MILITARY MEDICAL ETHICS IN OPERATIONS

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INTRODUCTION

José María Delgado Pérez

Ethics and the Military Medical Corps

"A good conscience is the best pillow to sleep on" (Socrates), or "the satisfaction of duty well done" (our parents and teachers).

Ethics is a constant feature of any professional activity; without it something important would be missing. However, it should not be relegated to being an elaborate subject that is taken for granted, or viewed as something that needs to be studied in depth. Let this paper serve as a focus for your attention, and allow the health doctrine in operations to be presented in all its dimensions. In fact, in the Joint Doctrinal Publication JDP 4.10 "Health Doctrine in Operations", health care is based on four general pillars: international law, ethics, specific national health-related legislation and accreditation.

Much can be written, said or discussed the usefulness of ethics. Utilitarian thinkers wonder what benefit they derive from studying and applying it. Do lovers of freedom-of-action ponder: does it limit my actions and reduce my options for response to behave righteously according

to morality? Sceptics and cynics ponder: ethics, what ethics, is it not so subjective and diffuse that it varies according to cultures, religions, countries or social groups? Do academics wonder whether ethics is unitary or professionally diverse? Can it be summarised in a code or guide to standards? Is it not enough, say the legalists, to turn to the Delphic oracle of International Humanitarian Law and the rules of engagement? We all wonder why it is that, as a fundamental pillar, it is not taught in a regulated way or used in daily practice.

Whatever the answers to these and other questions, we have some certainties. For those who form part of the operational Military Medical Corps, ethics is a tool for dealing with dilemmas arising from operations (for their specific professional competence in health), within the operation or mission in which they are taking part in. Concepts must not be confused; not everything legal is ethical and not everything ethical is legal. If the commander of an operation is aware of the ethical aspects of health, as a critical enabler, it will allow for better command and control of the operation – i.e., a greater likelihood of successful execution.

At a higher level, we have to decide whether we leave ethics to books bearing that term left stacked on shelves, and where scrupulously developed codes of ethics are forgotten in a hidden document that has no living application. Or where ethical actions lose any sense of continuity. Or where, from now on, in the best tradition of the critical spirit, it actively guides our actions.

To help the reader make up his or her own mind, we have asked four top experts to explore these questions.

The first, by colonel Juan Manuel Torres León of the Military Medical Corp (CMS) offers "An Overview of Medical Ethics in Military Medicine Practice".

The colonel has extensive experience in international deployments (operations and missions). He is a specialist in Internal Medicine, holds a master's degree in Health Law from the Complutense University of Madrid and a master's Degree in Bioethics and Biolaw from King Juan Carlos University (URJC) in Madrid. He was Head of the Accident & Emergency Department and Deputy Medical Director at the Hospital Central de la Defensa Gómez Ulla. His last active duty station (and later in the reserves) was the Joint Chiefs of Health for the Joint Chiefs of Staff.

This chapter analyses the interest in medical ethics in the planning, execution and monitoring operations and missions. These have now complex characteristics, partly due, among other factors, to advances in military technology.

The practice of military medicine involves the confluence of military and medical ethics, as professional ethics, which in certain circumstances may

result in dual ethics that need to be applied in real time and may involve different levels of decision-making.

It also outlines the current situation regarding the training that future medical officers receive in these areas, the training received by equivalent groups in neighboring countries, and several proposals for consideration.

The second chapter, entitled “The Military Doctor and Medical Ethics”, is presented by Dr Juan José Rodríguez Sendín - a specialist in Family and Community Medicine who holds a Master’s degree in Health Administration from the National School of Health and was President of the Spanish Medical Association (OMC) from 2009 to 2017, becoming President of the OMC’s Central Committee of Deontology, of which he is currently a member. He has published extensively on ethics and the medical profession.

“The Code of Medical Ethics consists of the rules laid down by the medical profession, which are binding on all practising physicians”. This chapter deals primarily with the hypothetical case of the doctor’s conflict of loyalties, arguing that the first obligation of any doctor is to provide medical care to all who need it.

Throughout the text there is an exposition and analysis of important aspects such as the “values and principles of doctors”, the “code of conduct of the world medical association for doctors working in armed conflicts and other situations of violence”, “the military doctor and the code of medical ethics”. It also covers the response provided by the code of ethics, which sets out what military doctors must assume in the face of various dilemmas such as freedom to prescribe, the obligation to inform superiors of his or her ethical limits, the duty of professional secrecy, the criteria for prioritising care, the expert function, the use of health care information systems, scientific research, conscientious objection and respect for the dead.

The chapter ends with some interesting scenarios for consideration, which will be of great interest after further reading.

The chapter entitled “Decision-making in ethics” is written by Dr Diego Gracia Guillén. Professor Gracia is a doctor specialising in psychology and psychiatry and is considered one of the great Spanish experts in bioethics, as well as a writer and leading philosopher. He is Professor of the History of Medicine at the Complutense University of Madrid. He was the director of the first master’s degree in Bioethics in Spain. He is a full member of the Spanish Royal National Academy of Medicine and a full member of the Spanish Royal Academy of Moral and Political Sciences.

He believes that one of the aims of ethics is to analyse the experience of “duty” and, therefore, and thus ensure that resulting decisions are the right ones. This procedure should begin with a detailed analysis of the facts, the competing values around the decision to be taken, and the possible courses

of action. Correctly applied, the whole process can be called 'deliberation' and should be based on 'prudence' - all of which is the result of a proper moral education.

Throughout, this chapter also explores concepts such as facts and values, conflict, circumstances, and consequences, protocol in decision-making and its consistency tests, as well as other issues of interest such as high moral standards and low moral standards are explored.

The topic is further enhanced by the use of case studies and the study of the complexity of competing circumstances, such as collective decisions, conscientious objection and conflicts, as in some cases between ethics and law.

Finally, excellence is addressed as the end of ethical decision-making, based on faith, hope and love, establishing the relationship between high moral standards and professional ethics.

The book concludes with the chapter on "Ethical perspective of health support in planning, conducting and monitoring operations", by Colonel David Cobo Prieto (MD) of the CMS.

Colonel Cobo is a doctor specialising in rheumatology. He has a diploma in Joint Staff Course, and he is currently Head of the Health Section (JMED) of the Joint Operational Command and has extensive experience in international deployments (operations and missions) as well as in the Ministry of Defence's Expert Medical System.

This chapter focuses on the ethical dilemmas perceived during the participation of the Spanish Military Medical Corps' in operations and missions. The study has been carried out by applying universal ethical principles and the related approaches employed by neighbouring countries. It also analyses institutional, group and individual responsibilities, that go beyond the scope of the Military Medical Corps and concludes that ethical analysis is a necessary tool for the decision-making process.

The text reviews the principles and values of ethics itself, the awareness of the role of the Military Medical Corps, the constraint of limited resources, the responsibility inherent to the CMS and the Military Medical Corps' internal and external projections in operations and missions.

In any case, each expert will leave us to quietly reflect afterwards on suggestions for clear areas for action based on typical cases and situations. If this were flamenco, this article would not cover all the musical forms, but it would highlight the specific forms that are easy to interpret, with a lively and enjoyable rhythm that encourages the listeners to dance. I suggest that military readers search the media for the two civilian contributors, who humbly preferred not to elaborate on their backgrounds, and they will

discover two sources of reference on the subject. I suggest that civilian readers find out more about the Military Medical Corps and, while they are at it, honour us by joining us as reservists.

This paper's civil-military collaboration is not a concession to fashion and political correctness; it is simply evidence-based medicine and necessity. In military operations, everyone (military and civilian health care) will, in one way or another, work together in the field and after the operation, to provide coverage and continuity of care for patients. Given this, we would be doing a disservice to the casualties (patients) and jeopardizing the operation if we did not establish common principles for whatever may be required.

Antipodean actors are those who are located at opposite points of the same space (war/peace), whose actions can be linked by an invisible but resistant line (ethics), who have common features and attributions (heal/relieve/recover), they coexist and cooperate under the same concept (health). These actors are part of healthcare, whether in war, crisis or emergencies. We know that we are the supporting actors in the great film of life, and that the main stars - the patients - will probably never read this.

This paper aims to whet the appetite in regard to individual reflection on that invisible line of resistance that binds us together. But it also aims to trigger a collective reflection (let's call it *institutional*) on the armed forces, which will open up a regulated path for developing the concept of ethics in the Military Medical Corps during operations. We have the capacity to sin in word, deed and omission. We sin by confusing ethics with legislation (international humanitarian law). And we would be sinning by omission if we did not treat it as something to be developed. Following a period of confession and determination to make amends, every sin has its penance: making up for lost time.

Having identified the problem, it is time to take corrective action in the form of lessons learned.

And now, on the advice of my father, I will be silent and allow readers to devote their full attention to reading the following chapters.

Chapter 1

AN OVERVIEW OF MEDICAL ETHICS IN THE PRACTICE OF MILITARY MEDICINE

Juan Manuel Torres León

Abstract

After the debate on the actions of health professionals during the so-called «war on terrorism» has been overcome, the current interest in medical ethics in the military field is related to the complex characteristics that military operations and technological advances have acquired.

This chapter highlights the problem of dual loyalty, an axis on which many ethical conflicts occur in the practice of military medicine move. Military and medical ethics are compared from the general point of view that their consideration as professional ethics shows, and an approach is made to the ethical framework of the military medical practice.

Finally, the current state of training in medical ethics received by Spanish military doctors is discussed, as well as the projects that other countries have carried out in this area and the initiatives that we could explore in our national system.

Keywords

Military medicine, ethics, dual loyalty, ethical framework of military medicine, ethical training of military doctors.

Introduction

Military doctors have always supported the armed forces following a code of conduct, no different from that of any doctor in his or her professional practice.

From a normative rather than an ethical perspective, the moral conflicts arising from warfare were first highlighted in Henri Dunant´s book *A Memory of Solferino*[1], in which the description of the suffering of the war wounded led to the birth of the Red Cross and inspired the beginnings of International Humanitarian Law (IHL). IHL recognises a special status for medical personnel, based on the necessary requirements for the medical care of the wounded in war. The International Committee of the Red Cross[2] summarises this status in two rules:

- "Medical personnel exclusively to medical duties must be respected and protected in all circumstances. They lose their protection if, outside their humanitarian function, they commit acts harmful to the enemy".
- "Punishing a person for the performance of medical duties compatible with medical ethics or compelling a person engaged in medical activities to perform acts contrary to medical ethics is prohibited".

The rules of IHL, in particular the Geneva Conventions of 1949 and the Additional Protocols of 1977, included duties and responsibilities already covered by classical ethics, such as respect, protection and humanity towards the sick. However, the only explicit mention of medical ethics in IHL is in Article 16 of Additional Protocol I, and there is no discussion over its meaning. Despite the interest aroused by medical ethics during the second half of the 20th century, especially after the emergence of bioethics[3], it must be acknowledged that there has been no obvious interest on the part of military medical professionals, or those outside the military institution, in dealing with ethical conflicts related to the practice of military medicine. It is paradoxical, however, that the events of the Second World War contributed to the medical ethics transformation.

The Nuremberg Code of 1947, published after the conviction of several German military doctors during the Nuremberg Trials, was the starting

[1] The International Committee of the Red Cross provides free access to the work via the following link: https://volunteeringredcross.org/wp-content/uploads/2019/09/Un-re-sane-of-Solferino-Henry-Dunant.pdf. [Accessed 1/12/2021].

[2] Henckaerts, J-M and Doswald-Beck, L (2005). Reprinted with corrections 2009. Customary International Humanitarian Law 1. Volume I. Rules. New York, Published in the United States of America by Cambridge University Press. [Accessed 1/12/2021].

[3] The term bioethics, in its current sense, was first used by Potter, Van Rensselaer, in 1971 in Bioethics Bridge to the Future.

point for the inescapable requirement of informed consent for experimental purposes, and this obligation was universally enshrined in the Helsinki Declaration of 1964[4]. Today, informed consent in the practice of medicine, is widely accepted as the right of the patient that best defends his or her autonomy.

The debate on ethical conflicts related to the practice of military medicine is a recent one, dating back not much further than the last two decades. However, this debate, which was initiated in the US and subsequently extended to a greater or lesser extent to other English-speaking countries, has not yet taken place in Spain for the time being.

There are several reasons for the interest in medical ethics in the practice of military medicine:

First of all, medical ethics was deeply compromised in the US military after it became known that health care personnel were involved in the interrogation and force-feeding of detainees in military prisons after 9/11, during the so-called "*war on terror*"[5]. These events eventually resulted in a public debate on the legality and morality of such interventions, been the political decision of not applying the IHL to these prisoners, at the core of the debate[6].

Secondly, the complex nature of modern armed confrontation has increased the moral discrepancies between adversaries and consequently, the difficulty of decision-making, including decisions related to medical care. The most complex factors include operating within coalitions or alliances against enemies that are not clearly identified - often involving non-state actors or the presence of proxy adversaries - the increasing number of civilian casualties, and advances in military technology.

When providing medical assistance to civilians or military personnel from other countries, cultural differences - as reflected in people's value systems - can determine the provision of care itself. This ultimately requires negotiation on the ground to provide care in a morally comfortable way.

The initial focus of medical ethics in the practice of military medicine was largely on human rights violations. However, the interest has been

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[4] World Medical Association Declaration of Helsinki. Recommendations to guide physicians in biomedical research in humans.

[5] On 21 September 2001, in the aftermath of the 9/11 attacks, President Bush delivered a speech to the US Congress in which he announced the beginning of the so-called "war on terror".

[6] In a decision that was later amended by President Obama, the Bush administration concluded that since Al Qaeda was not covered by international conventions, the Geneva Conventions would not apply and that their principles would only be respected "to the extent appropriate and consistent with necessity". Memorandum: Humane Treatment of Al Qaeda and Taliban Detainees. US Government: Washington DC; 2002.

extended to other situations where neither law, nor medical ethics nor the indispensable recourse to 'common sense' can provide solutions to specific problems. In other words, the need is beginning to emerge for practical ethics so that, applied by means of a method, can respond to a specific moral conflict at a specific time. This way of dealing with ethical problems is what bioethics has been thinking about since it began in the last third of the 20th century. And it now seems to be knocking on the door of military medicine.

The current interest in medical ethics in the field of military medicine has been reflected both at the institutional level and in the number of publications dealing on the subject throughout this century. In terms of institutions:

- The World Medical Association (WMA)[7] (of which the Spanish General Medical Council is a member) and the International Committee of the Red Cross[8] have published two documents on health care during armed conflict. Both agree on two conclusions: "Medical ethics in times of armed conflict is identical to medical ethics in times of peace" and that "If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients".
- Following the decision of the General Assembly of the International Committee of Military Medicine in 2009, the Reference Centre for International Humanitarian Law and Ethics[9] was established in Switzerland. Since then, the Centre has been organising an annual workshop on medical ethics, presenting different scenarios and focusing on an ethical dilemma in the field of medical support to operations.
- For the US Department of Defence (DOD), in the aftermath of 9/11 and the events that ensued, the focus on military medical ethics is a priority. In 2003, their Centre for Excellence and Research produced two volumes[10] that represented the most comprehensive work

[7] WMA Regulations in times of armed conflict and other situations of violence. Adopted by the 10th World Medical Assembly, Havana, Cuba, October 1956, and edited by the 11th World Medical Assembly, Istanbul, Turkey, October 1957, revised by the 35th World Medical Assembly, Venice, Italy, October 1983, the 55th WMA General Assembly, Tokyo, Japan, October 2004, editorially revised by the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, and revised by the 63rd WMA General Assembly, Bangkok, Thailand, October 2012. [Accessed 1/12/2021]. Available at: https://www.wma.net/polides-post/wima-regulations-in-times-of-arimed-conflict-and-other-situations-of-violence/

[8] CICR. (2015). Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies. [Accessed 1/12/2021]. Available at: https://www.who.int/hac/tech-guidance/ethical_principles_of_health_care.pdf?ua=1

[9] The New ICMM Reference Centre on International Humanitarian Law and Ethles, (2009). International Review of the Armed Forces Medical Services, Vol 83 (2).

[10] Beam, TE, Howe, EG (eds). (2003). Military Medical Ethics. Falls Church, VA, Office of the Surgeon General.

published on a hitherto largely unexplored field. In one of its chapters entitled "The Essence of Medical Ethics", Dr Edmund Pellegrino, at the time director of the US President's Council on Bioethics, insists on the idea of the same ethics for all doctors, although he goes so far as to argue for exceptionality when facing "the most extreme exigencies".

- More than 15 years later, the US DOD interest remains strong. The Department has promulgated an instruction on medical ethics in the military medical system[11] that resembles a similar model to that of the American Medical Association, although it has some peculiarities. Finally, a Medical Ethics Centre has been set up within the Department of Defence, with the aim of being a reference and a source of expertise in collaboration with other governmental, academic, and professional organisations in ethical dilemmas that may arise.
- The British Medical Association, which is sensitive to ethical issues in the practice of medicine within the UK Armed Forces, has also published a document which provides tools for decision making[12].

Publications on ethics in the practice of military medicine have multiplied in the course of this century.

A bibliometric study of English language publications[13] between the years 2000 and 2020 shows that, although there are publications from up to 15 countries, most of them are from the United States (72%) or the United Kingdom (13%), and only one third of the authors belong to a military institution.

This study divides the topics into nine areas and gives the number of annual publications written on each of them. The remarkable volume of articles on detainees in military prisons during the first decade of the 21st century has now become insignificant. On the other hand, publications on biomedical research, patient care and, especially mental health, have increased exponentially. Other topics such as disasters and triage

[11] On 08/11/2017, the US Department of Defence issued Instruction 6025.27, "Medical Ethics in the Military Health System". It was promulgated following the 3-032015 Report of the Defence Health Board, "Ethical Guidelines and Practices for US Military Professionals", which establishes "Principles of Medical Ethics" for the Military Health System. [Accessed 1/12/2021]. Available: DoD Instruction 6025.27, November 8, 2017 (whs.mil) and Ethical Guidelines and Practices for US Military Medical ProfessionalsFINALCompliant_1 (2).pdf

[12] Ethical Decision-Making for Doctors in the Armed Forces: a Tool Kit. [Accessed 1/12/2021]. Available at: https://www.bma.org.uk/media/1218/bma-armed-forces-tool-kit-oct-2012.pdf

[13] Zachary Bailey, BS et al. (2021). A Thematic Analysis of Military Medical Ethics Publications from 2000 to 2020-A Bibliometric Approach.

maintain the interest of what has been published over the last 20 years. It is noteworthy that three topics are not only the main focus of some of the publications but are also reflected as a topic of debate in most of the articles: dual loyalty, the ethical framework of military medicine and ethics training of military doctors.

I will focus my attention on these last three topics.

Dual loyalty

Dual loyalty can be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, real, or perceived, to the interests of a third party such as an employer, an insurer or the state[14]. In essence, it is the confrontation between a doctor's loyalty to patients and a third party's expectations of medicine.

Interest in dual loyalty has increased as the doctor-patient relationship has evolved from the classic paternalistic model, which largely ignored this debate, to the current model of a *horizontal* or *democratic* relationship[15] in which the interests of patients, doctors and institutions may at some point appear to be in conflict.

There are examples of such conflicts in different areas of medicine and on different issues. For example, in the area of prison health care, the problems are varied[16], although much of the debate has focused on the problems associated with prisoners' hunger strikes. In the case of public health, issues relating the breach of patient confidentiality, when it is motivated by a transmissible disease, can serve as an example.

The problem of dual loyalty in the practice of military medicine is not a new one, and interest in the subject has been fuelled by reasons that have contributed to the transformation of armed conflicts, from conventional warfare, military operations related to hybrid warfare, the grey zone or participation in operations in support of civilian authorities.

The analysis of these situations differs not only in the terms of the particular ethical dilemmas, but also by the identification of the level at which

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[14] International Dual Loyalty Working Group project. (2002) Dual Loyalty in Health and Professional Practice: Proposed Guidelines and Institutional Mechanisms. Boston, MA, Physicians for Human Rights; and Cape Town; South Africa, University of Cape Town Health Sciences Faculty.

[15] According to the name that Professor Diego Gracia gives to this relationship in the chapter "The practice of medicine" in the book Bioethics for Clinicians (Bioética para clínicos), 1st Edition. Madrid, published by Triacastela. 1999.

[16] Publisher. (2009). Ethical Notes on the Practice of Medicine in Prison. Rev Esp Sanid Penit. 2009; 11: 33-36.

they occur, since the actors involved are different and the problems may differ significantly depending on the level at which they occur[17]. We can distinguish three levels: a higher or political level; an intermediate or institutional level; and a clinical level, limited to the doctor and his or her patient.

In this way, the difficulty inherent to the context in which military doctors carry out their duties is recognized, while at the same time the responsibility of other parties is taken into account, although in the majority of the situations, the ultimate impact of the conflict will be that of a doctor who has to treat and make decisions about his or her patient.

In order to provide a further explanation, some examples will be given for each of these levels, without the intention to elaborate on the ethical principles involved:

1) At the *political level*, the conflict with one of the principles of medical ethics is usually related to the achievement of a “higher good”, which may concern to national security. The situation that has generated the most debate at this level has been the aforementioned involvement of military medical professionals in the interrogation of detainees in military prisons after 9/11, but there may be others, such as the following discussion on the autonomy of personnel.

