses with experiential examples from which to derive strategies for personal coping and professional behavior and decision making. This chapter describes the research that has focused upon the identification of these issues, the effects from uresolved issues, and those directions for future research to better prepare miltiary nurses before and during deployment.

INTRODUCTION

The War on Terrorism, beginning in 2001 with Operation Enduring Freedom (OEF) and continuing with Operation Iraqi Freedom (OIF) in 2003, has exposed nurses to situations and challenges for which many report feeling unprepared,

http://dx.doi.org/10.1891/0739-6686.34.227

particularly in terms of caring for those with multi-trauma injuries and devastating wounds suffered by military troops and civilians alike (Agazio, 2010; Middleton, 2009). Feeling unprepared and, in some circumstances, conflicted regarding treatment decisions, may lead to feelings of moral distress for nurses particularly if the situation was ethically challenging. These conflicts are not new for military nurses, or in wartime scenarios, but due to the length of the recent, and ongoing, conflicts, they were accentuated through repeated and extended deployments. Many nurses report that their nursing experiences during OEF and OIF have left an indelible mark on their practice (Agazio, 2010; Griffiths & Jasper, 2007; Middleton, 2009). Through understanding the types of situations and conflicts faced by military nurses, and importantly, how best the services can prepare their forces in anticipating and managing the issues, military nurses will be more prepared and at less risk for sequelae such as moral distress, posttraumatic stress disorder (PTSD), and burnout, than their predecessors.

Early in the war, military nurses were faced with injured individuals and mass casualty situations that challenged their experience and expertise. These injuries were primarily the result of motor vehicle accidents, grenades, and bullet wounds. However, in the second phase of the war, more injuries were a consequence of improvised explosive devices planted by insurgents resulting in extensive and high-acuity polytrauma requiring numerous complex surgical and medical interventions. The care of such injuries challenged the nurses' competency in the provision of care for complex polytrauma. However, in addition to the challenges to ensure quality care, the nurses, some for the first time in their nursing experiences, were also confronted with ethical issues for which they were ill-prepared. Due to limited resources and personnel, nurses were confronted with the need to triage care and resources. The admission of insurgents for receipt of care required that nurses provide care for combatants despite conflicting feelings and thoughts regarding care of the enemy. The nurses felt confused, uncertain, hopeless, angry, discouraged, and distressed as they coped with these issues, some of which directly affected morbidity and mortality. The nurses had not received any training on how to manage such issues and felt ill-prepared and forced to engage, despite personal beliefs.

The purpose of this chapter is to describe the research conducted to delineate the ethical situations faced by military nurses during wartime practice. The chapter begins with an overview of research in ethical issues experienced by civilian nurses as a background for differences in these issues in military nursing practice. Ethical issues specific to military nursing practice are discussed; in particular, research conducted regarding ethical issues emerging from wartime nursing is presented with specific attention to those studies conducted by nurses. Finally, the effects of unresolved ethical issues are discussed in some detail as this

area has received extensive study within the context of military nursing practice. The chapter concludes with recommendations for needed research and education that are especially targeted to the management of ethical dilemmas and detection/prevention of moral distress.

ETHICAL CONDUCT EXPECTED IN NURSING PRACTICE

In the United States, nurses use a national code of ethics to guide their practice. Early in basic undergraduate nursing education, nurses are introduced to the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements* (2015), most recently revised and adopted in 2015, which guides practice, both military and civilian. The *Code* details the obligations and duties nurses have for their patients and families and also designates what is considered ethical conduct in the nursing profession. The International Council of Nurses (ICN) also denotes ethical standards for nurses worldwide in the *ICN Code of Ethics for Nurses* (2012). This document outlines four fundamental responsibilities for nurses: "to promote health, to prevent illness, to restore health, and to alleviate suffering." Further, the code details four principal elements that outline the standards of ethical conduct:

1. Nurses and people: The nurse's primary professional responsibility is to people requiring nursing care.
2. Nurses and practice: The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning.
3. Nurses and the profession: The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education.
4. Nurses and co-workers: The nurse sustains a cooperative relationship with co-workers. . . . and takes appropriate action to safeguard individuals when their health is endangered by a co-worker or any other person. (p. 4)

These universal ethical standards for nurses do not differentiate based on time or place such as wartime, disasters, peacekeeping operations, or stateside care delivery. Absent from these guidelines, however, is how nurses may resolve their personal feelings in ethically ambiguous conditions and any directed action for "solving" an ethical dilemma other than adhering to the principal elements.

ETHICAL ISSUES' RESEARCH IN NURSING PRACTICE

Ethical issues are encountered by nurses in every facet of practice (Redman & Fry, 2000; Ulrich, Taylor, Soeken, O'Donnell, & Farrar, 2010). Nurses are

expected to provide competent and quality care to their patients and to act as their advocates. Early research has focused on (a) the ways in which ethical decisions are made; (b) attitudes and beliefs regarding ethical issues; (c) differences between nurses' and physicians' approaches to ethical situations; and (d) specific clinical issues with an ethical overlay (Harris, 2000). An example of a broad ethical issues research project was that of Grove (1996) in which he surveyed 573 nurses regarding ethical issues they confronted in practice, past education related to ethics, the resources they used to address ethical issues, how they rated their competencies related to the management of ethical issues, and barriers to the implementation of decisions (related to ethical dilemmas they encountered). The most common issues, ranked in order of frequency from the highest to the lowest, included issues with pain management, patient confidentiality, end of life, allocation of resources, organ donation, and fertility or abortion (Table 12.1). Patient autonomy; professional practice; patient noncompliance; housing and discharge; parenting skills; family conflicts; neonatal, cultural, religious, and quality of life issues were less frequent (Grove, 1996).

The majority of the nurses who participated in the Grove study (1996) indicated that they had not taken a formal ethics class in their undergraduate training. Those who had, reported that they felt better prepared for the management of ethical issues. Moreover, the majority indicated that they had taken continuing education classes on ethics since graduation. In terms of resources that helped the nurses address ethical issues, the majority indicated that workrated resources (role models, staff meetings, and physician, supervisor, and peer consultations) were used most frequently. However, the nurses also used professional resources (journal articles and books) and personal resources (church). Resources that were employed less frequently included family discussions, interactions with institutional ethical committees, and personal experiences (experiences with illnesses themselves, with illness and death among family members and friends, and prior patient experiences). The majority of the nurses rated their skills in specific competencies related to handling ethical dilemmas as excellent or good. They indicated that they were good or excellent in (a) applying state or federal laws governing nursing practice in reference to an ethical issue, (b) using the ANA nursing code of ethics to guide their actions, (c) using an ethical framework to assist in the assessment and resolution of a dilemma, (d) identifying the moral aspects of nursing care, (e) identifying and using interdisciplinary resources to assist in the clarification and resolution of a dilemma, (f) gathering relevant facts regarding a dilemma, (g) clarifying and applying values in assessing and resolving dilemmas, (h) proposing alternative actions for resolving dilemmas, (i) actively participating in the resolution of a dilemma, (j) choosing and acting on a plan for resolution, and (k) applying ethical theories and principles

TABLE 12.1
Ethical Issues

Ethical Issues	Focus of Concern
Pain management	Withholding of medication for fear of adverse effects and a hastened death, addiction, drug abuse, or drug seeking behaviors
Patient confidentiality	Determination when a patient's health problems affects others and notification of others who may be harmed
Allocation of scarce resources	Distribution of expensive treatment for patients at the end-of-life
Organ donation	Process for identification of appropriate donors and recipients
Fertility issues	Ownership of frozen or unused embryos
Patient autonomy	Patient choices in terms of right to die, right to refuse treatment, and right to being fully informed regarding care
Professional practice issues	Teamwork, respect, privacy, communication, and physician-assisted suicide
Patient noncompliance	Reluctance to continue costly treatments for noncompliant patients, particularly patients with self-induced medical problems, especially if those problems were not congruent with societal norms, such as illicit drugs or alcohol abuse
Lifestyle issues	Homeless patients for whom there was a lack of community resources for shelter and income; nursing home placements and family conflicts; parenting issues largely centered on drug-abusing mothers, abusive mothers, and teenage mothers

Source: Grove, 1996.

when addressing a dilemma. Barriers to the implementation of an action related to an ethical dilemma included patient, family, or physician preferences, institutional factors, and legal regulations.

Similarly, Gold, Chambers, and Dvorak (1995) used semistructured interviews with 12 nurses to identify ethical issues emerging from direct patient care in acute, long-term, and home care practice settings. Using thematic analysis, these researchers identified four areas in which the majority of ethical situations

occurred: (a) withholding of information and truth-telling; (b) unequal access or inequalities in care; (c) differences between business and professional values; and (d) breaking and reporting rules.