Dual loyalty and autonomy. In the US military, a mandatory vaccination order is considered legal, and therefore constitutional, if the vaccine has been approved by the FDA[18] or if the vaccine has been approved for emergency use and the President of the country issues a waiver of the informed consent procedure[19]. The issue of mandatory vaccination began to gain prominence after the Gulf War (1990-91) and the identification of a potential biological threat posed by *bacillus anthracis*, the causative agent of anthrax. In 1998, President Clinton’s administration ordered the use of an anthrax vaccine for members of the armed forces, which had been shown to be effective against subcutaneous anthrax, but had not been proven effective against airborne anthrax.

The Covid-19 pandemic has reopened the debate. In August 2021, the US Secretary of Defence announced his intention to seek President Biden’s approval for the mandatory use of the Covid-19 vaccine for his department’s personnel[20].

[17] Rochon, C (2015). Dilemmas in Military Medical Ethics: A Call for Conceptual Clarity. Bioethique Online. 4. https://doi.org/10.7202/1035513ar

[18] Food and Drug Administration

[19] 10 US Code § 1107

[20] Memorandum for all Department of Defence employees. Secretary of Defence AUG 09 2021. [Accessed 1/12/2021]. Available at: https://media.defense.gov/2021/Aug/09/2002826254/-1/-1/0/MESSAGE-TO-THE-FORCE-MEMO-VACCINE.PDF

Of course, on this issue of vaccination there may be intermediate courses of action, for example, making vaccinations a prerequisite before any military deployment, but without going so far as to require informed consent.

2) At the *intermediate level*, conflicts usually arise between one of the ethical principles of medicine and the pursuit of an objective that is in the military interest. Examples include the following:

a) Interventions aimed at "bio-enhancement". In the military, the term bio-enhancement refers to interventions designed to improve the performance of military personnel, the purposes of which go beyond what is understood to be the objective of medical support: personnel selection, disease prevention, and health promotion, maintenance and restoration.

The use of stimulants, such as the use of amphetamines by fighter pilots, has been recognised by the military authorities of some countries[21]. Today, advances in physiology, nutrition, genetics, neuroscience and engineering offer solutions to prevent or reduce fatigue or enhance mental or physical capabilities of a combatant in a demanding operational environment, so that the recruitment of "super-soldiers" is becoming an aspiration. From a practical point of view, the application of these advances could be seen as a simple risk/benefit analysis for the mission and the warfighter However, there is undoubtedly an ethical aspect to the issue, such as that of a medical intervention without a therapeutic or preventive objective and which could potentially cause harm.

b) The *instrumentalisation* of medicine. The use of medicine as a strategic tool to "win hearts and minds" has rarely been the subject of moral reflection. Physicians' experiences of planned health care for civilians, in low-intensity conflicts, are often associated with a sense of disappointment for a variety of reasons. These include the lack of follow-up of these patients, diagnostic equipment is scarce, the lack of translation or interpretation services, and the fact that care may be limited to the distribution of medication provided to the military operation by the logistical supply chain. The frustration that arises in these cases, is not caused by a lack of resources, but by the *instrumentalisation* of medicine, of which the doctor becomes a major part.

Of course, the moral experience may be different when other types of assistance are possible through planning with a priority medical focus. For example, surgery targeted at common diseases, vaccination and de-worming campaigns, dental care programmes, and so on.

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[21] Hart, L (2003). Use of 'go pills' a matter of 'life and death,' Air Force avows. LA Times. [Accessed 1/12/2021]. Available at: http://articles.latimes.com/2003/jan/17/nation/na-friendly

c) Medical Liability. The tactical environment of today's operations, characterised by non-permissive environments and isolated contingents, coupled with the doctrinal requirement to treat casualties within a tight timeframe, has led to the development of highly mobile medical treatment facilities (FST for its Spanish acronym) aimed at damage control surgery to enable initial stabilisation of casualties.

The problem that arises, and which has already been echoed in some publications[22], is that the demand for this type of FST is not met by surgeons who have the surgical competence to deal with very serious injuries in such an austere environment. That is, their day-to-day surgical practice does not match the techniques demanded in the field, which may involve facing a new ethical dilemma: accepting the erosion of their surgical competence to meet military expectations of an immediate and present damage-control surgical capability in any environment. This complicated view of competencies can be extended to other situations in which doctors are deployed in tasks outside their usual clinical practice and training.

3) At the clinical level, the dilemma is at a more restricted level, that of the doctor-patient relationship, where the traditional principles of medical ethics are more easily identifiable. Examples of such dilemmas are the following:

a) Confidentiality in the face of a *state of necessity* related to operability. Confidentiality of medical data is linked to the right to privacy and the duty of professional secrecy, although it is neither an absolute right nor an absolute duty.

There are exceptions that allow confidentiality to be breached, that can be summarised into two categories: those arising from a legal imperative, such as that imposed by knowledge of a crime, and those arising from a *state of necessity* to prevent harm to the patient him or herself or to a third party.

However, problems may arise due to difficulties or concerns in identifying and analysing the situations that allow for a breach of medical confidentiality. Other obstacles may result from an interest of a third party in both medical and nonmedical information obtained within the doctor-patient relationship for professional reasons. Finally, for the unjustified presence of a third party in the course of medical care for a nonmedical purpose. In any case, if there is justification for breaching confidentiality, the prior consent of the patient should always be obtained and, if a decision is made to breach confidentiality, it should be limited to the essential data.

b) Dual loyalty and its influence on triaging casualties. The triage of casualties for care in resource-limited situations is a problem closely related to the practice

[22] Edwards, MJ et al. (2018). Army General Surgery's Crisis of Conscience, J Am Coll Surg. 2018 Jun; 226(6):1190-1194. doi: 10.1016/j.jamcollsurg.2018.03.001. Epub 2018 Mar 8. PMID: 29524661.

of military and disaster medicine. Article 12 of the Geneva Convention states that triage must follow emergency medical criteria, whether for the soldiers themselves or for enemy combatants. Although it has been argued that priority should be given to those wounded who can return to combat as soon as possible[23], the reality of the data shows that the aim in these situations has always been to prioritise the most seriously wounded with a chance of saving their lives, and to treat all casualties as far as resources allow[24].

However, triage has its own ethical dilemmas. For example, giving priority to a compatriot over a soldier from another country (enemy or not) when the injuries of both are equally serious or even when the injuries of our colleague are somewhat less severe, and resources only allow one of the injured to be treated. IHL and the characteristic of universality of medical ethics dictate that the only criterion should be the severity of the injuries. Nevertheless, it is difficult not to accept that a sense of comradeship also imbues doctors and leads them away from the 'moral perfection' demanded by the agreed standard, while moving them closer to an intuitive moral judgement that impels them to help their colleague first.

In 2003, the International Dual Loyalty Group published[25] a Guide for the Practice of Military Medicine, summarised into 10 points. Several of them insist that there is no difference between the ethics of a civilian doctor and those of a military doctor. Other points address specific issues such as the prohibition on participation in biological or chemical weapons research; patient's right to confidentiality; triage; the non-participation of doctors in ill-treatment or torture; and the requirement to report human rights violations.

Despite the existence of guidelines such as that mentioned above, the response to situations like those described is not always clear. Thus, decisions are sometimes shrouded in a nebulous web of considerations of military interest, patient rights and welfare, legal norms and human rights that make them difficult to implement within the practice.

A framework for medical ethics in the practice of military medicine

The above-mentioned WMA Statement on Medical Ethics leaves no doubt that "medical ethics in times of armed conflict is identical to medical ethics in times of peace", been the physician´s "primary obligation to his

[23] Gross, ML (2006). Bioethics and Armed Conflict: Moral Dilemmas of Medicine and War. Cambridge, Mass, MIT Press.

[24] Rawling, B (2008). La mort pour ennemi: La médecine militaire canadienne (Death for the Enemy: Canadian Military Medicine). Ottawa, Canada, Agmv.

[25] Dual Loyalty Working Group. Dual Loyalty and Human Rights in Health Professional Practice. Proposed Guidelines and Institutional Mechanisms. Washington, Physicians for Human Rights.

patients". From a formal point of view, it does not seem difficult to support this claim with the powerful approach of the rules of IHL[26], national medical legislation and medical codes of ethics. However, it could be inferred from the wording of its own declaration that there are other "non-principal" obligations that may also be involved.

The primary consideration at stake here is not the accuracy of the WMA's statement, but its practical utility. Publications concerning the issue of dual loyalty - where it is claimed that "in reality, cases of conflict are few"[27] - merely point out that the problem of its application may arise when an exceptional military requirement competes with the independent ethical judgement of a doctor. The instruction already referred to, published by the US Department of Defence in 2017,whilst following a similar model to that of the American Medical Association's code of ethics[28], a comparison of the two texts show exceptions[29], including that contained in Principle 10 of the instruction: "Consider responsibility to the patient as a primary responsibility, but recognize there may be extraordinary circumstances related to the mission or military necessity that may require additional consideration and ethical consultation". The practice of military medicine can be included in a broader discussion of medical ethics and the responsibilities of physicians in certain professions (prison doctors, forensic psychiatry, public health). However, I believe that there is a special feature that stems from the influence of two different professional ethics in the same institution - the military and medical professional ethics - which converge in the role of the military doctor.

Traditionally, physicians and military personnel have identified behaviours and qualities that give distinctive characteristics to the profession. It is common for their own experience of what constitutes its rules and values, are internalised among its members, creating a distinctive '*military ethos*' or a '*medical ethos*', depending on the case, even without any study on this subject either during academic training or during professional life. Even in the course of one's professional life, one's won ethos can produce a bias in the process of training, that influences the objective analysis of reality. The question of what is meant by professional ethics is not a trivial one.

[26] Articles 16 and 10 (AP 2) of the Additional Protocols to the Geneva Conventions I and II respectively, stipulate that "under no circumstances shall any person be punished for medical activities consistent with medical ethics, irrespective of the person who benefits from them".

[27] Howe E (2003). Mixed agency in military medicine: Ethical roles in conflict. In: Beam, TE and Spracino LR (eds). Military Medical Ethics, Vol. 1. Falls Church, VA, Office of the Surgeon General. 2003:331-60.

[28] Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf [Accessed 01-12-2021].

[29] Richard, T et al. (2020). A Code of Ethics for Military Medicine. Military Medicine. 185: 527-531.

Professions that have a commitment to serve society generally observe their own rules, reflected in their professional ethics, which sets out the foundations and principles that underlie the "morality of the profession". These codes tend to lie midway between legal rules and ethics, although sometimes the law itself may define the code for a profession. This concept of professional ethics is controversial[30] and there are those who extend it to a more intimate sphere, constituted by "inner morality" or "personal conscience", which reflects on what is right to do and how it is translates into the way professional duties are carried out.

The tradition of deontology for doctors' dates back to the Hippocratic Oath (around 400 BC), later amended under the "Geneva Declaration"[31]. It is not the only medical code that exists. For example, the Spanish Medical College Organisation, under the 1978 Constitution, has its own code of ethics. Medical deontology covers the rights and responsibilities of doctors and patients, and is not included in ordinary legislation, perhaps as a precaution to avoid over-regulation of the profession.

The benchmark code of ethics for the Spanish military is legally regulated by Royal Decree, and the Royal Ordinances[32] constitute "the code of conduct of the military, defining the ethical principles and rules of behaviour in accordance with the Constitution and the rest of the legal system". Although, in my personal point of view that, the attribute given to some of the terms included within it, is arguable. The Royal Ordinances define discipline, courage, promptness in obedience and accuracy in service as fundamental virtues. These can be understood more as qualities related to positive characteristics for service rather than a virtue, understood as the condition of a person to act properly without being obliged to do so.

Other foreign armies have similar institutional publications[33] and there has been an increasing interest in them has grown over the last century.

[30] According to Alonso Hortal Alonso in his book Ética general de las profesiones (General Ethics of Professions) (2002): "Professional ethics reflects on what professionals do, should do or is good for them to do in order to be ethical in the exercise of their profession, whether or not it is written in a code".

[31] Declaration of Geneva, passed by the 2nd General Assembly of the World Medical Association (WMA) in Geneva, Switzerland, September 1948 and last amended by the 68th WMA General Assembly in Chicago, USA in October 2017.

[32] Royal Decree 96/2009, of 6 February, approving the Royal Ordinances for the Armed Forces, These Royal Ordinances repealed those that had been published in 1978, after the approval of the Spanish Constitution, although their tradition goes back to the old "ordinances" that regulated the functioning of the units, as well as including some rules related to the behaviour of a soldier.

[33] In the US, "The Army Ethic" chapter 2 of the doctrinal publication ADPR 1 The Army Profession. In France, "L'Exercis du métier des armes, fondaments et príncipes", In the UK: "The Military Covenant" and "Values and Standards of the British Army".

They all seek to establish guidance on the ethical principles, duties, values, virtues and rules of behaviour that should serve as a reference for soldiers as they serve their nation. The guide published by the French Army, which reflects on the foundations of the profession and sets out four principles of behaviour, is of particular interest. In Spain, General Moliner's publication on the ethical pillars of the military profession[34] is noteworthy, as it is a subject on which very little has been written.

Usually, law is placed on a different level from professional ethics, since its work is based on behaviour in terms of rights and duties that have the obligation to be fulfilled in order to guarantee a just and peaceful coexistence.

In medicine, however, the influence of medical ethics on law has been far-reaching, as many of its principles have been transposed into legislation. The main examples are the national Patient Autonomy Act[35] and the European Charter of Patients' Rights[36]. In the case of the military, I think the implementation has been in the opposite direction. It is not uncommon for the principles contained in codes of ethics to refer to what has already been legislated[37]. The anticipation of the law in this case can perhaps be explained by the need to express mandatory compliance because of the high stakes involved. Thus, in the case of legislation and war, of note are the UN Charter on the *ius ad bellum*, the IHL on the *ius in bello* and the norms that apply during the process of transition from armed conflict to a just and sustainable peace, or *ius post bellum*.

In short, in the military and among physicians we can identify traditions, codes and laws that constitute the rules of the game that guide their professionals. An understanding of these rules by military personnel (both medical and nonmedical) would avoid problems that are not so much of an ethical nature as of a legal one or are simply a matter of professional integrity. For example, making the mistake that doctors are combatants "with additional skills" in the medical field or, in of the specific case of medical personnel, the compromise of the demands of a third party which, even if "minimal", can lead to a "condescending" slippery slope from minor mistakes to those as serious as any that have been committed throughout history.

[34] Chapter 6 "Defence Ethics" of the book Defence: State and Society: The Case of Spain. 2018.

[35] Act 41/2002, of 14 November, a basic law regulating patient autonomy and rights and obligations regarding clinical information and documentation.

[36] European Charter of Patients' Rights. Rome, November 2002.

[37] When referring to the principle of humanity (Article 85), Section IV "Regarding Operations" of The Royal Ordinances transfer into International Humanitarian Law the rules that must govern the conduct of the military.

However, real ethical conflicts arise in concrete situations. In these cases, the guidance of law or ethics may not be sufficient to provide the best possible solution. This is where ethics becomes important because its essence is the practical application in deciding what the best solution to solve a given case is, in a given case. The emergence of medical bioethics in the last third of the 20th century has brought this vision of applied ethics, whose aim is to provide methods of analysis and procedures for solving problems in the field of medical-health sciences.

Bioethics, taking as a premise certain requirements considered as essential ("to be a secular, pluralist, autonomous, rational and universal ethics"), sought its philosophical foundation in different and even opposing theories - some deontological, others utilitarian - to create a system of principles with which all doctors have identified (we do not know whether all have done so with sufficient knowledge and skill): the principles of autonomy, beneficence, non-maleficence and justice. The reasoning for their application consists of a first deontological stage (*a priori*) in which the rules are established, and a second consequentialist stage (*a posteriori*) in which the exceptions to the rule can be determined. On the basis of these procedures, a specific method to analyse ethical concerns during the clinical practice can be developed. The outline of these procedures and method of hierarchisation of the principles proposed by Professor Diego Gracia[38], is an excellent example of how to approach these problems.

Professor Diego Gracia organises the principles into two levels: a maximum level made up of the principles of autonomy and beneficence, and a minimum level constituted by the principles of justice and non-maleficence.

The principle of autonomy, which allows to make an autonomous choice, and the principle of beneficence, which aims to do good with the patient's consent, are both situated in the private sphere and are explained by a person's convictions or highest aspirations. These are principles whose fulfilment is "to be desired".

The principle of non-maleficence, which ensures that people are not harmed by acts or omissions, and the principle of justice, which ensures non-discrimination and equal access to resources, fall within the public sphere and the common good. These are principles that are part of the ethics of duty and are the subject of law. They are principles whose fulfilment is "mandatory".

[38] Professor Diego Gracia deals with this topic in different articles and textbooks - two in particular: Chapter 33 "Medical Ethics" of the book Medicina Interna (Internal Medicine), Farreras Rozman, 13th edition, and the book Fundamentos de Bioética (Fundamentals of Bioethics) published by Triacastela, 3rd edition, 2008.

In applying the four classical principles of bioethics in military medicine, aspects of evaluation may arise that are absent in the civilian practice of the profession, and which may add a particular nuance to the assessment of these principles. For instance, considering the principles included at the level of maximums, in exceptional situations, can a military officer be considered as ceding his principle of autonomy, having sworn to defend his country even with the surrender of his life if necessary? Can this oath be understood as an "anticipatory consent", which by itself justifies any subsequent medical procedure, without the person concerned being asked? And with regard to the minimum principles standards, which standard of care should prevail when military doctors provide care to nationals (civilian or military) of the country where the operation takes place: that of Spain or that of the host nation? Could limited quantities of medicines be prioritised for a specific group of military personnel on the basis on their relevance to an operation?

Returning to the framework of medical ethics in the practice of military medicine, I think it can be concluded that there is no specific military medical ethics, even if it is recognised that many of the situations that motivate the debate are specific to this field, and it is likely that technological progress will lead to new ones that are beginning to emerge. Take, as an example, what is known in France as *the augmented soldier* (comparable to the term "super-soldier"), whose physical, perceptual, and cognitive skills are stimulated to strengthen operational efficiency and where these augmentations are increasingly sophisticated and not limited to equipment[39].

The ethical training of military doctors

There is a paradox between the interest in medical ethics and the apparent indifference shown by the teaching guides for medical students in our country to this subject. In the case of military students of medicine at the *Centro Universitario de la Defensa* (University Defence Centre), attached to the University of Alcalá, the subject "medical ethics" is included in the first year and consists of three credits. This is the common standard in other medical schools in Spain. However, for over 20 years, there has been a proliferation in our country of postgraduate and Master's courses in medical ethics, so associations have been formed at national and regional level, which offer courses or publish on the subject in journals or on their websites. It seems as if the lack of such training only becomes appreciated when one starts out in the profession.

[39] The Minister of the Armed Forces, Florence Parly, in her speech at the inauguration of the French Defence Ethics Committee on 10 January 2020, referred in this way to what she calls the "soldat augmenté".

In Spain, the ethical training of military doctors has either been provided through undergraduate academic education or acquired in a process of “infused science” through professional practice, or added by the particular interest that each individual has had in training in this area.

This situation is not surprising if we take into account the broad panorama of military ethics, already noted by General Moliner[40], regarding the non-existence in Spain of a civilian or military centre where courses or postgraduate studies in military ethics are taught.

However, if we look abroad, something new is emerging in the area of ethics and armies. Particularly interesting seems to be the recent creation in France of a Defence Ethics Committee, whose making was bound up with the concern to the problems related to the irruption of new technologies[41], and which will surely also have an impact on healthcare. Regarding to medical ethics in the military, the guidelines for action in some countries have been joined by the creation of training centres in military medical ethics, such as the Centre of Reference for Education on IHL and Ethics in Zurich, the Centre for Military Ethics at the King’s College in London and the US Department of Defence. At King’s College, an innovative educational tool has been designed in the form of a mobile phone app in which different scenarios are presented and the methodology and development of the cases is justified[42].

Courses may not be a panacea, but they provide a stimulus for moral insight into problems and help to develop skills to analyse the cases, recognise moral responsibility in clinical practice, admit that moral ambiguity exists and that the solution is not always perfect, nor can it always satisfy everyone.

According to my personal understanding, a specific medical ethics course for the military should initially aim to provide the skills and reasoning necessary to identify, understand and deal with ethical dilemmas, justify decisions (especially if under scrutiny by a third party) and promote an open attitude to debate before, during and after the resolution of each case. Regardless of the related training needs, there is one issue that has practical

[40] Juan A Moliner González in the first chapter entitled “La educación y formación en ética militar” (Education and training in military ethics) in the CESEDEN working document 03/2020 “Cuestiones sobre ética militar” (Issues of military ethics).

[41] Madame Florence Parly, Ministre des Armées. Lancement du comité d’éthique de la Défense Paris, 10 January 2020. [Accessed 1/12/2021]. Available at: https://www.defense.gouv.fr/content/download/600841/10126586/file/20200921_CE_avis%20soldat%20augmente.pdf

[42] Miron, M and Bricknell, M (28 Oct 2021). Innovation in education: the military medical ethics “playing cards” and smartphone application. BMJ Mil Health, Military-2021-001959. doi: 10.1136/bmjmilitary-2021-001959. Epub ahead of print. PMID: 34711675.

implications. This is the additional counselling need in certain situations and cases. What is proposed here is not something new in medical ethics. In Spain, most hospitals and primary care areas have a consultative body legally regulated by the health services of each autonomous community: the medical ethics committees. For further information, the reference to the regulation made by the former INSALUD[43] is noted at the bottom of the page. It is time to make proposals, easy to do when the road ahead is long, even at the risk of being wrong or committing the error of being overly ambitious.

Why not consider a military medical ethics committee in Spain? The need for one seems to be perceived, and the times ahead are going to be demanding in these matters.

Could this committee be an advisory body and not merely a teaching body? The ultimate need for those who will have to deal with an ethical conflict is to give the best possible response and, beyond theoretical and practical courses, advice will always offer added value.