Verena Tschudin, founding codirector of the International Centre for Nursing Ethics and founding editor of the journal *Nursing Ethics,* has published several articles reviewing directions in nursing ethics research. She synthesized the last decade of research on ethical issues in nursing in her 2010 article stating that the understanding of ethical issues has been extended into international dimensions with cross-cultural comparisons of ethical orientation; the emergence of moral distress as a concept of interest; and a better understanding of the impact of ethics on the work environment, relationships, and quality and delivery of care.

The study of military nursing in peacetime demonstrates that military nurses experience similar ethical issues. However, due to the military culture, some of the issues may be unique even in a peacetime setting. Gilchrist (2000) completed a master's thesis considering ethical issues of Air Force Nurse Practitioners (AFNPs) in clinical practice. She interviewed seven AFNPs using narrative accounts of situations that they had encountered in clinical practice. Analysis involved categorizing the issues according to the ethical principles of autonomy, nonmaleficence, beneficence, and justice. Issues such as fairness in accessing appointments and referrals in a managed care environment; inequity in allocation of resources; insuring confidentiality in test results such as for HIV; potential harm to patients due to being short-staffed; and time constraints in addressing all of the patients' needs were not unique to a military environment. Some of the unique aspects related to military nursing practice included prohibitions in providing care to retirees in some settings due to the implementation of Tricare, which is an insurance program for retirees and their families, and rules of confidentiality not being sacrosanct in an environment where commanders could require release of information such as HIV status or psychiatric care. Her recommendations included a need for more education and research with this focus.

However, war and humanitarian situations present numerous other ethical dilemmas for nursing. Ethical situations differ based on the patient care demands, combatant care, cultural differences, and resource allocation requirements.

MILITARY NURSING ETHICAL ISSUES IN COMBAT AND HUMANITARIAN ENVIRONMENTS

Research considering military nurses' experiences with ethical situations has been conducted both directly and peripherally through studies of nursing practice for

humanitarian missions and conflicts dating from previous wars through the current conflicts. In 2002, Harris delineated issues military nurses had in common with civilian nurses and the distinctive challenges faced by those engaged in army nursing practice. The purpose of the project was to describe the types and levels of distress caused by ethical issues and ethical education needs for both Department of the Army civilian and military nurses (Harris, 2000). This study included nurses who participated in operations in Kosovo, Bosnia, and Somalia. For data collection, Harris modified the Ethical Issues Scale (Fry & Damrosch, 1994) to be applicable for military nurses. The final report for this study is not available, but a portion of the project was published by nurse anesthetist students who extracted a subset of the data in order to analyze the responses of certified registered nurse anesthetists who participated in the survey. These respondents noted the nurses' desire for more education and preparation in the ethics of triage and the expected behavior of a health professional as a prisoner of war (POW) as the most concerning issues pre-OEF/pre-OIF (Jenkins, Elliott, & Harris, 2006). The most disturbing ethical issues noted by these respondents were related to conflicts with physicians in treatment decisions, working with impaired or incompetent colleagues, and staffing patterns. More applicable to wartime concerns, however, was their need to protect patient rights and dignity and risks to their own health in patient care delivery.

In 2000, Foley, Minick, and Kee explored the engagement in, and application of, nursing advocacy by military nurses deployed in Operation Joint Endeavor in Bosnia and Hungary in the 1990s. Using Heideggerian hermeneutic phenomenology, the team interviewed 24 nurses 3 months after their return to Germany. This operation was a peacekeeping mission, and nurses did not experience the same intensity or issues as in OEF/OIF, even though they also rendered care to the civilian populace during these missions. The authors noted that the learning of advocacy behaviors was somewhat haphazard and situational. They determined one overall pattern of safeguarding that included four themes of advocacy: for protection; for holistic care; for support of personhood; and for supporting the patient's voice. These themes echo the ethical principles, namely, autonomy, beneficence, and nonmaleficence in the advocacy activities described by their participants. The researchers also reiterated the need for more education, especially for new nurses, in learning and practicing patient advocacy. This team extended their project in 2001 to examine how nurses develop skills in advocacy. Advocacy was inherent in their definition of self and in their upbringing. Advocacy, in other words, was a core value participants brought with them into nursing. Advocacy was further developed as nurses worked with and watched other nurses' advocacy behaviors and by practicing advocacy that was supported by colleagues and supervisors. This led to increased confidence in choosing

appropriate actions in helping their patients. Investigators recommended follow-on work to provide examples and stories that other nurses could use in defining and learning effective advocacy skills (Foley, Minick, & Kee, 2000).

Similarly, Almonte (2009) used grounded theory methods to identify ethical issues and subsequent moral distress in Navy nurses who were deployed on the USNS *Comfort* in response to the 2004 tsunami in the Indian Ocean. Focused upon humanitarian missions rather than wartime experiences, 11 Navy nurses were asked to explain nursing practice aboard the U.S. Naval Hospital ship *Mercy*, which had been deployed to provide relief to Indonesia, Dili, East Timor, Nias Island, and Papua New Guinea over a 5-month period following tsunami and earthquake natural disasters in the region. For these participants, having to deny care because of mission constraints and the sheer volume of need left them with no other choice but to say "no" to many and to defer definitive care. Many felt they were unprepared to deal with the heartbreak of not being able to provide what they assessed as an appropriate level of care and that they needed more preparation for these situations. Alamonte encouraged further examination of the situations these nurses encountered while providing care to the indigenous people in the region and the ramifications for education and intervention for nurses experiencing distress as they realized limitations in terms of providing definitive and sustainable treatment.

Related Ethical Issues Identified in Military Physician Research

Based on evidence delineating the types of ethical issues encountered by military nurses, the literature does present some discussion of dilemmas encountered by medical officers and some ethical discussions directed toward exploring the principles involved and the actions taken to resolve these conflicts (Beam, 2003). Probably the most controversial discussion has been in response to Gross's article in which he asserts that military medical ethics are built more upon the expediency of returning soldiers to battle rather than on treating those most injured, meaning that the priority is to return soldiers to duty rather than to provide care to the seriously wounded. This article has garnered several counterarguments from other authors seeking to clarify the triage system process necessitated by battlefield conditions (Gatliff, 2008; Gross, 2008; Repine, Lisagor, & Cohen, 2005).

In his response, Edmund Howe (2008), longtime chair of the institutional review board at the Uniformed Services University of the Health Sciences, acknowledged that no matter whether one agrees or disagrees with Gross, he raises questions that need to be, at the very least, heard and debated. Triage is, and will continue to be, a controversial issue in situations during deployment where casualties overwhelm resource availability and choices need to be made in

prioritizing care. According to Repine et al. (2005), battlefield triage can assume basically two forms. The first is when the number and type of injuries do not exceed the capabilities of the unit and, in such situations, those with the worst injuries are cared for first. In the alternative situation, where the number and types of injuries exceed the capabilities of the medical unit, those with the most life-threatening injuries and those who are most resource demanding, may need to wait for definitive care until those with less severe injuries are treated. These authors find that in such situations, resources should be distributed to maximize the greatest good—to care for as many as can be helped with what is available. Further, they note that beneficence may also need to be sacrificed for one patient in order to provide care for many others. Patients and staff may find such choices difficult to accept, since the process of triage can require hard choices and demanding decisions in order to distribute care fairly in combat situations.

Other controversial issues in the medical literature consider the issue of dual loyalty: the obligations of medical officers in their duty to heal but also their sworn duty to support "the Constitution against all enemies foreign and domestic" that translates potentially into a conflict when physicians are asked to support military objectives (Army.mil, n.d.). London, Rubenstein, Baldwin-Ragaven, and Van Es (2006) noted that this dual loyalty can lead potentially to human rights violations, for example, when physicians become involved in interrogation techniques such as sleep deprivation or when they turn a blind eye to overly aggressive procedures. Benetar and Upshur (2008) discussed the fine line military physicians may face when caring for enemy POWs. Holmes and Perron (2007) and Singh (2007) directly accused health professionals of actual collusion with interrogators providing health information that could be used to design interrogation strategies and of engaging in unethical behaviors. Ritchie and Mott (2002), studying mental health and preventive medicine physicians, provided a historical perspective of ethical issues that emerged from Vietnam, Somalia, Rwanda, and Haiti. Primarily in this descriptive account, medical rules of engagement were discussed in terms of the balance that needs to be achieved between security requirements and provision of care and utilization of resources. For example, one incident they related concerned a man in Haiti who set fire to a woman in which he was injured following the attack. His medical costs for operations and postoperative care were estimated at $300,000. The staff had difficulty understanding the high-resource use for this individual, especially since he was abusive to members of the health-care team. In this situation, as in many of the countries in which humanitarian care is provided, the opportunity to transfer him to Haitian facilities was not an option because the infrastructure could not support his care. Thus, the ethical dilemma was situated between the need for careful resource allocation and care commitment.