Could it be related to a future centre for defence ethics? There are bound to be different opinions on this question. Medical ethics does not allow for interference, but is pluralistic and deliberative. Debate with others is always welcome. It seems relevant that, if such a step were to be considered in the future, both would be linked and there would be shared representation. The mutual understanding and relationship of these two professional ethics is likely to be a necessary milestone in dealing with any moral issues that arise.

Conclusions

- The current interest in medical ethics in the military has been stimulated by the complex nature of current operations and innovation in military technology.
- Dual loyalty is at the source of many of the ethical conflicts that arise in the practice of military medicine. It may can occurs in different levels: political, within the military institution itself, or the level that concerns exclusively the relationship between doctors and their patient. Even though the ultimate impact of the dilemma may rely on a doctor who has to decide about the patient, the responsibility of other parties also exists.
- The coexistence of two ethics, military and medical, would benefit from their mutual understanding.

[43] INSALUD Circular No. 3/95 DATE (30-3). Issues; health care Ethics Committees. Available at; http://www.san.gva.es/documents/151744/228971/7circular395in- salud.pdf

- The rules of medical ethics in the practice of military medicine are the same as those that apply to any other medical professional. There should be no specific military medical ethics, even though many of the conflicting situations are related to the particular practice of the profession in this domain.
- Training in medical ethics for military doctors is seen as a requirement that would need to be addressed with the practical purpose that applied ethics provides. This objective could be included as part of a more ambitious initiative: a future centre for defence ethics, with a training and advisory function covering the entire military institution.

Chapter 2

THE MILITARY DOCTOR AND MEDICAL ETHICS

Juan José Rodríguez Sendín

Abstract

The essential mission of the medical profession is to care for health and preserve *human* life. It is the doctor's duty to treat all patients with *humanity and* respect. Deontology is described in the documents, but where it really resides is *not in* the papers but in the commitments and personal conduct of doctors. The Code of *Medical* Deontology *(CDM)* IS MADE UP OF THE STANDARDS ESTABLISHED BY the medical profession , which are binding for all practicing doctors. In every situation the doctor *is at* the service of the patient and the sufferer, who must be placed before any *other* interest, even personal ones. If, in the exercise of his professional duty, the doctor has a conflict of loyalties, his first duty *will always* be to the person in need of medical care, to the wounded, to his patient. The doctor or health professional should never be prosecuted or punished for *fulfilling his or her* their ethical obligations.

Keywords

Conflicts, violence, values, commitments, code of ethics, dilemmas, secrecy, respect, responsibility.

Introduction and general remarks

The essential goal of the medical profession is preserve health and human life. It is the duty of physicians to treat all patients with humanity and respect. Physicians must always provide the necessary care impartially and without discrimination on the basis of age, illness or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social status or any other criterion or circumstance. They have an inescapable duty to care for the sick and injured, regardless of the aetiology, action or motivation that led to their condition. They must recognise the vulnerability of certain groups, including women and children. In no case should the provision of medical care to the wounded, sick or needy be prevented by any authority, or be considered a fault, whether civilian or military; on the contrary, it is an ethical and deontological duty to provide it in the best possible conditions at all times.

Consequently, doctors and health professionals should never be prosecuted or punished for fulfilling their deontological obligations. In order to carry out their duties, doctors have a duty to insist that governments (and military authorities where appropriate) provide the necessary infrastructure as a prerequisite for meeting the needs of patients, including safe drinking water, adequate food and shelter.

The Spanish Medical Association (OMC) is an active member of the World Medical Association (WMA) and accepts its recommendations so long as they do not contravene our Code of Medical Deontology (CDM) and our current legislation. Once published, the declarations approved by the OMC General Assembly are binding on all registered doctors and have the same impacts and obligations as the CDM. Accordingly, we will review the WMA's recommendations in this regard, the obligations set out in the CDM regarding the practice of military doctors in armed conflicts or peace missions in conflict areas.

The sick and wounded, civilian or combatant, must receive the care they need. In cases of emergency, doctors should provide urgent care within their capacity and capability. No distinction shall be made between patients, except as determined by clinical necessity. Physicians must have access to patients, medical facilities and equipment, as well as the protection they need to freely exercise their professional activities. Such access should include patients in detention centres and prisons, providing them with the necessary assistance, including free passage and any necessary professional independence. In carrying out their work, and where legally entitled to do so, doctors and health professionals should be identified and protected by internationally recognised symbols, such as the red cross, the red crescent and the red crystal.

The provision of medical care to the sick and wounded, whether civilians or combatants, may not be the subject of publicity or propaganda. The privacy of the sick, the wounded and the dead must always be respected. This includes visits of important political figures and also when they are wounded or sick.

Physicians should be aware that during armed conflict and other situations of violence, medical care is increasingly vulnerable to be affected by unscrupulous practices - such as making available substandard or counterfeit materials and medicines – and should seek to counter such practices.

Medical values and principles

The 1948 Declaration of Geneva[1] mentions two obligations that apply to physicians, both of which are fully in force today. Firstly, to exclude any discrimination in the treatment and care of their patients: "I will not allow considerations of religion, nationality, race, party politics or social class to come between my duty and my patient", adding its commitment to the value and defence of life: "I will maintain the utmost respect for human life from the moment of conception and shall not, even under threat, use my medical expertise against humanitarian laws".

The practice of medicine is not - nor has it ever been - an innocent activity, or even an ethically neutral activity. It is practised by women and men on behalf of other human beings in the presence and under the control of the state and the medical profession. Therefore, the practising doctor cannot fail to take sides on certain notions of man, life and death, health and illness, justice and injustice, in peace and war, among others... and this taking a stand is a fundamental ethical choice. The exercise of professional practice places doctors in a realm of non-aligned values, and even conflicting scientific, social, economic, political, military and ethical values, from which they cannot withdraw or defect because they are part in their commitments and obligations to patients. It is not surprising that actions and controversies arise around a more comfortable, less committed medicine, free from values and anthropological convictions or ethical commitments. It is in particular the interests, often economic and political, which are alien to the main object of medical care, which is the suffering human being, and exercised from a science without ethical principles. On the basis of these principles - and especially with regard to critical situations concerning life and death, in the case of war or situations of extreme violence – there is a need to reflect

[1] Geneva Conventions of 1949 and their Additional Protocols of 1977, the Universal Declaration of Human Rights (1948), International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights of 1966.

on how to resolve dilemmas presented by applying them in specific cases, along with the need to reach a consensus on binding rules established, supervised and controlled by the medical profession, which we know as codes of medical deontology.

The fundamental principle by which all physicians must act, simply because they are doctors, is the principle of humanity in preventing, alleviating and treating, in all circumstances, human suffering by providing impartial and efficient medical care in armed conflicts and other emergency situations, without discrimination and taking account of the Code of Deontology (CDM) of the Spanish Medical Association (OMC) and the principles of medical ethics, as adopted by national and international health professional institutions, in addition to the rules of International Humanitarian Law[2,3,4].

Serious violations suffered by medical personnel and medical facilities made it necessary to establish the guiding principles of humanitarian assistance based on humanity, neutrality and impartiality, as set out under International Humanitarian Law and in all codes of ethics for medical personnel. Organisations for the medical support of civilians and military personnel in armed conflicts share a document in which they express and demand a common goal of improving the safety of their personnel and property, as well as the ability to provide impartial and efficient medical assistance in armed conflict and other violent or emergency situations, invoking the principle of humanity under which human suffering must be prevented and alleviated in all circumstances. Adhering at all times to the principle of impartiality, whereby health care should be provided without discrimination of any kind. In addition to the CDM, doctors and all health

[2] Geneva Conventions of 1949 and their Additional Protocols of 1977, the Universal Declaration of Human Rights (1948), International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights of 1966; https://www.icrc.org/es/document/los-convenios-de-ginebra-de-1949-y-sus-protocolos-adicionales es/document/los-convenios-de-ginebra-de-1949-y-sus-protocolos-adicionales

[3] WMA regulations in times of armed conflict and other situations of violence. Adopted by the 10th World Medical Assembly in Havana, Cuba, October 1956, published by the 11th World Medical Assembly in Istanbul, Turkey, October 1957. Amended by the 35th World Medical Assembly in Venice, Italy, October 1983, and the 55th WMA General Assembly in Tokyo, Japan, October 2004. Revised by the 173rd Council Session in Divonne-les-Bains, France, May 2006, and amended by the 63rd WMA General Assembly in Bangkok, Thailand, October 2012. https://www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/

[4] International Committee of the Red Cross (ICRC), World Medical Association (WMA), International Committee of Military Medicine (ICMM), International Council of Nurses (ICN), International Pharmaceutical Federation (FIP). Ethical principles of health care in times of armed conflict and other emergency situations. https://www.icrc.org/es/document/principios-eticos-comunes-asistencia-salud-conflictos-otras-situaciones-violencia

professionals must be mindful of the rules of International Humanitarian Law, in particular the Geneva Conventions of 1949 and their Additional Protocols of 1977, and the international law, especially the Universal Declaration of Human Rights (1948), as well as the 1966 International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights.

The World Medical Association (WMA) Declaration on Armed Conflict, adopted at the 68th WMA General Assembly in 2017[5], sets out the duties of doctors in times of armed conflict, already instituted in previous declarations such as the WMA Declaration on "Ethical Principles of health care in Times of Armed Conflict and Other Emergencies"[6]. It is helpful to recall the considerations and recommendations made by the WMA in that statement:

- Armed conflict should always be a last resort. Physicians and medical organisations should alert governments and non-governmental actors to the human consequences of war.
- Physicians should urge politicians, governments, and others in power to be more aware of the consequences of their decisions regarding armed conflict.
- Armed conflict will always cause enormous human suffering. States and other authorities, including non-governmental actors who engage in armed conflict, must accept responsibility for the consequences of their actions and be prepared to answer for them, including before tribunals and international courts, and recommends that authorities recognize and cooperate to ensure that this happens.
- The impact of armed conflict will be greatest on women and vulnerable populations, including children, young people, the elderly and the poorest in society. Doctors should seek to ensure that the allocation of health resources does not have a discriminatory impact.
- Physicians must continually remind those in power of the need to provide these essential services in conflict-affected and conflict-disturbed areas.
- In the aftermath of a conflict, priority should be given to rebuilding the essential infrastructure needed to live as healthy a life as possible, including housing, sewerage, and safe drinking water and food supplies, followed by the restoration of education and work opportunities.

[5] WMA Statement on Armed Conflicts. Adopted at the 68th WMA General Assembly in Chicago, US, October 2017. https://www.wma.net/policies-post/wma-statement-on-armed-conflicts/

[6] WMA Statement on Ethical Principles for health care in Times of Armed Conflict. WMA 65th General Assembly in Durban, South Africa, October 2014. https://www.wma.net/policies-post/ethical-principles-of-health-care-in-times-of-armed-conflict-and-other-emergencies/

- It calls on parties to a conflict respect humanitarian law not to target medical facilities as military quarters or target health institutions, personnel and medical vehicles, respect established International Humanitarian Law (IHL), nor restrict access to health care for the wounded and patients, as set out in the WMA Declaration on the Protection of health care Personnel in Situations of Violence[7].
- Physicians should cooperate with any aid agency or institution to try to ensure that the parties protect the integrity of families and, where possible, remove people from direct and immediate danger.
- Physicians should be aware of the likely prevalence of post-traumatic stress syndrome (PTSD) and other post-conflict psychological and psychosomatic problems and provide appropriate care and treatment to combatants and civilians.
- Physicians, including forensic specialists, should assist families to ensure that efforts to identify the missing and dead are not used by the security services.

World Medical Association Code of Conduct for Physicians working in Armed Conflict and Other Situations of Violence

Whether in peacetime, in war or in the course of an armed conflict, armed forces doctors may be confronted with complex situations and ethical dilemmas that must be resolved in accordance with the principle of the least harm, taking into account the general rules established by the WMA[8], in which the OMC participated, which it has adopted as its own and which make the aforementioned duties a little more specific. Consequently, the following are considered deontologically unacceptable:

- Giving advice or performing a prophylactic, diagnostic or therapeutic medical act that is not justified for the patient's medical care and that is intended for military purposes.
- Applying any form physical or mental pressure directly or indirectly with the aim of forcing a person´s will. Nor weaken their physical or mental resistance without therapeutic justification.
- Using scientific methods to endanger health or destroy life.

[7] WMA Statement on the Protection of health care Personnel in Situations of Violence. Adopted by the 65th WMA General Assembly in Durban, South Africa, October 2014. https://www.wma.net/policies-post/wma-declaration-on-the-protection-of-health-care-workers-in-situation-of-violence/

[8] WMA regulations in times of armed conflict and other situations of violence. Amended by the 63rd WMA General Assembly in Bangkok, Thailand, October 2012. https://www.wima.net/es/policies-post/regulaciones-de-la-aimm-en-tieimpos-de-conflicto-armado-y-otras-situaciones-de-violencia/

- Using information from medical personnel to facilitate an interrogation.
- Tolerating, facilitating or participating in torture or any other form of cruel, inhuman or degrading treatment[9].
- Experiments on human beings are strictly prohibited when they involve individuals deprived of their liberty - in particular civilian and military prisoners and the population of occupied countries.

Of particular relevance to military doctors are the rules of the WMA Code of Conduct, in which the Spanish Medical Association (OMC) collaborated in drawing up and approved. And therefore, it considers mandatory that in all circumstances doctors must:

- Neither violate nor contribute to the infringement of International Law (International Humanitarian Law or Human Rights Law).
- Not abandon the wounded and sick.
- Not take part in hostilities.
- Remind the authorities of their obligation to search for the wounded and sick and ensure that they have access to medical care without unjust discrimination.
- Advocate and provide effective and impartial care to the wounded and sick (without reference to any unfair discrimination, even in the case of enemies).
- Recognise that the security of individuals, patients and institutions is a primary imperative to ethical behaviour and not take undue risk in the discharge of their duties.
- Respect wounded or sick individuals, their will, confidence and dignity.
- Not take advantage of the situation and vulnerability of the wounded and sick for personal financial gain.
- Not undertake any experimentation on the wounded and sick without their real and valid consent, and never where they are deprived of their liberty.
- Pay particular attention to the high vulnerability of women and children in armed conflict and other situations of violence and their specific health care needs.
- Respect the right of a family to know the status and whereabouts of a missing family member, whether or not that person is dead or receiving medical care.
- Provide medical care to anyone who has been detained.
- Advocate for regular visits to prisons and prisoners.

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9 Istanbul Protocol, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, inhuman or Degrading Treatment or Punishment, PROFESSIONAL TRAINING SERIES No. 8/Ver. 2.

- Denounce and act, where possible, to stop any unscrupulous medical practices, such as the use and application of substandard or counterfeit materials and medicines.
- Encourage authorities to recognise their obligations under international humanitarian law and other pertinent bodies of international law regarding the protection of health care personnel and infrastructure in armed conflict and other situations of violence.
- Be aware of the legal obligations to report the outbreaks of disease or trauma to the authorities.
- Do everything possible to prevent reprisals against the wounded and sick or medical care.
- Recognise that there are other situations in which medical care may be compromised. As far as possible, doctors should:
    - Refuse to obey an unlawful or unethical order.
    - Give careful consideration to any dual loyalties that the doctor may have and address this issue with colleagues and any authority.
    - As an exception to professional confidentiality and in accordance with the WMA Resolution on the Responsibility of Physicians in Documenting and Reporting Torture or Cruel, Inhuman or Degrading Treatment and the Istanbul Protocol (6), they must report torture, cruel, inhuman or degrading treatment of which they are aware, whenever possible with the consent of the individual, but also in certain circumstances, without explicit consent, where the victim is unable to express him/herself freely.
    - Listen to and respect the opinions of colleagues.
    - Reflect on and try to improve standards of care appropriate to the situation.
    - Report unethical behaviour of a colleague to their appropriate superior.
    - Maintain adequate health care records.
    - Support the sustainability of civilian health care disrupted by the context.
    - Inform a commander or other appropriate authority if health care needs are not being met.
    - Consider how medical personnel couldreduce or mitigate the effects of the violence in question, for example, by responding to violations of International Humanitarian Law or Human Rights Law.

Military doctors and the code of medical ethics

Deontology is described in documents, but where it is really to be found is not on paper, but in the commitments and personal conduct of physicians. The OMC has several publications, which it updates periodically, in which

it sets out its deontological ideology[10]. The one that stands out, as the reference and guide for all the others, is the Code of Medical Deontology (CDM)[11]. There is no difference in ethical standards or CDMs for civilian and military doctors. Nor is there one for peacetime or peace missions and another for war or military missions in zones of armed conflict. If in fulfilling their professional duties, doctors face a conflict of loyalties, their primary obligation is always to the person in need of medical care, the wounded, and their patients. In any situation, as with other members of the medical profession, doctors working for the armed forces are subject to the rules laid down in the OMC's CDM - not only in terms of diagnosis and treatment of patients, but also in regard to all other interventions they perform as medical professionals, such as prevention or research. What may change are the circumstances and critical moments for their application.

We must therefore heed the chapters and articles of the CDM that are most likely to affect military doctors in their professional practice. As it is mandatory, any registered medical practitioner should be familiar with the full extent of the CDM. We will attempt to review its contents, which may be affected by dilemmatic situations that military doctors may encounter.

In general, as stated in the preamble, all physicians must respect the essential principles of the medical profession, which are translated into the following basic attitudes, responsibilities, and commitments: encourage altruism, integrity, honesty, truthfulness and empathy, which are essential for a trusting health care relationship. They must also continuously improve in their professional practice and quality of care, based on scientific knowledge and self-assessment. The exercise of self-regulation in order to maintain social trust, through transparency, acceptance and correcting errors and inappropriate behaviour, and proper conflict management.

Article 5, which deals with general principles, summarises the obligations already mentioned and specifies that "A doctor serves human beings and society. A doctor's primary duties are respecting human life, dignity, and caring for an individual's and the community´s health". It revolves around the primary loyalty owed to the patient through non-discrimination and knowingly doing no harm. Of particular relevance to military doctors is Article 6, in recalling that "A doctor must not abandon any patient ". Article 7.5 recalls the obligation to report deficiencies to superiors, insofar as they

[10] Available at: http://www.medicosypadentes.com/articulo/la-omc-cuenta-con-siete-publicaciones-que-recogen-su-ideario-deontologico

[11] Code of Medical Deontology. Guía de ética Médica (Guide to Medical Ethics), OMC. 2011. https://www.cg- com.es/s¡tes/ma¡n/files/files/2022-03/cod¡go_deontolog¡a_med¡ca.pdf

may affect the proper care of patients. The obligations concerning patients' rights are covered in Chapter III, when Article 9 invokes the duty to respect patients' convictions as well as their privacy. Article 12 recalls the patient's right to decide freely, including the right to refuse treatment after receiving adequate information and knowing the effects of his or her decision. If a doctor has to treat a hunger striker, he or she must inform the hunger striker of the consequences of refusing food, as well as the expected outcome and prognosis. He or she shall respect the freedom of those who consciously and freely decide to go on hunger strike, including persons deprived of their liberty, and may invoke conscientious objection if they are forced to oppose this freedom. Article 13 deals with situations where patients are incapable of making decisions because they are in a situation of immediate risk to their lives, in which case the doctor, after informing his or her superiors, shall take the decision he or she deems appropriate.

It is not uncommon for the patient's consent to be given verbally, which is valid as long as it is recorded in the medical record. Where the proposed measures pose a significant risk to the patient, written consent must be obtained, as set out in Article 16. Article 19 deals with the duty to inform and record in the medical record, as well as the proper accessibility of the medical record.

Article 24 deals with limitations on medical practice for performing medical acts that are appropriate and normally done by other specialists. However, it accepts that other qualified doctors may carry out these procedures on an occasional basis, and especially in case of need. No doctor who has the necessary skills and knowledge appropriate to the level of use required, can be prevented from using them for the benefit of his or her patients. However, in such circumstances, nor in any other, may a physician be attributed the status of a specialist in that technique or subject where he or she is not. In military healthcare, remote medical or surgical care is important. An ultrasound examination or surgical intervention can be remotely supervised and managed where it is not possible to move the patient and the patient's life may depend on it. Although in the next edition of the CDM (currently subject to approval), the current Article 26.4 is fully updated and states that "it is ethically acceptable, in the case of second opinions and medical reviews, to use email and other non-face-to-face means of communication and telemedicine, provided that mutual identification is clear and privacy is ensured". Article 26.6 reminds us that "the rules of confidentiality, security and secrecy shall apply to telemedicine as set out in this CDM".

Of particular relevance to physicians is Final Provision 2 of the CDM, which states that "a doctor who acts under the protection of State Laws cannot be penalized deontologically ".

Deontological response to dilemmas for military doctors. Doctors must make their ethical boundaries known to their superiors

Governments, armed forces, and others in positions of responsibility, must comply with the Geneva Conventions, to ensure that physicians and other health professionals can provide care to all human beings in need, in situations of armed conflict or other situations of violence. This obligation includes the requirement to protect medical personnel and medical facilities. Privileges and powers conferred on physicians and other health care professionals in times of armed conflict and other situations of violence, must serve only the purposes of medical care and therefore may not be used for other purposes. If, for this or any other reason, a military doctor is forced to contravene ethical obligations, they shall inform their superiors as soon as possible. The provisions of Article 33.3 of the CDM, regarding conscientious objection, would apply by analogy: the doctor must inform the person responsible for providing the service and, optionally, the College of Physicians of his or her status as a conscientious objector.