ETHICAL ISSUES IN WARTIME MILITARY NURSING

Several publications by Army nurses who served at Abu Ghraib have tried to describe their efforts to treat detainees and enemy prisoners of war with respect and dignity, but clearly the issue is a "hot-button" one as evidenced by discussions in the medical literature. Many anecdotal accounts detail first-person accounts of military health-care providers' experiences. De La Rosa and Goke (2007) described the mental health mission within the team at Abu Ghraib internment facility. The ethical situations they encountered stemmed from cultural differences related to mental health care and some of the cultural biases that emerged during such encounters. Thompson and Mastel-Smith (2012) provided a descriptive account of deployment culled from multiple first-person accounts in the literature for the purpose of defining caring within the wartime setting. As with the previous article, they found that military nurses working with injured insurgents challenged "the ethical mandate to build a caring nurse-patient relationship" (p. 24). Emotional responses such as anger, fear, resentment, hatred, and prejudice conflicted with the ethical mandates of nursing. Many were able to move past the detainees' actions and view them as fellow human beings; however, many felt conflicting loyalties viewing those individuals as the enemy and perhaps the cause for harm to "friendly" forces (Germain & Lounsbury, 2007).

Haynes-Smith (2010) described the moral and ethical challenges she encountered while caring for Iraqi detainees during a deployment to Iraq in 2005. As she noted, "I was constantly aware that these detainees would harm or kill any member of my unit if given an opportunity. At the same time, I was bound by the rules of the Geneva Convention to provide the highest-quality care" (p. 31). She, like others, also struggled with stopping life-sustaining treatments to the detainees. As she described, "because of the fear of being accused of abusing detainees, my colleagues and I had to be extraordinarily careful" when there was a decision being made about a dying detainee (p. 31) that "added to the stress and strain of life in the combat zone." Kraemer (2008) also reported similar issues in the account of her experiences in Iraq. Further, she found it was difficult to reconcile the loss of life and what she perceived as the futility of treatment in many cases where every effort had been made to save life, limb, or eyesight.

Most often, insights into ethical dilemmas experienced by military nurses have emerged incidental to studies with a focus upon military nursing practice or reintegration issues. Using qualitative descriptive techniques, Mark et al. (2009) explored the deployment experiences of Army Medical Department personnel during 11 focus groups and 1 individual interview with 101 redeployed medical personnel from OIF/OEF. Some of the issues delineated by the participants reflected ethical issues that have been more clearly defined in more recent

studies. These participants identified resource allocation to be challenging in the care of the friendly forces and confusion related to caring for civilian casualties. They were unsure of how and when to transition foreign combatants to their own health-care system. They also were unexpectedly faced with treatment requirements for military personnel deployed with chronic conditions, which strained the ability to allocate resources. Ross et al. (2008) also identified ethical issues as part of their mixed-method qualitative study utilizing focus groups to interview 72 military nurses. Additionally, in this study, e-mailed surveys were distributed to commanders of deployed medical facilities to query participants about the content of the after-action reports that were completed at the end of their deployments. The purpose of the study was to qualitatively extract and analyze the content of after-action reports and the utility of using these reports for improving and directing training for future deployments. While the focus of the project was on the content of the after-action reports, ethical dilemmas were also compared to those in existing research. Participants commented upon the risky nature of caring for enemy POWs; the difficulties they experienced while caring for foreign national civilian casualties; resupply problems; and the scope of practice role and expectations as posing ethical conflicts. Rushton, Scott, and Callister (2008) collected accounts of nurses' experiences in the Gulf War as part of a larger project, Nurses At War, which was directed more at nursing practice than specifically at ethical issues. In their interviews of 11 participants, the authors noted that life/death issues were mentioned by the nurses as presenting ethical conflicts in the wartime environment.

Lang, Patrician, and Steele (2012) did not specifically study ethical situations in their comparison of nurse burnout and the practice environment among 105 medical personnel who had been assigned to a combat support hospital in Iraq. They found that, across all different levels of personnel, exhaustion and burnout were present. They hypothesized that in addition to perceiving lack of support by leadership and the stress from the practice environment, some of the ethical situations the personnel encountered could have increased feelings of depersonalization that, in turn, may have led to burnout. Similarly, Scannell-Desch and Doherty (2010) detailed multiple ethical issues in their phenomenological study that included 37 military nurses from all services who participated in individual interviews querying them on their experiences in both Iraq and Afghanistan between 2003 and 2009. As with so many of the studies, nurses in this particular sample commented on the difficulties caring for both the U.S. military personnel and the insurgents who injured them, at the same time. Similar to the participants in the study of Ross and her colleagues, these participants also found it challenging to care for the insurgents because of the potential danger they represented.

Comparably, Goodman, Edge, Agazio, and Prue-Owens (2013) conducted a qualitative study to describe the cultural factors that had an impact on military nursing care for Iraqi patients. The sample consisted of military registered nurses and licensed practical nurses who were assigned to a military combat support hospital in Iraq. The cultural differences identified in the study between the military nurses and the Iraqi patients contributed to ethical dilemmas. Findings revealed that the nurses expressed difficulty encountering cultural norms that conflicted with the provision of care. Gender issues resulted in differences in the care, and expectations, of female patients. Based on the dominant role of men, men were the primary decision makers and could dictate the provision or withholding of care to female members or children in the family. In addition, cultural customs in the context of social, political, and economic factors in Iraq impacted the provision of care. Patients expressed fatalistic views and exhibited dependent behaviors, which may be secondary to years of economic sanctions, repression, and scarce resources. Patients would not actively participate in care, which may include lack of participation in prescribed activities such as ambulation, incentive spirometry, and other activities. Findings indicated that the nurses felt ill-prepared to deal with these challenges.

Interestingly, nurse researchers collaborating with coalition forces have also conducted studies among their military nurse colleagues to discern ethical issues in recent military conflicts. Specific to a wartime environment, Griffiths and Jasper (2007), British nursing faculty, identified some ethical concerns in their grounded theory study conducted from 1999 to 2002. The research was conducted in part during the start of the war in Afghanistan and explored the effects of war on the nursing role. Using a grounded theory design, the investigators interviewed 24 British military nurses. Nurses reported experiencing moral distress due to the loss of their respect and humane caring for combatants who displayed hatred toward them. The participants also reported ambivalence regarding the duality of the role of being both a nurse and a military member, resulting in a conflict in their beliefs regarding the provision of care. The core category identified in this study was named "caring for war: transition to warrior" a concept that captured the duality of the two positions and emphasizes the ethos between the codes and values espoused in both roles. Dual loyalties have been discussed by physicians as well. As noted by Olsthoorn, Bollen, and Beeres (2013), in some situations, the call to provide care may conflict with the purpose of the mission or with available resources. For example, the Hippocratic oath requires that physicians provide care and relieve suffering, but at times they may not be able to provide that care as it would deplete the supplies needed for coalition forces.

Similarly, Finnegan et al. (2015) considered British nursing practice in Afghanistan. Their study consisted of interviews with 18 nurses who had served at Camp Bastion in 2013. Taking primarily an educational focus, the issues in this study were focused on the principle of beneficence. The nurses who participated in this research reported they felt unprepared to care for children who experienced severe traumatic injuries. They worried that their lack of education or skill in pediatric trauma might prevent their "doing good" and their ability to "avoid harm" when providing nursing care. By compiling the experiences of these nurses, the intent was to use the lessons learned to improve the predeployment preparation given to military nurses.

Lundberg, Kjellstrom, Jonsson, and Sandman (2014) qualitatively explored the experience of Swedish medical personnel participating in an international military mission from 2009 to 2012. While the majority of the 20 participants were nurses and most had been assigned to Afghanistan, the study included physicians and combat lifesavers who had completed assignments in Africa and the Balkans that were primarily peacekeeping missions. As with their American counterparts, the participants reported difficulties in caring for the enemy and concerns with prioritizing the allocation of resources toward their own forces, while balancing the care extended to the host nation's ill and injured. They also expressed concerns about the lack of infrastructure in the host nation, resulting in the inability to provide follow-up for those for whom they had provided care. Interestingly, these participants expressed role concerns and probable international humanitarian law violations for acting in the role of medical care providers while needing to complete military duties such as always being prepared to engage in hostile actions. This conflict was not evident in studies with American military nurses.

Most recently, and comprehensively, Agazio et al. (2011) were funded by the Triservice Nursing Research Program, to explore the management of ethical issues by military nurses during the conflicts in Iraq and Afghanistan (OIF/OEF/Operation New Dawn [OND]). This project emerged from an earlier study describing Army nursing practice in wartime and operations other than war. While describing the competencies needed in wartime conflicts, Army nurses in the earlier study related ethical difficulties in providing care to enemy detainees and host nation civilian casualties; participating in triage decisions; monitoring the use of resources in mass casualty situations when resupply was difficult; and caring for patients with multiple amputations or facing imminent death (Agazio, 2010). Ethically, the nurses were also concerned that the assignment of young nurses who were not ready to practice in an operational environment could pose a risk to patient care and consequently led to the provision of ongoing in-service

education for the younger officers and corpsmen assigned to their units. In the more contemporary, extensive, and ongoing study, Agazio and colleagues have preliminarily detailed ethical issues that can be categorized according to the ethical principles of beneficence, autonomy, and justice. Many echo those previously detailed in the earlier and related studies. Hopefully the findings from this study will be published soon as the study is completed in 2015.