Freedom when prescribing

Physicians must be free to prescribe (Article 23) but must also strive for the greatest possible efficiency in their work and the best possible use of the resources that society places at their disposal (Article 7.4).

Freedom to prescribe is not an absolute good with no barriers or limits are recognised. In today's medicine, freedom, responsibility and competence are closely intertwined and inseparable from the scientific, socio-occupational and economic issues that are inescapable in decision-making. Freedom when prescribing also implies taking into account the economic aspects of medical decisions and introducing the financial aspect, after deciding on the best response to the patient's need. It is therefore a deontological duty to make decisions and prescribe responsibility and moderation.

It is right and necessary for the different health administrations (civilian or military) to take measures to select medicines, provided that all medicines can be exchanged or substituted have similar efficacy, safety, and quality to each other. Initiatives of this kind do not reduce the quality of care; on the contrary, by optimising pharmaceutical spending, they generate financial savings that will allow other health care needs to be met. On the basis of the deontological criteria set out under Article 23, such action does not constitute any infringement of the doctor's freedom to prescribe, let alone a risk to the safety of patients.

The military doctor's duty of confidentiality

As stated in the OMC's Manual on Ethics and Deontology[12], the physician´s medical attitude with respect to confidentiality should be such that it is considered an inherent quality of the medical profession and "one of the pillars on which the doctor-patient relationship is based", as stated in Article 27.1 of the CDM. Medical confidentiality is a duty of the professional and a right of the patient. Secrecy is of particular importance in Chapter V of the CDM and must always be borne in mind, as should the exceptions to secrecy. Article 27.1 reminds us of this when it states that medical confidentiality is one of the pillars on which the doctor-patient relationship - which is based on mutual trust - is founded, whatever form their professional practice takes. Article 27.2 defines and clarifies: "Medical secrecy obligates a doctor to maintain the safekeeping and confidentiality of everything the patient has revealed to them, what they have seen and deduced, including the content of the medical record, as a consequence of their professional practice, and that is related to the health and privacy of the patient". Article 27.3 reminds us that the fact of being a doctor does not authorise him or her to know confidential information about a patient with whom he or she has no professional relationship. Infringing this mandate is not only classed as deontological misconduct, but also a criminal offence under the Criminal Code[13]. However, in armed conflict or other situations of violence, but also in times of peace, there may be circumstances in which the patient poses a serious risk to others or to the community and the doctor will therefore have to consider his or her obligation to the patient and to others under threat.

When we consider anyone's privacy (the *interior intimus*), we refer to that which is private, and is likely known only to that person or those closest to them, their private life, thoughts, feelings, desires, ideologies, religious beliefs or issues concerning intimate relationships. Therefore, to violate that privacy is to violate human dignity. However, not respecting the privacy of a person who has been seen as part of medical practice, especially when they are wounded, ill or deprived of liberty, carries additional deontological responsibilities, as it implies disregard for their autonomy and personal freedom.

Confidentiality is understood as an attitude of respect, of silence, of secrecy on the part of a doctor who, during the privacy of medical actions, has access to the essence of the intimate or private details about certain aspects of a person's life; and this will be related to the degree of privacy

[12] Manual de Ética y Deontología Médica (Manual of Medical Ethics and Deontology) (2011). Spanish Medical Association.

[13] Heading X: Crimes against Privacy, the Right to Self-Image and the Inviolability of the Home. Chapter I on the discovery and disclosure of secrets, Article 197 of the Criminal Code. https://codigopenalespanol.com/codigo-penal-articulo-197/

or intimacy of the given fact or details. Certain private matters may be accessible to the doctor without the express consent of the patient. Confidentiality is inherent in the doctor-patient relationship and forms part of the medical obligation and, therefore, it is independent and does not require any warning to be given by the person concerned. Article 27.5 of the CDM states that a physician may not participate in any health database unless there is a guarantee that the information deposited therein will be kept confidential. This extends to any similar activity using the information contained in the medical record. Article 27.6 states that doctors may participate in epidemiological, economic, management and other studies, on the express condition that the information used therein does not permit the direct or indirect identification of any patient. Reinforcing the importance of and obligation to confidentiality, Article 27.7 requires doctors to preserve patient confidentiality in their social, occupational, and family spheres.

Article 28 of the CDM is dedicated to the care that physicians must adopt with regards to the constraints that may alter the duty of confidentiality. Article 28.5 also stipulates that the death of a patient does not exempt the doctor from the duty of professional secrecy. As Article 28.1 reminds us, this responsibility concerns in the first place the medical director of a health care facility or service that treats the patient. Article 28.2 expressly prohibits in the public presentation of cases from containing any data or information that would help identify the patient. Article 28.3 states that for the presentation of cases with images and for teaching or scientific purposes, explicit authorisation must be obtained or anonymity must be preserved.

Nowadays, medicine is practised in multidisciplinary teams and therefore information has to be shared also with non-medical professionals. In these circumstances, the data is recorded as part of the clinical records in the information system by different health and non-health professionals, even mechanically. As they all have access to this information, they are all subject to confidentiality. A very important concept arises when it comes to establishing obligations, duties and responsibilities, shared medical confidentiality and medical confidentiality derived, that arises as a consequence (14) of the assistance provided by a team, which as such can reach a diagnosis, prognosis and treatment with greater levels of certainty. The various specialist doctors, as well as nursing, laboratory, pharmacy, physiotherapy, occupational therapists, auxiliaries, medical and nursing students and so on, all have the aforementioned duty of shared medical confidentiality.

We speak of a duty of medical confidentiality arising to other professionals when access to the information is a consequence of their work of management and administration. In these situations, the conduct required of

doctors is set out in Article 29 of the CDM: “A doctor must request absolute discretion from their health and non-health collaborators, with scrupulous observance of professional secrecy”. It is the duty and responsibility of doctors, in practising of team medicine, to preserve the confidentiality of all known patient data (Article 29.2). Article 29.3 requires physicians to provide a reasonable justification for communicating confidential patient information to other doctors. No physician, by virtue of being a doctor, may have access to or knowledge of a patient’s confidential information where they do not have a professional relationship with the patient.

Article 30 of the CDM covers exceptions to the duty of secrecy. Although, according to Article 30.1, professional secrecy must be the rule, the doctor may disclose confidential information exclusively and within its reasonable limits, in the case of notifiable diseases, birth and death certificates, if silence would lead to harm to the patient or other people, to a collective danger; or where the patient would be unjustly harmed by maintaining the patient’s secrecy and the patient agrees; in the case of ill-treatment - especially of children, the elderly and mentally handicapped or acts of sexual aggression; or where the doctor is called by the College of Physicians to testify in disciplinary matters.

By law physicians are exempted from the duty of confidentiality in the injury report, that every doctor must send to the judge when assisting an injured person. Or where the doctor acts as an expert, inspector, coroner, examining magistrate or similar. Or when in the course of legal proceedings for an alleged offence in which the patient’s medical records must be provided, the doctor informs the judge that he/she is ethically bound by professional secrecy and will endeavour to provide only the information necessary and appropriate to the specific case. In any case, the ethical duty of discretion always applies in all professional activities Thus, data that are not relevant to the case, or that belong to care processes other than the one being prosecuted, or because they are not specifically requested, may be protected.

As mentioned in the Manual of Medical Ethics and Deontology (11), a specific purpose of the medical record is judicial (civil or military), where, for example, there is a complaint or lawsuit for alleged malpractice, the record becomes evidence, being the best means to be aware of the actions undertaken by the reported professional(s). In this case, it is the patient who has an interest in knowing all this data, therefore he/she relieves the doctor of the duty of confidentiality and allows data that are usually protected to be published.

Criteria for prioritising treatment

Everyone is valuable in themselves - irrespective of any other consideration. Military doctors shall treat the war wounded, civilian or

military, equally and not in accordance with the side or ideology to which they belong. They shall give due priority only to the time, circumstances and situation of each patient. Faced with the inexcusable obligation to prioritise in certain situations, doctors must consider the duty of justice that calls for a balanced, proportional, and equitable response between what they *must* do and what they *can* do. The bioethical principle of applied justice calls for prioritising interventions in population groups that will best capitalize on it. It is unacceptable to apply *a priori* exclusion on any grounds such as age, race, sex or side to which a wounded person belongs. In any case, having decided on the possible response, the doctors shall never leave any patient who needs care to his fate, even in situations of disaster or epidemic, unless he is compelled to do so by the relevant authority or there is an imminent and unavoidable life-threatening risk to the doctor's person (Article 6.2). Article 36.1 regarding end-of-life clarifies: "A doctor has the duty to try to cure or improve the patient whenever possible. Once no longer possible, the obligation to apply the appropriate measures to ensure the patient's greatest possible well-being and dignity remains, even when a shortening of life may result".

There is no specific articulation in the CDM that would be necessary to carry out. In light of the CDM, the Central Deontology Committee produced a report on prioritising decisions regarding critically ill patients during a health catastrophe[14]. In it, the following considerations were proposed:

The fundamental criterion must be based on the likelihood of each patient's survival. The following cannot be used as a means of prioritisation: the order of request for care, the order of arrival at hospital emergency departments, or the age of patients alone.

Extreme caution should be exercised if there is a difficulty of uniform application when it is the situations and resources of the different care facilities that are different. Not all clinical situations or very advanced and irreversible situations should require hospital admission. Setting short-term life expectancies is acceptable, even to avoid therapeutic obstinacy. However, setting medium-term limits, such as chronological criterion, represents a very risky decision that should be made on an exceptional basis and using the relevant assessment tools; and, under no circumstances, the clinical impression alone.

Decisions such importance must be individual and personal, because although the processes may coincide, each patient will be different. Scientific

[14] Central Ethics Committee. (March 2020) Prioritising decisions about critically ill patients in a health disaster. General Council of Medical Colleges of Spain (CGCOM). https://www.cgcom.es/notas-de-prensa/informe-de-la-coiTiision-central-de-deontolo-gia-en-relacion-la-priorizacion-de-las

knowledge is essential, but it is not sufficient to help patients to be cured or to live as well as is possible with their illnesses.

Physicians shall never abandon any patient who needs care, even in situations of disaster or epidemic, unless compelled to do so by the relevant authority or there is an imminent and unavoidable life-threatening risk to the doctor himself or herself (CDM Article 6.2).

The military doctor as an expert

The deontological regulation of medical expertise is contained in Article 62 of the CDM, which, under Point 62.1, highlights the obligation to respond to calls by judges and courts and to assist any administrations in those matters that, being within their competence, are in the common good. According to Article 62.2, under no circumstances shall this undermine the patient's rights, except in the exceptions set out in the same CDM.

Article 62.4 reminds us that doctors should not accept medical opinions for which they are not professionally qualified or if they are not prepared to defend it at oral hearing. Where required to do so, they are entitled to avail themselves of the right to object of conscience. It is important to bear in mind Article 62.5 states that "The position of expert witness is incompatible with being or having been the attending physician of the person involved ".

If the expertise requires a medical examination of the person being examined, doctors must inform patient of their identification, mission and appointment and inform them that the patient's statements may be included in the report to be drawn up and made public. If the patient refuses to be examined, the expert merely informs the person giving the order (Article 64.6). Article 64.7 requires that, taking into account the circumstances of the person being examined, the ethical rules governing examinations of any patient to preserve their privacy and modesty shall be of the utmost rigour, and shall take account of the expert witness' circumstances, given that the person being examined will be in an inferior situation compared to the expert witness. Article 64.9 reminds us that if, in the course of their work, a medical expert discovers any fact or circumstance that entails a significant risk to the life or health of the patient or third parties, they must first inform the person concerned and, and eventually the corresponding authority.

Health care information systems

In the forthcoming version of the Code of Medical Deontology, the chapter on information and communication technologies, artificial intelligence and health databases, the content of which has already been approved by the General Assembly, will have a prominent position. It will stipulate that during medical practice that entails the use of information and communication

technologies, the ethical principles of the medical profession must be respected in the same way as when medical practice does not involve the use of these systems.

The use of telecommunication systems (telemedicine, Internet - social networks - computer networks, mobile telephony and other telematic means), the same established deontological rules that govern the doctor-patient relationship shall apply as shall the defence of patient rights and safety, as well as respect for health care professionals. When using communication systems, physicians should be aware of the significance of their actions and of the direct and indirect harm they may cause, for which they must be held accountable, both deontologically and legally.

When using the Internet or other telematic systems - especially social networks and telephone messaging applications - for health care or teaching purposes, physicians must take utmost care to ensure patient confidentiality, secrecy and security, paying special attention to the privacy settings of these systems. Where health information needs to be stored on laptops or other external data storage devices, security measures should be taken encryption of files or similar measures.

The development, management and use of results from large health databases should be governed by the values and ethical principles of the medical profession, which are based on: non-identification/identifiability of individuals, privacy of individuals, with controlled access and transparency. Identification of the database management entity, whose reputation should be based on trustworthiness, honesty, transparency, etc. of the database management. It will always be contrary to medical deontology to collaborate in processes and procedures that violate human dignity and equal access. Intentional manipulation of data or results obtained from large health care databases constitute a breach of ethical duties in which doctors should never take part.

Research: prisoners as the object of study

As early as 1956, in its Rules for Times of Armed Conflict (4), the WMA included for the first time, material from Nuremberg in one of its declarations. Paragraph 3 states: “During times of armed conflict and other situations of violence, standard ethical norms apply, not only in regard to treatment but also to all other interventions, such as research. Research involving experimentation on human subjects is strictly forbidden on all persons deprived of their liberty, especially civilian and military prisoners and the population of occupied countries”.

In the case of civilian research in occupied countries or in countries where peace-keeping missions are carried out, the international standards

mentioned in the updated Declaration of Helsinki[15] must be taken into account as well as the ethical limits of medical research on human subjects, which are dealt with in Chapter XIV of the CDM. Of particular importance is Article 59.1 which reminds us: “Research involving human subjects should be done where scientific progress is not possible by alternative means of comparable efficacy or at those stages of research where it is indispensable. It is the responsibility of the research doctor to take all possible precautions to preserve the physical and psychological integrity of the research subjects. Special care must be taken to protect individuals from vulnerable groups”. The good of the person involved in biomedical research must prevail over the interests of society and science (Article 59.2). Their explicit consent must always be obtained after they have been provided with full information on the research to be carried out, including risks and discomforts. They must be informed of their right not to participate and their right to withdraw freely at any time from the research, without any prejudice (Article 59.3). All civilian and military detainees are excluded as they are not at liberty.

It is Article 60 in Chapter XV of the CDM, on torture and humiliation of persons, which states that “A doctor should never participate, support, admit or cover up acts of torture or harassment, regardless of the arguments put forward for it”. On the contrary, they are required to report them to the competent authority. It then goes on to add in Article 60.2 that “a physician shall not engage in any activity that involves manipulation of the mind or consciousness”.

The military doctor’s conscientious objection

When faced with intrinsically unjust laws and orders, it is never permissible to submit to them. The right to conscientious objection is a right that must always be exercised, because of the uniqueness and gravity of the values at stake. Conscientious objection is only such if there is a strict and insurmountable moral motive behind it, as we have already mentioned, the doctor must communicate this to his or her superiors as a deontological limit.

[15] WMA Declaration of Helsinki. Ethical principles for medical research involving human subjects. Adopted by the 18th World Medical Assembly in Helsinki, Finland, June 1964 and amended by the 29th World Medical Assembly in Tokyo, Japan, October 1975; the 35th World Medical Assembly in Venice, Italy, October 1983; the 41st World Medical Assembly in Hong Kong, September 1989; the 48th General Assembly in Somerset West, South Africa, October 1996; and the 52nd General Assembly in Edinburgh, Scotland, October 2000. Note of Clarification, added by the WMA General Assembly in Washington 2002, Note of Clarification, added by the WMA General Assembly in Tokyo 2004; the 59th General Assembly in Seoul, Korea, October 2008; the 64th General Assembly in Fortaleza, Brazil, October 2013. https://www.wma.net/es/policies-post/declaracion-de-helsinki-de-la-amm-principios-eticos-para-las-investigaciones-medicas-en-seres-humanos/.

Medical practitioners conscientious objection is set out in Chapter VI, Article 32.1, and defines conscientious objection as “the refusal of a doctor to submit, on the basis of ethical, moral or religious convictions, to conduct that is required of him or her, whether by law, by mandate of the authority (civil or military) or by an administrative decision, in such a way that to do so seriously violates his or her conscience”. Article 33.1 reaffirms that conscientious objection must always operate in a moral sense, so that acts of conscientious objection must be rejected as genuine objection if they are motivated by expediency or opportunism.

False forms of conscientious objection constitute a deception and serious deontological deficit that contribute to creating a social mistrust towards conscientious objection. Consequently, instead of being seen as social progress of tolerance and respect for individual freedoms, recognising moral identity in societies of heterogeneous principles and values that must live together in peace, conscientious objection may end up being discredited as a value and viewed an abuse and an aggression against non-objectors that would lead to its restriction. In any case, and in view of the provisions of Article 33.3, military doctors must inform their superiors of their conscientious objector status in circumstances that require it. Article 35 states that conscientious objection cannot result in any harm or advantage to any medical practitioner invoking it.

Respect. Respect for the dead

As Gonzalo Herranz[16] said, this does not refer to the polite respect that doctors owe their patients. Nor the aforementioned obligatory respect for secrecy, privacy and confidentiality of data. Nor the respect for the patient’s modesty during physical examination, or the duration of the consultation. Nor respect for the patient’s questions with an obligation to answer them politely. Instead, we are talking about the respect that leads us to admit and act with the awareness that all human beings are something valuable in themselves; that they have their own value; that they exist and decide by right, independently of us, of the observer, under all circumstances. With respect, physician recognises the unique and irreplaceable value of human life, and not only considers everyone to be equal but is committed to all patients equally, respecting their decisions. All human beings are equally valuable in themselves. As Professor Herranz states, “respect empowers and inspires physicians to respond to the highest value of every human life, with healing, preservation and rehabilitation of their patients, palliative care and confort”. It is also their duty to protect the personal values of people

[16] Herranz Gonzalo. (3 October 1985). El respeto, actitud ética fundamental en la medicina (Respect - a fundamental ethical attitude in medicine). Inaugural lecture of the 1985-86 academic year at the University of Navarra. Pamplona.

who are weakened or incapacitated by illness. This enthusiasm will enable them to defend and demand respect for the patient's decisions, regardless of the degree to which the doctor personally agrees with them, so long as these decisions are protected by law and do not contravene good medical practice.

Respect is not only sensitivity and feeling for others, for other human beings with their own identities and desires. It is above all responding, acting and deciding with respect for the human being, who has the right and capacity to make decisions on what affects his or her health and life. Doctors must always consider and respond to the patient's values and objective wishes. They must act without interfering, responding proportionately to the extent that one's own principles and values allow. As Professor Herranz said, this is not a servile response, but a reasonable, proportionate one, as far as our conscience allows. Medical respect is respect for every human being, but especially for the suffering, the needy, the weak, the handicapped, the disabled, the incapacitated for whatever reason, and especially after death. A corpse deserves the respect of that which the patient had expressed in life.

The extreme opposite of respect is inhuman or degrading treatment of a corpse, which constitutes an extraordinary moral degeneration on the part of anyone who does so - whether civilian or military. Respect for a corpse is a general principle applicable to citizens, morgues, clinical practices, laboratories and so on, that has explicit legal, ethical and deontological references and also with the recognition of the dignity of the dead person, which requires specific practices of respect for the corpse and its histopathological components. A body is not only a source of organs or tissues for transplantation, or for learning relationships and anatomical variants, it is also part of a model of relationships based on respect and recognition for other patients, their families, vulnerable people, living or dead, of respect for the humanity of which we are all a part. A body retains some of the characteristics, desires, and wills of the person to whom it belonged. It is not possible to respect the living without respecting the dead. Respect is a powerful inhibitor of selfish and opportunistic manipulation or falsification of valuable data, of selfish appropriation of the deceased.

Respect for a human being who has died cannot be dependent upon the circumstances of the time. The exaggerated individualism in our society seems to manifest itself more and more strongly every day, especially in certain economic, social and health sectors. They are concerned only with self-interest, where every rule has value as long as it offers immediacy and personal utility. In the field of medicine, doctors and those who regulate it can take proportional or similar responses to those described, which can

lead to a total objectification of a human body[17], so that the body becomes an object of interest, whose parts are considered useful products be studied, researched or replaced. The value placed on the objective shall not justify the improper treatment of the deceased human being his or her body.

Our Penal Code also covers this in article 526: "anyone who, in disrespect to the memory of the dead, violates graves or tombs, desecrates a body or its ashes or, in a spirit of outrage, destroys, alters or damages funerary urns, pantheons, tombstones or niches, shall be punished with a prison sentence of three to five months or a fine of six to 10 months".

Article 28.5 of the CDM establishes that "a doctor must maintain professional secrecy even after the death of the patient". Only that which is worthy of respect is respected. A corpse deserves respect because it possesses the dignity of a human being[18]. From the concept of dignity following a person's death stem rights and obligations towards their body, organs and tissues - including respect for the person's wishes expressed, verbally or in writing, in accordance with their beliefs. This consideration is especially important in countries and territories of different faiths and cultures from those of the occupying forces in armed conflicts or peace missions. Respect is the response to the recognition of the dignity that every individual deserves, by virtue of being human, and with it the dignity of their corpse, regardless of characteristics or attributes they may possess. A person's dignity survives death and retains rights and meanings. For doctors, the CDM is extremely demanding.

A corpse has rights that correspond to the dignity of the person and which do not expire at death and can be claimed and enforced by relatives. Any moral or physical injury caused to a corpse can and should be reported by the family, who legitimately represents the deceased. And so, we can describe rights pertaining to a corpse that do not expire and that will be exercised by the relatives, such us the rights to: physical integrity; to dispose of the corpse or its remains; respect for the deceased person's will expressed verbally or in writing; and the memory of the deceased, which includes the right to honour, image, identity and privacy.