EFFECTS OF UNRESOLVED ETHICAL SITUATIONS OR DILEMMAS

Researchers have considered what happens in situations where nurses experienced conflict between what their conscience and understanding of ethical behavior dictated should be done and what actually occurred. Redman and Fry (2000) completed a systematic review of five studies conducted with nurses from four specialties to consider situations where nurses were prevented from acting from their sense of moral principles, where the moral values conflicted with those of other health-care providers concerning the morally defensible action to be taken in a situation. In many instances, the research team found that the conflicts were less likely to be experienced as moral uncertainty (not knowing which principles were in conflict), but more often moral distress, where the nurse knows which choice is the right choice to make, but where organizational or institutional constraints prevent this action being chosen. Perhaps this situation is one that military nurses also face in the deployed environment, with courses of action possibly influenced by considerations of equitable distribution of resources, institutional policies, command structure, or environmental constraints.

In 2002, Fry, Harvey, Hurley, and Foley interviewed 13 Army Nurse Corps officers, who participated in Vietnam, the Persian Gulf War, or humanitarian missions, to develop a model of moral distress in military nursing (Fry, Harvey, Hurley, & Foley, 2002). These researchers recognized the unique environment in which military nurses practice and sought to validate if indeed moral distress could be identified, and if so, whether the characteristics were different than their civilian counterparts. The dangerous environment and field conditions, coupled with atypical patient conditions and application of military triage principles, were found to place military nurses at risk for moral distress. Specific situations that were the most bothersome included not being able to treat patients because of resource demands or availability; not being able to provide definitive care for non-life-threatening problems or chronic conditions; and behaviors of other team members that were not ethically congruent. The team found that once military nurses identified a need for ethical decision making and

encountered a barrier to the "desired moral action," moral distress occurred. The nurses related implementing advocacy behaviors, but if these were ineffective, the moral distress persisted, which had both short- and long-term effects on nurses and consequences for their nursing practice. Similarly, studies conducted with civilian nurses have also linked the consequences of moral distress to negative impact upon nurses.

Following this study, Harvey led members of this same team to engage in a subsequent study of 34 military nurses who had deployed in a military crisis situation. These nurses had either deployed after 1990 or served in Vietnam. Stories of moral distress were elicited using an interview guide, and content analysis was used to identify aspects of moral distress in the stories. These findings further helped to develop and validate the dimensions of moral distress experienced after a military deployment (Harvey, Fry, Hurley, & Foley, 2000).

More recently, Bradshaw (2010) developed a Moral Distress Model based on the results of a grounded theory study of 10 military nurses deployed by the Canadian Forces. The theory addressed the processes involved in the development of moral distress as a result of the deliberation and moral impact processes. Moral deliberation was initiated when the nurses considered two or more moral options and ended when a single option was chosen. Moral options were compared to each other by assessing which option may be the most morally correct and/or which option held more benefits than risks. Moral distress occurred when the choice was blocked or the nurses underestimated the impact of their inaction, particularly when their decisions were based upon experience, core values and beliefs, and bioethical principles. Throughout the deliberation process, each nurse was influenced by perception, external influencers, and environmental aspects. Perceptions referred to the opinions and views of the nurses that influenced their consideration of issues such as collegial and chain-of-command support and impact on their career and the team and were based on their personal experiences, observations, assessment of the situation, and their thoughts of how other people might possibly react to their moral action choice. External influences (e.g., decisional power, team/intraprofessional dynamics, mandates and regulations, and daily challenges) and internal influences (e.g., commitment to one's core values and beliefs, fortitude, tolerance, and resources) were also considered. Finally, definition of the environment included such aspects as the presence of danger, atypical patient conditions, and finite resources that also influenced the process.