In the case of military doctors, respect for prisoners, the affected communities, the wounded, and for corpses in general (regardless of the armed side to which they belong) is particularly relevant. For none of these

[17] Guzmán Lozano, JA, Aspectos bioéticos y jurídicos del manejo del cadáver. Un análisis del estatus mortem y su consonancia ética en la praxis (Bioethical and legal aspects of corpse management. An analysis of the status mortem and its ethical consonance in praxis) (www.uca.edu.ar).

[18] Julián Pinto B, et al. (2018). Necroética; el cuerpo muerto y su dignidad postuma (Necroethics; the dead body and its post-mortem dignity). RE- PERT MED CIR. 27(l):55-64. Reflexion-Necroetica-cuerpo-muerto.pdf (fucsalud.edu.co)

is there any exception to the medical conduct and respect for the rights expressed above, whether in times of peace or war, in international or local armed conflicts. Respect for a corpse is manifested by the preservation and protection of human remains in its integrity and in the funeral honours corresponding to the deceased's beliefs. It must be remembered that any act carried out on the corpse must have been consented to by the person while alive or expressed in a testamentary document or before witnesses. Thus, no scientific purpose, organ transplantation or otherwise, may override respect for the dignity of the deceased and the right of the deceased's lawful relatives to dispose of the remains.

The ICRC database[19] on Customary International Law (IHL) under Rule 113, Volume II, Chapter 35, Section B, on "Treatment of the Dead" states: "Each party to the conflict must take all possible measures to prevent the dead from being despoiled. Mutilation of dead bodies is prohibited" This applies to both international and non-international armed conflicts. In international armed conflicts, this decision to respect corpses is not new. It was first agreed at international level in 1907 during The Hague Convention[20] and later incorporated into Geneva Conventions I, II and IV[21], and also in the Additional Protocol of 1977[22]. Many countries, including Spain, have included measures into their military legislation to ensure respect for corpses and to prevent the dead from being stripped or robbed of their belongings.

Mutilation or ill-treatment of a corpse in armed conflicts deserves special mention, as it is considered a crime against human dignity, as covered by the Statute of the International Criminal Court and also applies to deceased persons (commentary to Rule 90)[23]. Such prohibition and criminalisation was made concrete in military manuals in many countries and under several official declarations, especially after the horrors of World War II. The obligation to take all feasible measures to prevent the dead from being dispossessed in non-international armed conflicts is set out in Additional Protocol II.

Proposed short case scenarios for deliberation

- A prisoner patient has just died in a field hospital. Less experienced military doctors attempt to perform orotracheal intubation or invasive imaging techniques to test and improve their capabilities.

[19] Customary IHL - Rule 113. Treatment of Deceased Persons (icrc.org)

[20] Hague Convention (X) (1907), Article 16 (ibid, Paragraph 125).

[21] 1st Geneva Convention (1949), Art 15, first paragraph (ibid, Para 126); 2nd Geneva Convention (1949), Art 18, first paragraph (ibid, Para. 127); 4th Geneva Convention (1949), Art 16, second paragraph (ibid, Para 128).

[22] Additional Protocol I (1977), Art. 34, Para. 1 (adopted by consensus) (ibid, Para 59).

[23] Elements of ICC Crimes (2000), Definition of committing outrages upon a person's dignity as a war crime (ICC Statute, footnote 49 to Art 8(2)(b)(xxi)).

- A group of soldiers take photos of themselves next to the bodies of those killed in combat, which are ready to be placed in their coffins, and upload the image to social networks.
- A military medical pathologist has over the years built up his own collection of anatomical specimens to be used for teaching purposes.

Chapter 3

DECISION-MAKING IN ETHICS

Diego Gracia Guillén

Abstract

The experience of “duty” is universal in the *human* beings. The purpose of ethics is the analysis of this experience and the development of procedures in order to ensure that our *choices of duty* are correct, *To* do this, first it is necessary to start by making a detailed analysis of the “facts” of the case, secondly, identifying the “values” involved in the decision to be taken *and*, thirdly, looking for the different possible courses of action, Our “duty” coincide always with the optimal course of action, which is the one that promotes the most or harms the least the values at stake, The procedure to do this correctly is *called “deliberation” and* its term is “*prudence*”, Such is the goal of an proper moral education.

Keywords

Ethics, deliberation, prudence, excellence, ethical training of military doctors.

Introduction

Human acts are planned acts. We plan to go to see a friend, go for a walk, study, etc. When a human act is not planned, where it is merely automatic, or takes place without our foreseeing it (e.g.: an earthquake, an unforeseen event, etc.) we are not responsible for it, nor can the act be considered moral. Moral acts are only those that are planned. And there is always a moral moment in the planning. It is that moment when we ask ourselves whether or not what we are planning *should* be carried out. This is the specific point of ethics, the question of duty: what we should or should not do.

Because people need to continually plan actions and make decisions all the time, the question of duty is one of the fundamental ingredients of human life. It will not occur in the mind of a young child, or a person suffering from severe dementia. However, once a certain degree of mental maturity is reached, the experience of duty arises immediately and naturally in all human beings. Thus, we begin to ask ourselves about what we should or should not do, or what we have done but should not have done, and so on. Analysing this phenomenon and educating people to make the right decisions in the area of duty is the subject of ethics. The aim is to answer the question of what should or should not be done or, in other words, what decisions we should make at any given moment.

Facts and values

Whether something should or should not be done always depends on the *content* of the project or plan. And this content is always and necessarily composed of two factors or elements - namely, the "facts" and the "values"[1]. Every project necessarily contains these, because they always occur together. The division between them is made for simple practical reasons, because it helps us to better analyse them. But in the plan or project, they always go together. For example, If I plan to build a house, I will have to include in the project matters of fact (for example, whether I have the building materials that I need for the project). But I will also necessarily include questions of value (for example, am I building the house to live in it comfortably, or to sell it and make money). The latter is a financial value, whereas the other is a vital value of well-being, of comfort. Nobody would build a house if it wasn't for a reason. And their motives are always of value.

[1] Gracia, D (2003). Facts and values in medical science and practice. In: Baca, E and Lázaro, J (eds). Hechos y valores en psiquiatría (Facts and Values in Psychiatry). Madrid, Triacastela, pp 43-70. Gracia, D (2008). Constructing health: facts, values, duties. In: Sanfeliü, I. (ed). Sujeto encarnado, sujeto desencarnado: estudios psicosomáticos (Incarnated Subject, Disembodied Subject: Psychosomatic Studies) Madrid, Biblioteca Nueva, pp. 103-130.

Value is what motivates us to do things - that is, carry out projects and turn them into reality[2]. We always act for the same reason - to *add value*, as economists say. The thing is: the value we seek to add is not solely financial. There can be many others: the value of life, the value of health, the value of friendship, and so on. Values are the *engines* of human life. Facts, as Aristotle already intuited, do not move to action. Facts are what they are, and nothing more. It is values that drive action. This is obvious in the case of financial value, but it can and must be said of all the others[3].

Duty

From this brief description of the topic of facts and values, we can now define the category of *duty* somewhat more precisely than before. Human duty always consists of the same thing: of "adding value" to reality, promoting the realisation of positive values (life, health, well-being, pleasure, love, friendship, wealth, etc.) and preventing the realisation of contrary values (death, illness, discomfort, pain, hatred, enmity, poverty, etc.). This is our only duty: the promotion of positive values and the removal, as far as possible, of negative ones[4].

What has been discussed so far is elementary, and therefore not usually the subject of much discussion. Every human being can verify this by reflecting on his or her own experience. The problems begin when, based on this elementary and unquestionable description, we take it into the real world. Because then we are faced with a number of factors that complicate decision-making. One of these factors is that there is usually not just one value at stake, but several, and they are often at odds with each other. If we walk down the street and see a person being assaulted, or robbed, we all know what our duty is: to help the person in need and prevent a value from being harmed, be it justice, physical integrity, life, or any other value. No special knowledge of ethics is required for this.

The problem is that, in the examples above, these are not the only values at stake. When two people quarrel, we all know that it is our duty to promote peace. What often inhibits us from doing so is the fear of being

[2] Gracia, D (2015). La construcción de los valores (The construction of values). In: Academia Chilena de Medicina, Reflexiones sobre Bioética (Medical Academy of Chile. Reflections on Bioethics). Santiago, Medical Academy of Chile, pp 65-105. Gracia, D (2016). Values and Bioethics. In: Sema, P and Seoane, JA (eds). Bioethical Decision Making and Argumentation. Switzerland, Springer, pp 17-29.

[3] Gracia, D (2013). Valor y precio (Value and Price). Madrid, Triacastela.

[4] Gracia, D (2015). Hechos, valores y deberes en la toma de decisiones clínicas (Facts, Values and Duties in Clinical Decision-Making). In: Medical Academy of Chile. Reflexiones sobre Bioética (Reflections on Bioethics). Santiago de Chile, Medical Academy of Chile, pp 229-261.

hurt or killed, etc. In other words, what we fear is that our intervention will not only fail to resolve the conflict but will complicate it, since now not only the value or life of the victim may be at stake, but also that of the party involved in the conflict.

Conflict and unrest

Here, we uncover one of the problems posed by the world of value: its "conflictual nature". It is an exceptional situation where only one value is at stake in a human situation. Several values are generally involved, and they are also often incompatible with each other. For example, in the situation given above, there is a conflict between protecting my life and protecting the life of the person being attacked, if feek that by intervening I would be put my own life at risk. This is not an exceptional case.

Conflict is always present in the world of values and constitutes one of its fundamental aspects. Let us take a medical example. To save one value, life, the surgeon tells a patient that he must remove his tumour. But these values (life and health) may conflict with others, such as the patient's autonomy, or with his or her religious beliefs - for example, with Jehovah's Witnesses who are unwilling to sign the consent form for blood transfusion if necessary. This is what happens in real life, values clash. And it then becomes difficult, sometimes very difficult, to know what *should* be done. Duty is inseparable from value.

Even though concrete decisions may be difficult and complex, and even though we may make mistakes in making them, the general principle is crystal clear: our moral obligation is always the same - namely, to promote as far as possible the realisation of positive values, and avoid harming them (promoting negative values). Every positive value has a negative counter-value. If there is life, there is death; if health, sickness; if justice, injustice; if solidarity, lack of solidarity; if peace, war; and so on. Moral duty obliges us to promote as far as possible the bringing about of positive values, life, health, justice, peace, and so on, and avoid bringing about negative values, death, disease, injustice, war and so on.

Circumstances and consequences

The general principle described above is very simple, but its practical application is somewhat more complex. This is because values are abstract, but their realisation depends on specific situations, such that in order to know what we *should* do, we need to include in the equation two elements that we have not analysed so far: the *circumstances* of the case and the foreseen possible *consequences*. To continue with the above example, the surgeon should perform the best operation he or she can. And he should do

so not in an abstract way, but taking into account the circumstances of the case and the foreseeable consequences. Operating in the Mayo clinic is not the same as operating in a field hospital, or in a time of peace as opposed to a situation of war, or on a Jehovah's Witness as opposed to someone who is not, and so on.

The problem with circumstances and consequences is that we can never really know them exhaustively and accurately. When it comes to consequences, this is obvious, since these are future events for which our ability to foresee and predict is always very limited. And in regard to circumstances something similar happens, because the human mind is not capable of exhausting the circumstances of any act, however elementary it may be. When driving a car on a road and trying to overtake a lorry, you have to take into account the main circumstances: the length of the lorry, the distance of the vehicle in front, etc. However, we will never be able to take into account all the circumstances that could affect our decision. For example, we cannot know whether the truck driver will fall asleep, or swerve, or have a heart attack, or have a tyre puncture, or whether our own car will have a puncture, and so on. No matter how hard we try, we can never be absolutely sure that we will overtake the truck.

All we can do is to take into account the factors that are statistically most likely or most risky. That is why our decision can never aim to be *certain* but instead only *prudent*. Moral decisions, decisions of duty, are always of this kind: prudent or imprudent. And prudence is about making the right decisions under conditions of uncertainty, as human decisions always are. When we overtook the lorry at great risk, because the oncoming car was very close, we say we were reckless. Hence, our moral obligation is not to get it right or wrong, but to be prudent. Even when trying to be cautious, we can still end up killing ourselves when overtaking the truck. Conversely, when acting recklessly, we still might not end up killing ourselves. That is the reality. However, our moral obligation is not to *not* kill each other, but to be prudent. That is our "duty"[5].

Deliberation

Prudent decision-making requires education and training. Prudence is taught. And the process that seeks prudent decision-making is called *deliberation*[6]. Deliberation is the process, and prudence is the term. Impulsive,

[5] Gracia, D (2019). Minimal bioethics. Madrid, Triacastela.

[6] Gracia, D (2003). Ethical case deliberation and decision making. Medicine, Health Care and Philosophy. 6:227-233. Gracia, D (2011). Deliberation and Consensus. In: ChadWick, R; Ten Have, H and Meslin, EM (eds). The SAGE Handbook of Health Care Ethics. London, SAGE Publications, pp 84-94. Gracia, D (2016). Deliberation. In: Then Have, H (ed). Encyclopaedia of Global Bioethics. Switzerland, Springer, pp 813-818.

immediate, spontaneous, reflexive, undeliberate decisions are often unwise. Doctors, and especially psychiatrists, are well aware that there are many factors in our psyche that work against prudence. Uncertainty always generates fear, anxiety, and this triggers what Freud called “ego defence mechanisms”, the first of which is denial, which prevents us from seeing reality as it is and thus severely distorts our decision-making process. Only through training and education can the anxiety of uncertainty be managed and prudent decisions made. This should be taught from primary school onwards, but is conspicuously absent from our educational curricula. Hence the importance of sessions in which training is given in deliberative skills, so that we know how to make decisions that are as unbiased and mature as possible. Particularly when we have important decisions about other people’s lives in our hands - as is the case in medicine and military practice[7].

A very important aspect of the pursuit of prudence is learning and applying a method before making any important decisions. This is something that is now fundamental in all important activities in life today. Pilots have to follow a strict protocol before taking off in an aircraft, as do doctors who perform surgery or give cancer treatment. Protocols are fundamental to decision-making - both technical and ethical - if only because anything technically wrong is, by definition, ethically wrong. Only a protocol can advise on the optimal course of action in a complex case, and therefore what can be considered ethically correct[8].

Protocolising the taking of decision

Making an ethically correct decision requires the following steps, which follow the order of facts, values and duties described above:

[7] Gracia, D (2001). La deliberación moral: el método de la ética clínica (Moral Deliberation: The Role of Methodologies in Clinical Ethics). Med Clin (Barc). 18:30297-6 Gracia, D (2001). Moral deliberation: The role of methodologies in clinical ethics. Medicine, Health Care and Philosophy. 4(2):223-232. Gracia, D (2001). Moral deliberation. Bulletin of the Chilean Academy of Medicine. 38:29-45. Gracia, D (2004). La deliberación moral: el método de la ética clínica (Moral Deliberation: The Role of Methodologies in Clinical Ethics). In: Gracia, D and Judez, J (eds). Ética en la práctica clínica (Ethics in Clinical Practice) Madrid, Triacastela, pp 21-32. Gracia, D (2011). Teoría y práctica de la deliberación moral (Theory and Practice of Moral Deliberation). In: Feito, L; Gracia, D and Sánchez, M (eds). Bioética; el estado de la cuestión (Bioethics; the Status of the Matter). Madrid, Triacastela, pp 101-154. Gracia, D (2013). Deliberative pedagogy. In: Blanco Mercadé, A and Nüñez Cubero, Maria P (eds). Bioethics and the art of choice. León, Association of Fundamental Bioethics and Clinic (ABFyC), pp 165-185. Gracia, D (2018). La deliberación y sus sesgos (Deliberation and its biases). Boletín de estudios de filosofía y cultura Manuel Mindán, Calanda (Bulletin of Philosophy and Culture Studies Manuel Mindán, Calanda) XIII, pp 13-25.

[8] Gracia, D (2011). Deliberation and Consensus. In: Chadwick, R; Ten Have, H and Meslin, E (eds). The SAGE Handbook of Health Care Ethics. London, SAGE Publications,

Part 1: Deliberation on the "facts"
1. Presentation of the clinical case
2. Analysis of the clinical aspects of the case (diagnosis, prognosis, treatment).
Part 2: Deliberation on the "values"
3. Identification of the ethical issues involved
4. Choice of the ethical problem to be deliberated
5. Identification of the conflicting values that form part of that problem
Part 2: Deliberation on the "should"
6. Identification of extreme courses of action
7. Search for intermediate courses of action
8. Choice of optimal course(s) of action
Part 4: Consistency testing of optimal courses.
9. Legality test: is the course of action that you have chosen legal?
10. Publicity test: would you be willing to defend your chosen course publicly?
11. Time test: would you make the same decision if you could delay it by a few hours or a few days?
Final decision

The correct application of a protocol[9] requires knowledge, but also training. Each point in this table requires a detailed analysis which clearly cannot be conducted within the constraints of this article. For example, Part 1 - "Deliberation on the facts" comes to be identified with what doctors are used to doing in the course of any clinical session. The subsequent parts should be seen as an extension of the method of the clinical session, in which the analysis is extended from clinical facts to the values at stake and possible courses of action, as befits what should be called a clinical ethics session. This is also the work of the so-called Clinical Ethics Committees (CEC)[10]. For further details, it is useful to review some texts that are complementary to this one.[11]

[9] Gracia, D (2020). Ética médica (Medical Ethics) In; Rozman, C (ed). Medicina interna (Internal medicine), 19 ed. Barcelona, Elsevier. Vol 1:29-36.

[10] Gracia, D (2003). Teoría y práctica de los comités de ética (Theory and Practice of Ethics Committees). In: Martínez, JL (ed). Ethics Committees. Bilbao, Desclée de Brouwer/Universidad Pontificia Comillas, pp 59-70.

[11] Gracia, D (1997). Cuestión de principios (A matter of principle). In: Feito Grande, L (ed). Estudios de bioética (Bioethics studies). Madrid, Universidad Carlos III/Dykinson, pp 19-42.

From Protocols to Concrete Decisions

We have already said that anything technically wrong is, by definition, ethically wrong. This is a basic principle that we must never forget. But having stressed its importance, it should be noted that the reverse is not true, and therefore not everything that is technically correct is ethically good. This is the second principle that must not be forgotten. Protocols determine what is right "in general". However, this does not preclude that in particular cases it is not correct. We must add moral correctness to technical correctness, such that the decision is not only technically correct, but also ethically good. How good a decision is, is always specific, concrete.

There are concrete, very specific, situations in which the assessment of the circumstances of the event in question and the foreseeable consequences of our decision render it necessary to make an exception to the rule, or to the general criterion. The fact is that "right" in general is not always, and not in all circumstances, "good". This is why in the procedure described above, Part 3 refers to "courses of action" - characterised by the fact that they are always concrete, circumstantial and need to be identified every time we seek to make a morally good decision. Values are always abstract (life, health, autonomy, justice, etc.), but when two or more values conflict in a concrete situation, in order to make the right decision we have to start by identifying the different possible courses of action.

This is not an easy work and it requires education and training. We often oversimplify the analysis of courses of action and this leads to poorer decision-making. This leads us to reduce all courses of action into two categories: extreme and potential intermediate courses (which are take a secondary priority). The human mind is more capable of seeing black and white than the range of greys. The problem is that the intermediate courses of action are often the optimal ones, as they seek to bridge the multiple conflicting values, as opposed to just one of them.

The right decision will always coincide with the optimal course of action - namely, that which promotes or brings about most of the values at stake, or harms them the least. The optimal course of action is nearly always an intermediate one. This is what Aristotle meant with his rule of *mesotēs*, and the well-known Latin proverb: *in medio virtus*, virtue is in the middle, not in the extremes. Our moral obligation always demands that we seek and choose the optimal course. In ethics, any decision other than the optimal one is a bad one.

High and low moral

The Spanish language has expressions that have been attracting the attention of philosophers for a long time. Spaniards say that someone has

"very high moral standards", or has "low moral standards". As a paradigmatic example of the importance of the former in human life, the example is given of the fighting spirit shown by a modest football team - Alcoyano - which fought to the end, generally without success, when competing against the big teams.

Whether or not what is attributed to Alcoyano is true, it is a fact that high moral standards are essential for individual and collective fulfilment in life. This is especially so when human beings feel compelled to give everything they can and more - even when they are about to be defeated, as is the case in some of the situations we call heroic. We are witnessing it right now in the way Ukrainian society is acting - and most particularly among its military corps. An army with low moral standards will never be able to win a battle. Nor will an individual be able to give all that he or she can and should.

Today this has been given the technical name of burnout - a veritable epidemic, not only in the case of individuals but also in the case of groups and communities that are essential to the proper functioning of society. One example of this is the worrying increase in burnout among professionals such as doctors.

The burnout theory is something very recent. However, some things are already crystal clear. One is that burnout is highly correlated with vocation. Some professions such as the priesthood, medicine and the military are highly vocational[12]. They all require "high moral standards". Without them, they become impossible. These are activities at odds with mediocrity. They demand all or nothing. And when a person's life is affected by the demands of everything, "burnout syndrome" appears, and it is highly contagious and spreads like an epidemic[13].