Within the environmental aspects, Bradshaw (2010) identified several factors that contributed to developing moral distress: (a) issues around patient care delivery, (b) chain of command, (c) lack of moral preparation and training

in moral dilemmas, and (d) lack of professionalism. Issues around patient care delivery largely related to the type of patient and the resources available. Finite resources and resupply resulted in the prioritization of care, the manner in which care was provided, and the length of time care could be provided or sustained. Provision of care was based on the type of patient. Medical rules of eligibility or entitlement to care and the country's poor or nonexistent health-care infrastructure were factors that influenced the delivery of care to civilians. Chain-of-command issues were related to the failure of senior leadership to act equitably, in a timely fashion, and in a manner consistent with the maintenance of good order and discipline of subordinates. Lack of moral preparation and training in moral dilemmas referred to lack of knowledge of how to address and cope with moral dilemmas, such as disobeying an order, reporting of infractions, fraternization, and medical decision making. Lack of professionalism referred to the lack of respect and recognition between physicians and nurses and between officers and enlisted/noncommissioned officers. The nurses expressed feelings of marginalization, the absence of professional recognition, and physicians' lack of respect for nurses' input.

Within her study, Bradshaw (2010) found that when the impact of the decision was negative, the result for the nurses included feelings of guilt, regret, self-loathing, emotional withdrawal, self-blame, and self-doubt. Situational resolution and self-reflection were used to help the nurses achieve acceptance, reconciliation, self-protection, and the ability to cope with the outcomes. When this resolution was not possible, the results could lead nurses to implement drastic actions such as changing and/or compromising personal core values and beliefs, leaving the nursing profession, leaving the military, and/or losing their sense of self.

It is important to understand the cause and effect of moral distress for nurses and, for that matter, other health professions as well, since moral distress has been associated with burnout, dissatisfaction with and leaving the nursing profession, compassion fatigue, and disinterest in the provision of quality patient care (Corley, 2002; Corley, Minick, Elswick, & Jacobs, 2005). It is premature at this time to definitively declare that OEF/OIF nurses are experiencing moral distress, but it appears that they may be at risk since many have experienced ethical situations that have yet to be explored and described. It is important to understand the sources and types of ethical dilemmas faced by military nurses in wartime situations as well as their reactions and management of those situations. Ideally, nurses should be prepared ahead of time for the situations and dilemmas that may confront them and also receive education as to courses of action. Researchers have found that those who are more involved in participating and determining courses of action in ethical dilemmas have been found to

feel less dissatisfied with the resolution decision and, as a consequence, perhaps experience less moral distress and/or sequelae (Corley, 2002; Corley et al., 2005; Sundin-Huard & Fahy, 1999).

MILITARY NURSES' PSYCHOLOGICAL RESPONSES TO ETHICAL ISSUES

Several nurse researchers have also identified the adjustments necessitated during reintegration after the intense experience of being in the wartime environment. Gibbons, Hickling, and Watts (2012) conducted an extensive systematic review of factors influencing stress response and postdeployment adjustments. They compiled studies that included Vietnam health-care professionals through the current conflicts. A major finding was that moral issues related to patient care decisions contributed to stress during and after deployment. Particularly bothersome issues were not delineated, as this was not the purpose of the integrated review. Comparably, Rivers, Gordon, Speraw, and Reese (2013) and Owen and Wanzer (2014) both identified moral issues occurring in more contemporary conflicts as factors in postdeployment adjustments. Psychological distress experienced upon return was related to a perception that there was a lack of understanding by stateside colleagues in relation to their adjustment after the deployment. While not specifically detailing the situations that may have precipitated the distress, previous work in the area of moral distress has been linked to feelings of stress during the readjustment period.

CONCLUSIONS AND RECOMMENDATIONS

To date, the majority of research on ethical issues experienced by military nurses in wartime has emerged from a limited number of qualitative studies and related research considering reintegration adjustments and from humanitarian missions. The consensus from these studies has identified ethical dilemmas emerging from the provision of care to enemy detainees and host nation civilian casualties; triage, polytrauma, and death/dying care provided to American forces; and utilization/allocation of resources. More research is needed that utilizes larger samples and quantitative research methods to elicit issues across all services in order to delineate, as in Fry's earlier studies, the frequency, types, and levels of distress associated with the ethical issues encountered during wartime. From this information, educational interventions could be structured to better prepare nurses to anticipate these situations and equip them with potential management strategies to assess and address these issues in wartime situations. Work such as that by Agazio and her team will identify some of those strategies to assist nurses who deploy for future conflicts.

Retention of military nurses has been an ongoing challenge (Zangaro & Kelley, 2010). Previous research has demonstrated that military nurses experience emotional and moral distress during reintegration as a consequence of unresolved ethical situations that they experienced during wartime deployments. Moral distress, in turn, can potentially contribute to PTSD, burnout, and retention issues in the military and/or nursing practice. The better we equip military nurses to successfully negotiate the ethical situations they encounter in wartime environments, the better the chance for improved patient care quality and outcomes and for protecting the well-being of nurses and other military medical personnel.

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