The goal of ethics is excellence. This is why it has so much to do with *vocation*[14]. This term comes from the Latin *vocare*, meaning to call. Vocation is that inner call that says, or at least whispers, not what we want to be, but what we *have* to be, such that if we do not achieve it, we will consider

[12] Far, SB and Korhan, O (2023). Role of Occupational Burnout Among health care Professionals: A Systematlc Revlew. In: Callslr, F (ed.) industrial Engineering In the Age of Business intelligence. GJCiE 2021. Lecture Notes in Management and Industrial Engineering. Sprlnger Nature Swltzerland AG. https://dol.org/10.1007/978-3-031-08782-0_23

[13] Gracia, D (2004). Medice, cura te ipsum; sobre la salud física y mental de los profesionales sanitarios (Medice, Cura Te Ipsum; On the Physical and Mental Health of health care Professionals). Madrid, Real Academia Nacional de Medicina (Spain's Royal Academy of Medicine).

[14] Gracia, D (2010). Vocación y ética (Vocation and Ethics). In: Marañén; Physician, humanist and liberal. Madrid, National Society of Cultural Commemorations (SECC), pp 115-131.

ourselves failures. Ortega y Gasset said that the voice of vocation calls from the deepest part of each person, which he called the "unbribable depths", so that only by being faithful to it can we consider that in this life we have been what "we were meant to be".

And this is what Ortega considered the best possible definition of ethics. It is said, Ortega continued, that ethics is about what "ought to be". But what it is really about is "*having* to be", because *ought* to be is generic: it tells us what should or should not be done in general. On the other hand, *having* to be is individual, concrete and non-transferable, and obliges us to do at each moment that which is imposed on us as a moral imperative[15]. A good example of this is the character of Don Quixote de la Mancha[16]. Cervantes' account says that he was a good person, appreciated by his neighbours in the village of La Mancha where he was born and lived. At the end of the book we learn that in his homeland he was called "Alonso Quijano *the good one*". He seemed to comply with all moral and social norms, as a good citizen. His conduct was irreproachable from the perspective of "*ought* to be".

But at a certain point, around the age of 50, when people reach what Dante called *il mezzo del cammin* and, looking back, they judge the distance they they look back and assess the second and final part of their lives, it seems that Don Quixote was not very satisfied with himself, even though he had punctually fulfilled the dictates of his "duty to be". Then he realised that it had not been "what it was meant to be", and that this was his last chance to make it happen. And after arming himself as a knight-errant, he went out into the fields of Montiel to undo wrongs, redeem captives and protect maidens. What others, including the priest, saw as madness, was nothing more than an attempt to faithfully fulfil his own calling and to be, no longer what others thought he should be, but instead what a voice was telling him, from the depths of his unbribable depths, that he "*had* to be".

Don Quixote went to the fields of Montiel out of pure ethical coherence. Otherwise, he would not have been able to look at himself without feeling shame. And in doing so, he gave us an example of the "high moral standard", even though being true to oneself requires countless sacrifices, and even death. Everyone *must be* what he must be. Even if it means heroism or brings death.

[15] Ortega y Gasset, J (2006) Pidiendo un Goethe desde dentro (Asking for a Goethe from Within). In: Complete Works, Volume V. Madrid, Taurus, p 130.

[16] Gracia, D (2007). Meditación del Quijote (Meditation on Don Quixote). In: Association of Fundamental Bioethics and Clinic (ABFyC). La bioética, tarea de humanización (Bioethics, a Task of Humanisation). Madrid, Association of Fundamental Bioethics and Clinic (ABFyC), pp 37-60.

Case studies

Having established and clarified the procedure, it is perhaps useful to look at some practical cases to see it in operation and to add some concrete recommendations to what has already been said.

An initial case study has to do with the role of the armed forces themselves. Let's consider a war situation. It is useful to imagine it in concrete circumstances, because these are the only real situations. In the abstract, we are all pacifists and believe that in an ideal world there should be no wars and therefore no armies. The fact is that they have existed since the birth of mankind, and therefore seem inherent to the human condition itself. How can the judge the morality of war given that it violates fundamental human values such as life, health, well-being and so on?

If, according to the principle we have established above, ethics consists in the promotion of positive values and the avoidance of negative ones, it is clear that our duty can only be to promote peace, not war. From this we can already draw a first conclusion - one that is classic in the annals of ethics: offensive wars are much more difficult to justify morally than defensive ones. Nobody can start damaging the values of others, unless they have a very strong justification, which must be of value. In principle, and apart from exceptional cases, this means that offensive wars should be considered immoral.

When it comes to defensive wars, there is a clear conflict of values. War is waged to prevent the injury of a positive value, be it life, peace, territorial integrity or whatever. In a defensive war, these positive values conflict with other values, such as the lives of the invaders, which we are also obliged to respect. It goes without saying that all these conflicting values cannot be respected at the same time, because defending some of them may lead to harming others. This is what in technical language is called "tragedy" - the violation of values that we cannot avoid. When faced with tragedies, the moral duty is not to ignore them (which would lead to many more values being damaged) but instead to minimise their damage as much as possible. The optimal course, which is the only one that can be considered ethically correct, is always the one that optimises the promotion of positive values or minimises the violation.

Collective decisions

Another classic problem is that of collective decisions. This is as true in medicine as it is in the military. Think, for example, of a surgeon performing an operation, or an intern prescribing treatment. Their decisions affect a larger or smaller group of people, which in the case of a surgical operation will be everyone involved in the surgery, and in the case of a military

operation, everyone who takes part. In both cases, decisions are made by those who have the authority to decide and command others, meaning that others should, in principle, obey them.

There is a specific ethic of those who have command functions. This is what is known in the literature as the *Captain of the Ship* Ethics. But there may be situations where the general rule that one has the duty to give orders and others to obey is not sufficient. This is the case, for example, when the person in charge clearly makes a wrong decision. It might be thought that subordinates are required to obey blindly, even if they have good reason to consider the decision to be clearly wrong. This is the doctrine of *blind obedience*, which has a long tradition in history. Ethically, such an attitude is indefensible. If a subordinate has good reason to believe that the decision taken is clearly wrong, their first obligation is not to obey it but to bring the case to the attention of their superiors in order to correct the decision and thus avoid harming positive values that such a decision would cause.

Conscientious objection

It may also be the case that the superior's decision is not considered wrong, but may be unacceptable to a particular person because of his or her personal system of values and beliefs. This is a conflict that has been resolved in the last half century, since the Second World War. Before that, any conscientious objection was treated as an act of disobedience to authority and punished very severely, including with life imprisonment. From that date onwards, what is now known today as conscientious objection began to take shape - a principle accepted and respected by virtualy all democratic law.

In fact, the Point 1 in Article 30 of the Spanish Constitution of 1987 states that "Spaniards have the right and duty to defend Spain", while Point 2 adds that "the law shall establish the military obligations of Spaniards and shall, with due guarantees, regulate conscientious objection, as well as other causes for exemption from compulsory military service, and may impose, where appropriate, an alternative social service".

The conscientious objection provided for under the Spanish Constitution relates to military service - undoubtedly because it is the one that was of most concern at the time when the constitutional text was drafted. Today, given that membership of the armed forces is voluntary, and not compulsory as in the past, conscientious objection is restricted almost exclusively to the health care sector - in particular since legislation was enacted decriminalising abortion and euthanasia.

The response of health care professionals to these laws has generally been one of rejection, refusing to participate in acts that directly threaten

the lives of foetuses, embryos or human beings. It is a curious fact (as was once the case with conscientious objection to military service) that most objections raised are not really objections, since they are not *conscientious* objections, which are the only ones protected by law. Many pseudo-objections are hidden under the umbrella of conscientious objection and are made not out of reasons of conscience but out of ignorance, convenience, to avoid what people will say, and so on. It goes without saying that genuine conscientious objection is perfectly respectable from an ethical point of view, but that pseudo-objections are not. And experience shows that they are the most numerous[17].

The conflict between ethics and law

There is one final conflict that needs to be highlighted. It occurs with a degree of frequency between ethics and law. Law, especially that which most directly relates to the value of life - criminal law - does not generally refer to what must be done but what must *not* be done because it is forbidden. The function of law is not to tell people what they must do but what they *must not* do. In this, it is clearly different from ethics. To use a football metaphor, we could say that the law is expressed in the rules, which prohibit handballs, offside, and so on. It establishes the minimums that are essential for the simple act of kicking a ball to class it as a football match. However, the regulation cannot and should not say more. By following rules, you can play football like Messi, like Ronaldo or like someone with no skills at all.

Well, the aim of ethics is not simply to follow the rules, but seek the optimum result, and allow each player to play his or her best football. This has led to the popularisation of terminology which in principle has to be considered incorrect. It distinguishes between "ethics of minimums" and "ethics of maximums". Law would be the ethics of minimums and Ethics (with a capital E) would be the ethics of maximums. The problem with this dichotomy is that it makes people think that what is important is to first meet the minimums because the maximums are considered to be for those who aspire to excellence. This is a complete mistake. Firstly, because the so-called ethics of minimums is not ethics as such, but law. And secondly, because in ethics there is always an obligation to aim for the maximum - that is, the optimal course of action, as we have already seen. All ethics are necessarily ethics of maximums.

A surgeon who does not perform the best surgical operation that surgeons are capable of performing in the particular circumstances in which

[17] Gracia, D and Rodríguez-Sendín, JJ (2008). Ética de la objeción de conciencia (The Ethics of Conscientious Objection). Madrid, Organización Médica Colegial/Fundación de Ciencias de la Salud. https://www.fcs.es/ lista-publicaciones/11-etica-de-la-objecion-de-conciencia

they find themselves is not a “good surgeon”. Similarly, a judge who does not give the best possible verdict is not a “good judge”. In ethics, anything less than optimal is bad.

The issue of excellence

The conclusion of this whole chapter is that ethics is not concerned with what is good but with what is optimal, because any sub-optimal course of action in a given situation is bad. These days, in the literature this is expressed by the term “excellence”. Ethics is about excellence, and moral training and education and seek nothing more than to promote excellence in human decision-making. Not just in the decisions of those with high responsibilities like doctors and the military, but in the decisions of every human being.

In fact, the ethics of excellence have been promoted most by neither of these two groups but instead by another group in which the issue of ethics was supposed to be of lesser importance - that is to say: business theory. In 1982 a book was published that soon became a bestseller: *In Search of Excellence*. Written by two business school professors, Tom Peters and Robert H Waterman, the authors explain why they wrote it and the vicissitudes of its development[18].

What Peters and Waterman do not explain in their book is why doing things well, or in the best possible way, should be called “excellence”. They could have used other terms, such as “good” or “optimal”. But the term excellence has a tradition that makes it indispensable - at least in Western culture. There is a text by Aristotle that says: “the excellence of the horse (*híppou areté*) is what makes it good and enables it to run, carry the rider and face enemies”[19]. In this very modern translation, *areté* has been translated as *areté par excellence*. But this was not the normal translation over the centuries.

In fact, the classical medieval translation by Willem van Moerbeke reads: “equi virtus equum studiosum facit, et bonum ad currendum, et ferendum assesorem, et expectandum bellatorem”. The Greek term *areté*, which is the physical ability to do something well, was translated into Latin as *virtus*, virtue. It was a poor translation, if only because *virtus* derives from *vir*, male, which has its counterpart in the Greek *anér*. Virtue derived from this root is *andrefa*, bravery, virility, courage, meaning that *virtus* should have been reserved for translating *andrefa*, rather than *areté*. This was not the case and this is a source of continuing confusion. For example, the text transcribed above from Aristotle should be translated as: “the virtue of the horse is

18 Peters, T J and Waterman, RH (1994). In Search of Excellence. Barcelona, Folío.

19 Aristotle. Ética a Nicémaco (Nicemachean Ethics). I 6: 1106 to 18-20.

what makes it good and enables it to run, carry the rider and face enemies". But anyone would realise that to call a horse "virtuous" is to apply to it a qualifier that belongs only to human beings. Hence the modern decision to translate *areté* not as virtue but as excellence, because then the phrase takes on its full meaning: an excellent horse is one that runs a lot, carries its rider and faces its enemies.

This small philological disquisition helps us understand why the concept of *excellence* is so important in ethics today. On the face of it, this is nothing new, as it is already found in the Greek philosophers. Ethics seeks excellence, which is the ability to do something well, or more precisely, the ability to act optimally. As we have already said, this is precisely what ethics is all about: choosing the optimal course of action in every circumstance, because all other options are by definition bad. It therefore follows that ethics is the theory of excellence.

This can be found in the founding texts of Western ethics, and therefore is over 2000 years old. It was rediscovered a few decades ago by the authors of management theory and has now become a key category in their doctrine. A good business manager is one who gets his or her workers and employees to excel as they make excellent products of whatever type (screws or houses). This is the so-called theory of business excellence, and it is something we can only welcome it. But it is curious, and somewhat humiliating, that the theory of excellence has emerged from the world of business management, while in areas as important as medicine (where one is managing not screws but people) its influence has been minimal - at least until now.

Excellence and ethics

Ethics is identified with the pursuit of excellence. Contrary to what has been said over the centuries - that a moral life consists in fulfilling, however reluctantly, the basic *precepts*, and that the pursuit of *perfection* is for a very ambitious or highly select few - it needs to be strongly emphasised that ethics always demands the maximum, because in any given situation we must always make the best possible decision. Any other decision is, by definition, bad.

This is true for every human being and in every kind of decision-making, but especially so in areas like medicine and the military, where human values and cherished possessions are at stake. Here, too, philology and history can tell us something. Let us return to the Greek term *aretée*. When it functions as an adjective, it allows different levels: the positive, the comparative and the superlative. The positive is, precisely, *aretée*. That which is comparative is *areíon*, which in Greek means better, superior, braver. And that the

superlative is *arístos* - the best, excellent, and optimal. It goes without saying that, from this superlative derive terms common in our language, such as “aristocracy”, the meaning of which is that the power of government should be in the hands of the best along with, by extension, the power to make decisions that affect the lives of individuals and societies.

This applies directly to the areas we are dealing with here: the military and medicine. The only ethically correct decisions are those that are optimal, excellent. But this is true for any human decision, and particularly true to professionals whose decisions affect people’s lives. For such professionals, anything less than excellence is not just bad, but *very bad* - both for the individuals concerned and for society as a whole. They are rightly called professions of excellence.

Faith, hope and love

When Peters and Waterman conducted their study on why some companies were successful and others were not, they concluded that a key factor was the way in which they were managed - not in terms of the factual issues (organisational routines, protocol compliance, timekeeping, etc.), but the question of value. Things worked well when the management of values was right. For the latter, it was essential that people had a very positive appreciation of what they were doing. A person who does not do their work with enthusiasm cannot work well or be excellent at it.

As this seems to be a feeling or state of mind that is difficult to control, perhaps it would be a good idea to make it concrete (as proposed by Laín Entralgo) by referring to the classic three theological virtues: faith, hope and love[20]. Not just theological virtues, he said, but also human virtues, and of course also occupational virtues. He or she who does not “believe” in what they are doing cannot live well or work well. Faith is fundamental in life in general, and in professions in particular. Believe in what you do. And along with that, *hope* that in so doing they are contributing to increasing the value of human society, to making the human species a little better. This is the virtue of hope, without which it is impossible to initiate any project, however small or humble.

And above all, *love* is necessary. You have to love what you do, and do it as diligently as possible. *Diligo* is the Latin verb for to love, though it is not the only one: others, such as *amo*, also means to love. But there is a very noticeable difference between them. In loving, one is enriched by what is loved. Hence, love always has a certain selfish aspect. Diligence however is completely different - to the point of being the opposite. Diligence leads

[20] Laín Entralgo, P (May-June 1983). Creencia, esperanza y amor (Faith, Hope and Love) Cuenta y razón, 11, pp 29-41.

to giving, not receiving. It is given for the very value of giving and for the value of what is given. There is a selfish love, but there is a selfless, creative, diligent love. Diligent love creates value, increases value through what it does, however humble, or even insignificant, it may be.

High moral standards and professional ethics

Faith, hope and love. This is the only way to strive for excellence, which, as we know, is the goal of ethics. The result is what is known in our language as the "high moral standards", as discussed earlier. There are people with high moral standards and others with low moral standards. The pursuit of excellence demands the former. A search that is not optional among humans, but is obligatory. This is our duty, our only duty. All other duties flow from it. And with them, our own condition as human beings.

Chapter 4

ETHICAL PERSPECTIVES OF HEALTH ASSISTANCE IN PLANNING, CONDUCTING AND MONITORING OPERATIONS

David Cobo Prieto

Abstract

The aim of this chapter is to expose the ethical dilemmas *perceived in* the performance of the Spanish military health during military operations, both in its internal *projection (support, evaluation and* psychobiological training of its forces or treatment of prisoners) and *external (assistance and* support in disasters, humanitarian aid and promotion of stability and security).

This approach is based on the perspective that gives the universality of ethical principles while exploring the orientations that the countries around us offer *to resolve* these problems. The analysis takes into account the different individual, group or institutional responsibilities limited or not to military health. A systematized approach, offered by programmed *training* and the creation of structures of analysis and support in military health ethics in operations, is considered a valuable tool for decision-making in this field.

Keywords

Ethics, military health, responsibility, values, ethical principles, health care, humanitarian aid, personal autonomy, military operations.

Introduction

To round off this paper, we thought it would be interesting to follow up on the chapter that Torres León dedicated to ethics in the practice of military medicine, with a perspective focused on health care ethics related to military operations.

In the exercising the health care function, the application of universal ethical principles is combined with the need to incorporate values and idiosyncrasies based on belonging to a certain type of society[1], respect for human rights, and the necessary harmonization with the specific organizational model of Spanish military health care. With the help of the experience offered by the approach to health care ethics adopted by our neighbouring countries[2], a perspective is presented on the experience of the Military Medical Corps in operations, in relation to ethical conflicts and the initiatives that could be taken to facilitate the practical management of conflicts in this field.

Principles and values

In Chapter 3 of this paper, Gracia Guillén offers us an approach to the field of health care ethics, based on respect for human dignity and a method that serves as a model for the self-regulation or evaluation of ethical behaviour. From the extreme of behaviours that are fully accepted as "laudable", a range of behaviours is presented whose degree of general acceptance decreases to an opposite extreme, where aberrations of human behaviour are repudiated by the vast majority of individuals and societies.

It is at the intermediate level, where ethical and moral attitudes, whether individual or group, are qualified differently according to the primacy we

[1] Bricknell Martin, CM and Mirón, M (October-December 2021). Medical Ethics for the Military Profession. Revista Científica General José María Córdova (Colombian Journal of Military and Strategic Studies, Volume 19, Number 36, pp 851-866. https://doi.org/10.21830/19006586.814

[2] Darré, E, Evolution éthique du service de santé des armées face aux problemes poses par les nouvelles formes de guerre (Ethical evolution of the armed forces health service when faced with the issues posed by new forms of warfare). [Date consulted 13/06/22]. Available at: https://lexdih.wordpress.com/divers/bibliographie/evolution-ethique-du-service-de-sante- des-armees-face-aux-problemes-poses-par-les-nouvelles-formes-de-guerre/. Williams-Jones, B et al. (2015). Ethische Spannungen im Einsatz - Erfahrungen von kana- dischen Militararzten. Ethische Spannungen im Einsatz - Erfahrungen von kana- dischen Militararzten. Den Gegner retten? (Ethical Tensions in Deployment - Experiences of Canadian Military Doctors. Save the Enemy?) Militárárárzte und Sanitáter unter Beschuss (Military Doctors and Physicians under Fire.) Ethik und Militár (Ethics and the Military) | Published 2015/1.

give to certain values or principles considered valid when they come into conflict. This primacy of some over others will certainly influence the resolution of the ethical dilemmas we face.

As in the preceding chapters, this article is framed within the values that generally permeate our society and recognises the degree of divergence that can occur in the priority and weight assigned to different principles, values and human rights when facing a specific case - something that is linked to coexistence in a plural and democratic society. In the Spanish Armed Forces, behaviour that violate human dignity are systematically internalized as reprehensible. Thus, it can be said that the ethical dilemmas faced by health care professionals arise from the need to give appropriate weight to each of the principles and values when defending human rights. And they have to do so in an environment of limited resources and a variety of legitimate rights and interests to be protected, both individually and as a group.

Applying ethical values or principles is something that is presumed to be inherent in individuals who have chosen a profession of helping and caring for others. In terms of the military profession, this is imbued with the values and ethical principles of the society from which it is nurtured, while at the same time being accentuated by the characteristics of the vocation that drives them to choose this path, defence of the values and elements that constitute the basic pillars of a society in the face of external enemies (stability, security, freedom, democracy and human rights), along with an assumed capacity for personal sacrifice.

Thus, in most cases, deviations from the ethical values and principles that are inherent in respect for human dignity and human rights (both in exercising the military profession and in the area of healthcare) derive mainly from a lack of understanding and internalisation of some of them (individually, as a group or in society as a whole), or from a disproportionate appreciation of the defence of some to the detriment of others, which may be overridden. Thus, the absolute and sole primacy of a nation's security enables the enemy to be dehumanised, creating a breeding ground for unjustifiable behaviour, such as that carried out in Abu Ghraib prison (Iraq) in 2003-04, where the possible acquiescence or complicity of military health personnel was criticised[3].

The previous chapters have already pointed out the four principles that should guide the actions of health care professionals: autonomy, beneficence, non-maleficence, and justice[4]. In each case it is necessary to assess the

[3] Annas, G (2005). Unspeakably cruel - torture, medical ethics, and the law. N Engl J Med, 19/5/05, 352(20):2127-32, doi: 10.1056/NEJMlim044131.

[4] Beauchamp, T. and Childress, J (2001). Principles of Biomedical Ethics, 5th ed. New York, Oxford University Press.

extent to which they conflict with the principles already mentioned as pertaining to the military function and, finally, the possible conflict of both groups with other principles - such as those corresponding to humanitarian aid and disaster-relief activities: humanity, impartiality, neutrality and independence[5] (although some include others such as universality, vocation to service, proselytising and unity).

In previous chapters, Rodríguez Sendín and Torres León have given us normative references which doctors, working nationally or internationally, must follow in their actions, according to ethical guidelines and as required by the conventions and protocols of International Humanitarian Law to which Spain has adhered, World Medical Association approvals[6], the Oviedo Convention on Biomedicine and Human Rights[7], and national regulations - in particular, the Spanish Medical Association (CDM) Code of Ethics[8], which would logically apply to the guidelines, principles and codes of ethics approved by the respective professional associations of the other basic specialities of the Military Health Corps.

The approach to the ethical dilemmas presented below should always take as its ethical and deontological frame of reference the thinking contained in these articles together with the ideas presented in the previous chapter by Gracia Guillén. In short, not to separate ourselves from the values that were attributed at the time to the Andalusian doctor Albucasis - one of the fathers and founders of modern surgery: curiosity, vocation, experience, skill and professionalism, but also humility, compassion, kindness and

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[5] UNOCHA. (2012). What are Humanitarian Principles? 30/8/12. [Date consulted 11.05.2022]. Available at: https://reliefweb.int/report/world/ocha-message-humanitarian-principles-enar

[6] World Medical Association. (2012). WMA regulations in times of armed conflict and other situations of violence. In handbook of WMA policies. Rev. October 2012. [Date consulted 10/5/22]. https://www.wma.net/policies-post/wma-regulations-in-times- of-armed-conflict-and-other-situations-of-violence/

[7] BOE. (1992). Instrument of Ratification of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine), approved in Oviedo, 4 April 1997. BOE (Official State Gazette of Spain) 251. 20/10/1992. [Date consulted: 1/6/22]. Available at: https://www.boe.es/eli/es/ai/1997/04/04/(1)/con

[8] Spanish Medical Association (OMC). (2011). Code of Medical Ethics. Guide to Medical Ethics. [Date consulted: 8/5/22]. Available at: https://www.cgcom.es/si- tes/main/files/files/files/2022-03/codigo_deontologia_medica.pdf; World Medical Association. (2012). International Code of Medical Ethics. Rev. October 2012. [Date consulted 10/5/22]. https://www.wma.net/policies-post/wma-regulations-in-times- of-armed-conflict-and-other-situations-of-violence/ ICN Code of Ethics for the Nursing Profession. [Date consulted 19/5/22]. Available at: https://www.consejogeneralenfermeria.org/component/jdownloads/sen- d/25-cie/351-07-cdigo-deontolgico-del-cie-para-la-profesin-enfermera

justice, exercising his profession without distinction as of social rank and guaranteeing care for the weakest and most disadvantaged[9].

Awareness of the role of the Military Medical Corps

Dual loyalty has been identified as the source of many of the specific ethical problems faced by Military Medical Corps staff in balancing their duties to individuals with the principles and objectives of a military organisation.

The question "Are you more a doctor or a soldier?" has sometimes been put asked of us military doctors and other members of the Military Health Corps (CMS). And the question has been asked not only by civilians outside military life, but also by army and navy personnel and (particularly surprisingly to me) by some military doctors. The question implicitly admits an unbridgeable dichotomy between providing health care to the military or other groups of people in an ethical way and supporting or not hindering the strategic, operational and, above all, tactical objectives sought in military missions and operations.

This dichotomy means fully (or at least partly) accepting the basis of the current lines of thinking that since the second half of the 20th century have been highlighting the issues involved in being a military doctor (and by extension could be applied to nurses, psychologists, dentists, pharmacists or veterinarians) without breaking the ethical principles that necessarily guide our academic training and vocation[10].

Conversely, the distinction that is often made - almost automatically - within the Military Medical Corps is between medical care and operational healthcare. Both approaches reveal an incomplete understanding of *the raison d'être of our corps*; operational health care consists of providing health care, at the best levels of training and performance, in places where the formal health care system does not reach; without quality care there is no operational health care - in short, the *search for excellence* noted by Gracia Guillen in Chapter 3[11]. To the extent that this health care on national territory does not have as its primary objective the preparation of health personnel

[9] Fernández Raigoso, YF (2021). El cirujano de Al-Ándalus. Aproximación a la vida y obra de Abulcasis de la mano de Antonio Cavanillas de Blas (The Surgeon of Al-Andalus. A Look at the Life and Work of Abulcasis by Antonio Cavanillas de Blas.) Revista de Medicina y Cine (Journal of Medicine and Film), 17 (1). Salamanca. Pp 57-70. https://doi.org/10.14201/rmc20211715770

[10] Sidel, VW and Levy, B (2003). Physician-Soldier: A Moral Dilemma? Military Medical Ethics, Vol. 1. Washington, DC, Office of The Surgeon General at TMM Publlcations Borden Institute, Walter Reed Army Medical Center 20307-5001. [Date consulted 15.05.2022] . Available at: https://medcoe.army.mil/borden-tb-mil-med-ethics-vol1

[11] Annas, GJ (2008). Military Medical Ethics - Physician First, Last, Always. N ENGL J MED 359; 11. 11 September 2008. [Date consulted 16/5/22]. www.nejm.org

for their employment in missions, the support of these health care staff once deployed, the assessment of military personnel who are going to be or are already deployed, and the recovery of wounded or sick personnel during deployments, would be viewed as laudable and irreproachable health care from the point of view of their medical care work. However, it would involve tasks that are others' main responsibility, and the "military" qualifying term should therefore be dropped.

Limitation of resources

The health support capabilities deployed during an operation must be appropriate to the mission, the size and the composition of the force, environment, the casualty estimation/calculation, and the health risks in the area of deployment. As we shall see, many of the ethical debates that arise are accentuated by the logical limitation of health resources that can be deployed. However, waiving them can never be contrary to what is "ethically reasonable". Therefore, it is important to note the ethical responsibility that is used during planning and generating military capabilities, the resolution of which lies outside the sphere of the Military Medical Corps.

If we do not consider the development and acquisition of sufficient health care in terms of resources and staff to support the use of health care support capabilities appropriate to the scenarios envisaged for use by the armed Forces, we will be irremissibly doomed to respond unsatisfactorily - not only from an operational but also from an ethical point of view - to the following questions: are we able to offer sufficient health support appropriate to the risk to which we are exposing our staff? To what extent are we dependent on friendly countries or do we have to rely on the capabilities of the country of deployment?

Obviously, remembering this basic principle means calling upon the responsibility of those involved in analysing and developing military capabilities, especially health care staff in view of their knowledge in terms both of resources and personnel. It is difficult to find a sufficient reason for not having this capability in place and there must be good reasons and rationale for not ensuring the best possible health support for deployed forces, regardless of the maximum degree of acceptance a military force may have and show for the risk of a mission and operation.

Ethical responsibilities of the Military Medical Corps and other groups

The requirement to comply with ethical principles in military health care activities, and the monitoring of their observance, rests not only on individual decisions but also on specific groups, committees, institutions and bodies, each with its own level of responsibility.

Clearly, the first group to note are the members of the cares Military Medical Corps themselves, including members of the Military Health Corps, who will be the main object of discussion. However, other groups that play a decisive role in the approach to various ethical problems must be taken into account. As noted above, military and non-military analysts and commanders responsible at strategic, operational and tactical levels for shaping operations need to be aware of the legal, deontological and ethical limits of the Military Medical Corps' performance so that they can take them into account in their decisions, This is not always easy without a guided approach and any lacking will inevitably lead to a clash of expectations and objectives to be assumed.

Health support personnel who are not part of the Military Health Corps, when acting together with them or in isolation in accordance with their specific instruction, training and education, are another group to be taken into account when putting together any guide, support or training system in the area of ethics.

Finally, the system should also take into account the group corresponding to civilian personnel of the Ministry of Defence who are integrated into and complement military health on national territory and who sometimes have direct responsibilities in preparing and sustaining operations - such as the pre-mission evacuation of personnel.

Internal and external prominence of Military Medical Corps actions

For the sake of clarity, and in line with other works on ethics in the Military Medical Corps, we have chosen to address the various ethical problems according to how prominent they are within the armed forces.

On the one hand, there is an internal sphere of action that corresponds to the problems arising from a specific mission. This cannot be done by another health care system and is entirely the sole responsibility of the Military Medical Corps. It includes supporting own forces and persons who, within the legal framework of the law of conflict, fall under the responsibility of the Military Medical Corps, the care of prisoners and detainees; measures to enhance the psychological and physiological capabilities of the military should also be included here. The external area, on the other hand, includes health care assistance and health support programmes for the civilian population, as well as health training for other armed forces. Although we could include others, these have been selected as the most relevant in terms of the ethical conflicts that may arise in the Spanish Military Medical Corps when participating in operations. The intention when presenting these issues (albeit in a limited way) is to generate sufficient interest in the need to systematise the analysis of the ethical aspects of the Military Medical Corps in the planning, conducting and sustainment of operations.

Internal prominence of Military Medical Corps ethics in operations

The three aspects of this internal prominence are assisting the forces themselves, helping the wounded and detainees, and enhancing soldiers' psychobiological capabilities.

Assisting own forces

The primary purpose of health care support in military operations is to promote, preserve, recover, and restore the health of participating personnel, minimising any resulting physical and mental consequences. The main principles or values that have been introduced into the ethical debate and criticism of the Military Medical Corps are no different from those that make up ethical behaviour in the field of health care and experimentation in the civilian sphere given that, as the previous articles rightly point out, they are no different at all.

In this section we will look at the specific conflicts that can arise in the Military Medical Corps' application of the principles that should guide their actions (personal autonomy, beneficence, non-maleficence and justice[12]) and others, including personal autonomy and privacy and the right to one's own image, as well as assessment of the risk to oneself or third parties that might arise for a given operation.

A review of the ethical debates that have taken place since the Second World War regarding the Military Medical Corps along with the assessment of its own staff reveals the recurrent presence of the same problems, but a different approach in different countries and an evolution towards a greater emphasis on personal autonomy and privacy. This evolution has led to the previously noted criticism of the presence of a health service as an integral part of the armed forces[13] which has been refuted by Madden and Carter[14].

The defence of the Military Medical Corps is clearly shared by this author, in terms of most of the arguments put forward by Madden and Carter. However, he disagrees in other areas - partly because of the underlying reasoning, partly because of the cases offered as examples, for the simple reason that they would not fit the case of the Spanish Military Medical Corps and the way it is integrated into the armed forces.

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12 Gillon, R (16 Jul 1994). Medical Ethics: Four Principles Plus Attention to Scope, 309 (6948): 184-8. doi; 10.1136/bmj.309.6948.184.

13 Cfr. 95.

14 Madden, W and Cárter, BS (2003). Physician-Soldier: A Moral Profession. Military Medical Ethics, Vol. 1. Washington, DC, Office of The Surgeon General at TMM Publications Borden Institute, Walter Reed Army Medical Center 20307-5001. [Date consulted 15/5/22]. Available at: https://medcoe.army.mil/borden-tb-mil-med-ethics-vol1

Priority: the patients' needs or the mission?

One of the most frequent debates about the role of the Military Medical Corps in caring for the forces themselves, the main one has been the conflict of interest between the role of a physician and *military* doctor, as a possible cause of detriment to a patient's care and even making imposed medical decisions that may be counterproductive to health. Most of the cases presented correspond to United States' involvement in high-intensity conflicts, in decision-making within the health care functional chain and by medical or paramedical staff themselves, but also in politics and the military chain of command.

One of the cases repeatedly cited in the articles is the British decision, in the face of penicillin shortages and Allied plans for the invasion of Sicily and the rest of Italy, to prioritise the treatment of soldiers with sexually transmitted diseases - as opposed to combat casualties with serious wounds - with the aim of their early recovery for combat. Presented in this way, the case is offered as a paradigmatic conflict of interest between the needs of patients and prioritisation based on purely medical criteria; the prioritisation is justified, as a greater good and one that would save more lives and achieve the intended military objective, in which the future of society was at stake.

What surprises this author is that no one appreciates certain facts that can be seen in the article published by one of those in the decision, and which are highly illustrative[15]. First, it was ultimately a political decision - not a military or medical one - taken at the highest level, even with the support of the health care chain of command. Secondly, a determining factor, which is omitted when the case is cited, is that the use in terms of benefit/risk of penicillin in the treatment of gonorrhoea was already sufficiently tested and proven, while the use for war wounds was not (which would have led to the same decision today).

Finally - and highly relevant - is when reference is made to the comparison between the benefit to someone who is held responsible for his own illness and reproached for "immoral" conduct compared with someone who has received unjust harm, while making a sacrifice for his country without having voluntarily put himself at risk. In short, the intention is to reinforce the case based on previous bad or good behavioural criteria - something that should be avoided in medical decisions in terms of the principles of non-discrimination for reasons unrelated to the need, as already noted.

[15] Howie, J (1979). Gonorrhoea - a question of tactics. BMJ. Vol 2 (December 1979), No. 6205, pp 1631-1632. ISSN 1468-5833. [Date consulted 16/6/22]. Available at: https://doi.org/10.1136/bmj.2.6205.1631

What would be helpful is to contrast the gravity between the two groups, without entering into moralistic assessments of behaviour.

The lesson of this case is that, whether we like it or not, human nature leads us to value certain behaviours and blame others. This justifies the natural inclination of health care professionals to prioritise in extreme cases their own family, Military Medical Corps staff and military colleagues. Overcoming this propensity to adjust our decisions according to the ethical behaviour or proximity of the patient will be even more difficult in situations where the enemy's behaviour has completely lacked humanity and respect for the law of armed conflict and International Humanitarian Law (as will be discussed later).

The multiple duties of a doctor or nurse during military operations

Military doctors and nurses attached to a military unit may perform a variety of functions for a group of military staff. On the one hand, they have a purely health care role, where national regulations regarding patient autonomy apply in full[16] - this work is the responsibility of the armed forces' Social Institute (which can arrange the use of military hospitals) and not the Military Medical Corps. However, this also applies to a limited extent to urgent primary care and emergencies during the times that they are conducting their professional duties. This sets us apart from other armed forces with which we share a mission, where the Military Medical Corps is provided on a full-time basis and at all levels, including the treatment of dependant family members.

They also have a responsibility to promote military health – a responsibility they share with national and regional bodies for the general population. They perform tasks similar to those carried out by occupational doctors at company level. Finally, they exercise control over sick leave, approving sick leave reports and issuing opinions that can be considered binding for the unit commander, who formally grants sick leave and acts as the initiator with their process reports to declare partial (fit with limitations) or permanent incapacity for service.

With the exception of the latter function, health care staff performs the above functions fully and uniquely during operations, in addition to liaising with training and health facilities of other nationalities. France's Military Medical Corps' code of ethics includes several of these tasks (prevention,

[16] BOE (2002). Act 41/2002, of 14 November - a basic law regulating patient autonomy and rights and obligations regarding clinical information and documentation. BOE 274, updated 5/6/21. [Date consulted: 1/5/22]. Available at: https://www.boe.es/eli/es/l/2002/11/14/41/con

diagnosis, care, expertise, assessment of aptitude, and discharge control) - in particular for the speciality of medicine[17].

This sometimes results in a lack of clear differentiation between different tasks that may require different solutions. For example, the decision to continue on a mission at increased risk to health (from the point of view of soldiers as patients) falls within the scope of a soldier's autonomy as a patient, as well as the information generated during his clinical care. However, the same situation, assessed from the point of view of job evaluation or the protection of the health of others, limits the scope of the military's decision, because it is up to others to decide whether to take a risk themselves, for third parties, or for the mission.

This limitation on the scope of decision-making and other duties and rights is reflected in the codes of ethics mentioned above, but most clearly in the International Commission for Occupational Health's Code of Ethics for Occupational Health Professionals[18]. Accordingly, under Article 10, examinations required under national laws or regulations must only "be conveyed in terms of fitness for the envisaged work or of limitations necessary from a medical point of view when assigning tasks or during exposure to occupational hazard, with the emphasis on proposals to adapt the tasks and working conditions to the abilities. As far as necessary to protect health, and subject to the informed consent of the worker concerned, information of a general nature concerning their fitness for work, or related to health, or the probable effects of occupational hazards [...]".

To supplement this, Article 11 deals with dangers to third parties, stating that "[...] in the event of particularly dangerous situations, the management of the undertaking and the enforcing authority must, if national law so provides, be informed of the measures necessary to protect other persons. In his or her recommendation, the occupational health professional should try to balance the employment of the worker involved with the health and safety of others who may be at risk".

With these assumptions in mind, it will be easier, deontologically and ethically, to decide whether or not to continue with the mission and to whom this responsibility belongs. Thus, although the final decision rests with the military command, the appropriate information provided by health

17 Ministry of Defence (France). (2008). Décret n.° 2008-967 du 16 septembre 2008 fixant les règles de déontologle propres aux pratldens des armées (Decree 2008-967 of 16 September 2008, establishing the rules of deontology specific to military practitioners). Journal Officiel de la République Française (Official Journal of the French Republic) No. 0218 18.09.2008.

18 International Commission for Occupational Health. (2014). Code of Ethics for Occupational Health Professionals, rev. 2014. [Date consulted 20/6/22]. Available at: https://www.icohweb.org/site/core-documents.asp#

personnel will, in this area of decision-making, distinguish between a permitted area of discretion from one where the limitations and risk to the patient or third parties do not allow a decision to be taken other than the immediate interest of treatment and/or discharging the patient from the operation, either temporarily or definitively.

The same need for information from the command arises when there is a need to evacuate to higher-level health centres in the area of operations or national territory and where the decision needs to take account of the risk-benefit balance, the possible means of achieving it, and the degree of availability and cost, whilst avoiding the use of means disproportionate to the emergency and needs of the patient (which is in line with the action guided by good governance and equity as set out in Article 23 of the CDM).

Clear guidance on how to separate functions during day-to-day activity and different types of documentation is essential to facilitate decisions. And there is currently room for improvement that needs to be addressed. In my opinion, understanding this makes it easier to address most of the so-called conflicts of interest between military objectives and patient needs[19].

Most of the cases reported in the literature relate to medium- or high-intensity conflicts, where decisions are made that take into account not just the patient's health interests, and exclude the patient from the decision-making process, such as the reintegration of soldiers into combat units - even though their approach from a purely psychiatric point of view would suggest another decision[20].

As far as Spain is concerned, situations that require a mission to continue against the patient's health interests, or against their will, can be deemed to be non-existent. However, a similar unforeseen ethical conflict could arise in the context of armed conflict, where it is necessary to preserve the operability and combativity that is compromised. On the other hand, there is also the Spanish case, in which the precautionary principle is maximised in situations of potential risk to military personnel or third parties, especially in decisions involving the withdrawal of weapons or driving licences, due to the risk arising not only from intentionality, but also the potential for accidents.

[19] Vollmuth, R, health care Professionals between Medical Ethics and Military Duties. [Date consulted: 19/6/22]. Available at: https://military-medicine.com/arti- cle/3198-health-care-professionals-between-medical-ethics-military-duties.html; Weisfeld, N et al (2008). Military Medical Ethics: Issues Regarding Dual Loyalties: Workshop Summary. [Date consulted: 11/6/22]. Available at: http://www.nap.edu/cata- log/12478.html

[20] Quinn, M and Wilkes, SN et al (2008). Military Medical Ethics; Privacy, Military Necessity, and the Dual Roles of Military Psychiatrists. The American Journal of Psychiatry Residents' Journal, June 2020.

The most common cases in our operations are quite different, where a or restriction or limitation of activities is imposed from a medical point of view, and this goes against the will of the person concerned to continue working or not to accept the sick leave. The reasons for this rejection are diverse, with loyalty and a sense of duty motivating him to fulfil his mission, comradeship motivating him to stay with his group, and benefits for his military or economic career, the latter also being worthy of consideration as it is a reasonable personal aspiration. This decision by the soldier to remain on the mission will normally be supported by the patient's own command, partly for operational benefit, but in most cases because of the sense of protection and support felt towards subordinates, as long as there is no serious risk to the mission, soldier or third parties.

In order therefore to make a correct decision, the patient and their command must be fully informed of the capacity of the person concerned, their limitations and the probability of occurrence of the risks assumed and any factors that increase it (which must be documented) so that the decision is made taking account of all relevant elements. In any case, from an ethical point of view, the command should follow the physician´s final recommendation where the risk is probable and of sufficient magnitude[21].

Treatment of detainees and prisoners

The principles and values set out above act as a moral imperative to assist one's own, allied or enemy forces without distinction. This must therefore the guiding for action and is assumed in our Military Medical Corps. Detainees or prisoners become our responsibility to the same extent as our forces, which normally will not generate conflict if sufficient resources are available and must be taken into account in resource planning and logistical support to avoid creating avoidable conflict among deployed medical personnel.

However, it would be hypocritical to hide the fact that there may be exceptional situations arising from resource constraints inherent in overseas deployments in which ethical values and duties may be in conflict. In the overseas deployment of Spanish military personnel, the State (and consequently the Military Medical Corps) takes on an ethical commitment to offer these staff the greatest possible protection - a commitment that is enshrined under national and international doctrine. As has been said, this is the main reason for the Military Medical Corps guaranteeing as far as possible during deployments the quality of care that is offered on Spanish

[21] Howe, EG Mixed Agency in Military Medicine: Ethical Roles in Conflict? Military Medical Ethics. Vol. 1 Washington, DC, Office of the Surgeon General at TMM Publications Borden Institute, Walter Reed Army Medical Centre 20307-5001. [Date consulted: 15/5/22]. Available at: https://medcoe.army.mil/borden-tb-mil-med-ethics-vol1

territory to all citizens, without any distinction, aiming to provide maximum protection to those who are sacrificing and risking their lives in defence of values, during a mission that has been assigned to them by a government backed by the will of the people.

Moral conflict is not, as many articles on military medical ethics assume, born out of operational necessity or dehumanisation or contempt for the enemy, but out of a sense of abandonment of that ethical commitment and the natural inclination of every individual to protect those closest to us[22]. This inner conflict is accentuated when confronted with an enemy who has transgressed every limit of respect for human dignity and when one is faced with the choice of saving one or the other. In my opinion, the application offered by Gracia Guillén should be a valid method of approaching the conflict.

Although there is a current debate[23] on the potential for prisoners to take part in medical experimentation programmes, if they can do so under the same conditions and with the same rights[24], we simply have to remember the dramatic cases that led to the creation of the Nuremberg Code in the 20th century[25], to support the fact that this potential admissibility should in no case be extended to the case of detainees or prisoners during an armed conflict - that is, adversaries in charge of a military force of another country. In the following section the criteria for the inclusion of subjects in human-based research and experimentation processes, will be reviewed with Rodríguez Sendín and Torres León.

I am sure that no member of our Military Medical Corps would participate in the torture and degrading treatment of prisoners, or in any act that could benefit them[26], regardless of the benefit that could be obtained. However, it is important to be aware and alert to the possible initiation of a slippery slope based on decisions that are seemingly irrelevant or which seek

[22] Gross, M (2015). Kameraden zuerst? Militárisehe vor medizinischer Notwendigkeit (Comrades first? Military Connection Before Medical Necessity), Den Gegner retten? (Save the Enemy?) Militárárárzte und Sanitáter unter Beschuss (Military Doctors and Physicians under Fire.) Ethik und Militár (Ethics and the Military) | Published 2015/1.

[23] El País online. (2019). Expertos en bioética respaldan el experimento con presos violentos que paralizó Interior (Bioethicists back experiment on violent prisoners that paralysed Interior). Online 9/3/19. Available at: https://elpais.com/elpais/2019/03/08/ciencia/1552062521_588321.html [Date consulted 1/9/22].

[24] García Guerrero, J (2010). Los presos como sujetos de investigación biomédica (Prisoners as biomedical research subjects). Cuad, Bioét, XXI, 2010/2nd; 185-198. [Date consulted 28/6/22]. Available at: http://aebioetica.org/revistas/2010/21/2/72/185.pdf

[25] Shuster, E (13 November 1997). Fifty Years Later: The Significance of the Nuremberg Code. N Engl J Med, 1997; 337:1436-1440. doi: 10.1056/NEJM199711133372006.

[26] LIfton, RJ (29 July 2004). Doctors and Torture. BMC Med EthIcs 22. N Engl J Med, 2004; 351:415-416, doi: 10.1056/NEJMp048065.

an apparently good outcome, but ignore the principles that need to be followed[27].

A particular case is the forced feeding of prisoners if they refuse to eat, which, as Rodríguez Sendín notes, should fall under personal autonomy[28], in line with the principles and ethical criteria issued by medical societies internationally[29].

In this case, an issue of legality would arise, as several judgments by Spain's Constitutional Court issued prior to clarification of these criteria did not fully admit this personal autonomy when the motives may not be a genuine intention of wanting to die but instead a form of protest (a hunger strike could not be admitted as a form of blackmailing the State), because there is a special duty to protect the person as a prisoner, or because it is not possible to corroborate, once he has lost consciousness, his or her will to remain on hunger strike[30] - arguments that have been widely criticised. In any case, the problem would probably result in a judicial decision, which, depending on the interpretation of what is agreed, could even lead to conscientious objection on the part of health care staff.

Experimentation and psychobiological performance enhancement

Ethical dilemmas stemming from or evolving out of experiments or the development of psychological and physiological capacity building programmes have represented a clear area for ethics committees[31], and bring complex assessments - as pointed out in previous articles, embodied in the successive amendments to the World Medical Association Helsinki Declaration[32] or the Oviedo Convention mentioned above.

[27] Vollmuth, R (2021). Die Gefahr der "Schiefen Ebene" Sanitatspersonal Zwischen Medizinethik und militarischem Auftrag (The Danger of the "Slippery Slope" Health Workers Between Medical Ethics and Militaristic Mission). BMC Med Ethics 22 153. [Date consulted 18/5/22]. – https://military-medicine.com/article/3198-healthcare-professionals-between-medical-ethics-military-duties.html

[28] Boyd, W (October 2015). Ethics case: Force-Feeding Prisoners Is Wrong. American Medical Association Journal of Ethics. Volume 17 Number 10: 904-908.

[29] World Medical Association. WMA Malta Statement on Hunger Strikers. Updated October 2017. [Date consulted 19/7/22]. Available at: https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/

[30] SSTC 120/90 of 27 June 1990 and 137/90 of 30 July 1990.

[31] Cho, MK et al (2008). Strangers at the Benehside; Research Ethics Consultation. Am J Bioeth, 8/3/08, (3): 4-13. doi: 10.1080/15265160802109322.

[32] World Medical Association. (1964). WMA Declaration of Helsinki. Ethical principles for medical research involving human subjects. Updated October 2013. [Date consulted: 19/7/22]. Available at: https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/

A more indirect and distant relationship in terms of field operations would be the ethical issues that arise in animal experimentation, in a world that is increasingly aware of the need to avoid animal harm and discomfort. This issue will not be explored in depth, in which we will have to comply at least with the different rules that have been created to regulate it[33].

External prominence of ethics in the Military Medical Corps in operations

Health care for civilians

In a study of American medical personnel, the rates of those who considered the possible provision of humanitarian aid as a determining factor for joining and remaining the armed forces were 48% and 62% respectively, while 25% considered it a negative factor[34]. I would venture to say that in our Military Medical Corps it is one of the most rewarding tasks for our military and health care personnel, born out of an awareness of service to, and compassion for, others.

In providing health care support to civilians in an area of operations, ethical discussions have arisen from two seemingly contradictory approaches. On the one hand, from the point of view of the principles of medical organisations, health personnel have an ethical imperative to care for all, especially the vulnerable and anyone in a critical situation. On the other hand, there is an ethical rejection of the involvement of armed forces in humanitarian aid work, including the involvement of Military Medical Corps personnel. How can these two policy guidelines be reconciled?

Over the last few decades, guidelines, directives and protocols have appeared in relation to the provision of humanitarian aid, endorsed by international organisations, as already mentioned in other articles in this document. All of these guidelines set out the ethical principles that should guide humanitarian aid, both in conflict zones and during disaster crises, in pursuit of the main objectives of providing humanitarian assistance, saving lives and alleviating suffering. These principles are: humanity (which is also a fundamental ethical value), impartiality, independence and neutrality.

Doubts or criticism about the impossibility or difficulty for military contingents to apply these four principles have led to a rejection, or at least mistrust and suspicion, of their involvement in humanitarian aid work.

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[33] Available at: https://www.uab.cat/web/expenimentacio-aimb-aniimals/legisla- cion-y-guias-1345736970421.html

[34] Driftmeyer, JE et al, (2004). Humanitarian Service and recruitment and retention of uniformed Services medical personnel. Mil Med, 2004 May; 169(5):358-60. doi: 10.7205/milmed.169.5.358.

In general, there is no problem in understanding that the Military Medical Corps is capable of providing humane care to the civilian population. Criticism arises in relation to the other three principles in the face of a humanitarian disaster (the latter being understood as non-discrimination on the basis of nationality, race, gender, sexual orientation, religion or affiliation to a particular political group, with priority given to the most vulnerable), neutrality (especially in armed conflicts) as one of the parties may be favoured, and independence from interests beyond purely humanitarian assistance.

As a result, there are drastic positions calling for the exclusion of armed forces from humanitarian actions in support of civil society. Even more maximalist positions reject this option for organisations such as the United Nations, because in many conflicts it points to responsibility and blame, which in their view would break the principle of neutrality, and they argue that health-related aid should be solely dedicated to the goals of saving lives and alleviating suffering. The consequence is to completely decouple the provision of health-related assistance not only from efforts to provide stability or security, but even from the defence of human rights[35].

Furthermore, this position against the use of military forces in this role, is supported by the negative experiences from their use by several countries or coalitions in programmes that involve Military Medical Corps personnel. These programmes were initially conceived strategically and operationally as a bloodless and civilised way to win “hearts and minds” among the population. Criticism has focused mainly on two problems that undoubtedly have ethical roots.

Firstly, a problem stemming from the reason for their creation, which was not to provide health aid to the population but purely strategic interest; if there had not been no military mission, it would not have been considered in any case. This has meant that they have not been done following a detailed study of the population’s needs and health situation, or in coordination with the authorities, bodies and organisations responsible for local structures and assistance programmes, to the detriment of the objectives that any humanitarian or development aid initiative ought rationally to consider. This lack of planning has not been unique to the military, but has been observed among different types of organisations or support initiatives.

Secondly, mainly because of their initial shortcomings, these programmes have shown a lack of planning development in terms of resources, capacities, and specific objectives. Military missions in many countries have

[35] Von Pilar, U & Redepenning, B (2015). Respect and Distance - Doctors without Borders and the Military. Den Gegner retten? (Save the Enemy?) Militárárärzte und Sanitáter unter Beschuss (Military Doctors and Physicians under Fire.) Ethik und Militár (Ethics and the Military) | Published 2015/1.

not considered what a real programme in support of the population entails, which has resulted in few resources (if any) and inadequacy of resources employed, leading to cosmetic or counterproductive assistance[36].

In the light of these negative experiences - and without going into the arguments in favour of the option of humanitarian action based on the four principles - reality shows that renouncing military capabilities that are difficult to provide by civilian organisations (or because they are limited and insufficient) would mean deprive the population in need of resources that could objectively save lives and alleviate suffering - something that may be ethically difficult to defend, whether in the context of purely humanitarian aid, disaster relief operations, peacekeeping or peace enforcement missions or, more likely, as part of a declared war.

For this reason, the main guidelines set by the United Nations establish restrictive, but not prohibitive, criteria for the involvement of armed forces' in humanitarian aid work. These include disaster relief[37] and complex scenarios[38]. In line with these references, intervention directives and guidelines have been established by the European Commission[39] and the Council of the European Union[40]. Mention should also be made of the

[36] Eagan Chamberlin, SM (2013). The complicated life of a physician-soldier; Medical readiness training exercises & the problem of dual loyalties. Den J. Biomedical Science and Engineering. 6, pp 8-18 JBiSE. http://dx.doi.org/10.4236/jbise.2013.610A1002

[37] UNOCHA. (2006).Guidelines on the Use of Foreign Military and Civil Defence Assets in Disaster Relief - "Oslo Guidelines". Updated November 2006 (Revised 11 November 2007). [Date consulted: 17/5/22]. Available at: https://www.unocha.org/sites/unocha/files/OSLO%20Guidelines%20Rev%201.1%20-%20Nov%2007_0.pdf

UNOCHA. (2018). Recommended Practices for Effective Humanitarian Civil-Military Co- ordination of Foreign Military Assets (FMA) in Natural and Man-Made Disasters. Version 10, 5 September 2018. [Date consulted: 16/5/22]. Available at: https://www.unocha.org/sites/unocha/files/180918%20Recommended%20Practices%20in%20Humanitarian%20Civil-Military%20Coordination%20v1.0.pdf

[38] UNOCHA. (2003). Guidelines on the Use of Military and Civil Defense Assets to Support United Nations Humanitarian Activities in Complex Emergencies. March 2003 - revised June 2006. [Date consulted: 17/5/22]. Available at: https://reliefweb.int/report/world/civil-military-relationship-complex-emergencies-iasc-reference-paper

UNOCHA. (2004). Inter-Agency Standing Committee (IASC) Reference Paper on Civil-Military Relationships in Complex Emergencies. 28 June 2004. [Date consulted: 21/5/22]. Available at: https://www.unocha.org/sites/unocha/files/01.%20MCDA%20Guidelines%20March%2003%20Rev1%20Jan06.pdf

[39] European Commission. (2018). The European Consensus On Humanitarian Aid. The humanitarian challenge. Ver. 1.0, 5/9/18. [Date consulted: 10/6/22]. Available at: https://ec.europa.eu/echo/files/media/publications/consensus_en.pdf

[40] Council of the European Union. Military support to EU disaster response - Identification and coordination of available assets and capabilities. Doc. 9462/3/06 REV 3 and doc. 14540/06 + COR 1. [Date consulted: 9/6/22]. Available at: https://data.consilium.europa.eu/doc/document/ST-9462-2006-REV-3/en/pdf

24 Principles and Good Practices of the Good Humanitarian Donorship initiative, which currently encompasses 42 countries and organisations[41] - including Spain - and covers the same parameters described above and includes among its principles the promotion of the 1994 Red Cross Code of Conduct in Disaster Relief[42].

The basic criteria for such involvement are threefold: the use of military capabilities as a last resort, that there is no comparable and sufficient civilian alternative, and that, although control of these capabilities remains within the military chain of command, the action is subject to the direction and coordination of the humanitarian organisation (primarily UNOCHA) responsible for overall humanitarian assistance in the area.

At the level of mission planning and objectives, these criteria are directly applicable to the use of health capabilities not only in pure humanitarian support missions but also in support of stability operations[43] - in terms both of support of security reforms[44] and reconstruction and development[45]. In situations of medium- and high-intensity armed conflict, where the presence of civilian coordination in the area is complicated or impossible, all possible efforts will also be made to encourage direction and coordination by international organisations such as UNOCHA.

In order to avoid a discrepancy between the duty of health care personnel to act towards any person in need and this limitation on armed forces involvement, and by inclusion of the Military Medical Corps in support of the civilian population, it must be borne in mind that this limitation is made in the planning and conduct itself, such that the responsibility for its execution lies with political decisions and the military chain.

[41] Good Humanitarian Donorship (GHD). 24 Principles and Good Practice of Humanitarian Donorship. Updated online June 2018. [Date consulted: 23/5/22]. Available at: https://www.ghdinitiative.org/ghd/gns/principles-good-practice-of-ghd/principles-good-practice-ghd.html

[42] International Committee of the Red Cross and International Federation of Red Cross Societies. (1994). The Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief. [Date consulted: 9/6/22]. Available at: https://www.ifrc.org/sites/default/files/2021-07/code-of-conduct-movement-ngos-english.pdf

[43] Bricknell, MC and Hanhart, TN (2007). Stability operations and the implications for military health services support. J R Army Med, Corps. 2007 Sep; 153(1):18-21, doi: 10.1136/jramc-153-03-04.

[44] Bricknell, MC and Thompson, D (2007). Roles for international military medical services in stability operations (security sector reform). J R Army Med, Corps. 2007 Sep; 153(2): 95-98, doi: 10.1136/jramc-153-02-04.

[45] Bricknell, MC and Gadd, RD (2007). Roles for international military medical services in stability operations (reconstruction and development). J R Army Med, Corps. 2007 Sep; 153(3):160-4, doi: 10.1136/jramc-153-03-04.

When the focus of responsibility shifts to the armed forces and health care staff who have already been deployed, the values and principles remain the same, but their impact and applicability vary, acting not as part of deliberate programming, but in reaction to specific local situations. Here, we are faced with the obligation to act in accordance with our ethical duty as health professionals.

There are two compelling reasons for doing so to be offered on a limited basis: the long-standing justification of limited health care resources, and the need to comply with the code of conduct and the restrictive employment criteria of the armed forces. In these specific situations we must also ask ourselves whether, in the absence of an alternative, we are the last resort and we are not interfering with local health capacities or support organisations. A procedure that has been established in many countries and organisations such as NATO or the European Union is already in the planning stage of determining the so-called medical rules of eligibility (MROE) that determine who is to be treated in a military health care scenario - be it a field hospital or smaller hospital - and according to what priority.

In general, priority is given to wounded and sick members of one´s own forces, then to prisoners and civilian casualties caused by one´s own actions, and finally to life-threatening emergencies or those with a high risk of loss of limb or senses among other groups. The controversy stems from the internal prioritisation among these groups. Authors such as the aforementioned Gross not only defend the prioritisation of one's own comrades in extreme situations based on the bonds of social and emotional connectivity, but even reject reprehensibly the assumption of responsibility for civilian casualties resulting from collateral damage caused by the actions of one's own forces[46], which is refuted by authors such as Miller[47]. To avoid ethical debates and conflicts arising from these eligibility rules, it has been decided in many cases to remove them, as in the BARKHANE operation[48]. Although the opinion of the participants in this article is in favour of such a decision, leaving the decision to the individual case, we must not forget that the ethical conflict remains[49].

[46] Gross, ML Saving Life, Limb, and Eyesight; Assessing the Medical Rules of Eligibility During Armed Conflict Am J Bioeth, 17;10, 40-52, doi; 10.1080/15265161.2017.1365186

[47] MIller, JP (2017). A Care Ethics Approach to Medical Eligibility in Armed Conflict. Am J Bioeth. 17,102,017 (10);61-63, doi; 10.1080/15265161.2017.1367867. PMID: 29020555.

[48] Lamblin, A et al (2021). Ethical challenges faced by French military doctors deployed in the SAHEL (Operation BARKHANE): a qualitative study. BMC Med Ethics, 22 153 (2021). https://doi.org/10.1186/s12910-021-00723-2

[49] Tobin, J. (2005). The challenges and ethical dilemmas of a military medical officer serving with a peacekeeping operation in regard to the medical care of the local population. J Med Ethics, 2005; 31:571-574. doi; 10.1136/jme.2004.008839.

Also subject to ethical debate is the different course of care used for patients after accidents and emergencies, depending on whether they belong to one group or another - with the wounded or sick from deployed military forces being evacuated to their countries of origin (usually with higher standards of healthcare) while others are referred in most cases to local health organisations. What this situation reflects is an undeniable reality: the differences in levels of care that exist between the different countries of the world, and it is not a specific ethical problem of the health contingents deployed, which cannot (and should not pretend to) make up for a system's overall shortcomings. In our system, decisions to evacuate back to national territory for humanitarian reasons are political, and are usually in response to requests from civil organisations or initiatives. It is up to the political sphere to weigh up the values at stake.

Health training of other armed forces and law enforcement bodies

The instruction, training and teaching activities of the Spanish Armed Forces in developing other countries' armed forces always include conveying an ethical culture based on International Humanitarian Law. For this reason, it is important to stress that health training activities are particularly conducive in implementing this educational function, especially at the most basic levels of instruction. The results of incorporating this ethical teaching within other training activities have always been satisfactory. They show the desirability of the staff providing it being fully aware of this role and able, not only to provide as comprehensive answers as possible to the ethical concerns of those being trained, but also to raise these concerns if they do not arise spontaneously.

Systematising the application of ethical parameters in the Military Medical Corps in operations

The willingness of our health professionals to behave ethically is manifest and indisputable. As is the attitude of respect on the part of the military command structure for the actions of health care staff in accordance with the law and their subjection to nationally and internationally accepted codes of ethics and principles. However, as this working paper has tried to show, there are reasons to defend the need to implement measures that ensure a systematised and regulated approach that guarantees at all times an optimal response - the excellence which Gracia Guillén has reminded us.

The first of these reasons is, as we have seen, that responsibilities go beyond the health care staff. The second is that the problems presented in many of the cases are complex, and cannot or should not be solved by individual decisions and must rely on previous cases and the ethical

approach of specialist organisations[50]. The third is that this systematised approach limits the scope for inappropriate pressure in decision-making, whilst also avoiding disproportionate freedom leading to unjustified individual decisions on the part of health care staff. Finally, there is evidence that in neighbouring countries such measures have had a beneficial effect.

Some of these measures have already been advocated and outlined in previous papers:

- Strengthening ethics education in both initial and continuing education.
- Developing guidelines for ethical behaviour - including:
    - A guide for managers to provide a better understanding of the ethical framework for health care workers in relation to decisions for which they may be responsible.
    - An ethical guide and/or protocols for health care workers - especially for those who may be working in isolation without supervision.
    - A repository of cases for reference and to avoid repeating wrong approaches.
    - Online access to resources[51].
- Establishment of a military health ethics committee, similar to that already in place in military hospitals, to conduct situation analyses, help establish training needs and appropriate programmes, and serve as a reference organisation for resolving conflicts. This committee should have an appropriate link to the ethics committees of the relevant professional associations.
- Assessment of a possible code of ethics for the military health care service, which, while accepting the validity of the full application of the codes of ethics of each profession, integrates them and affects the specific aspects of the military health care service.

Conclusion

Health care personnel in the armed forces have always demonstrated a commitment to the highest ethical standards; and have been supported by commanders at all levels. However, it should not be forgotten that there

[50] Howe, EG. Medical Education. (October 2007). Teaching Military Medical Ethics at the Uniformed Services University of the Health Sciences. Virtual Mentor, American Medical Association Journal of Ethics. Volume 9, Number 10: 688-691.

[51] British Medical Association. Ethical decision-making for doctors in the armed forces: a tool kit Guidance from the BMA Medical Ethics Committee and Armed Forces Committee. [Date consulted: 22/6/22]. Available at: https://www.bma.org.uk/media/1218/ bma-armed-forces-toolkit-oct-2012.pdf

are daily cases where there are conflicts between values that are difficult to address. Approaching them and the rationale used for optimal solutions may vary over time, and eventually new dilemmas will arise as a result of society's evolution itself. These determining factors support the idea of implementing a system that improves ethical analysis capabilities to achieve excellence in our decisions and behaviour and the search for internal (or personal) and external (or societal) satisfaction.

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