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MILITARY HEALTHCARE ETHICS

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NORTH ATLANTIC TREATY ORGANIZATION

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NORTH ATLANTIC TREATY ORGANIZATION (NATO)

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NATO LETTER OF PROMULGATION

18 June 2025

1. The enclosed Allied Medical Publication AMedP-8.19, Edition A, Version 1, MILITARY HEALTHCARE ETHICS, which has been approved by the nations in the MILITARY COMMITTEE MEDICAL STANDARDIZATION BOARD, is promulgated herewith. The agreement of nations to use this publication is recorded in STANAG 6562.

2. AMedP-8.19, Edition A, Version 1, is effective upon receipt.

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4. This publication shall be handled in accordance with C-M(2002)60.

For Thierry POULETTE
Major General, FRA (A)
Director, NATO Standardization Office

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RECORD OF RESERVATIONS

CHAPTER	RECORD OF RESERVATION BY NATIONS
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RECORD OF SPECIFIC RESERVATIONS

[nation]	[detail of reservation]
BEL	Chapter 2.2.-2.4.3: These paragraphs are not relevant to the current STANAG and should be deleted. They include legal opinions that do not conform to general international law and non-conform or confusing use of legal terminology. These paragraphs are, in any case, not shared by Belgium.
CAN	Canada considers the Law of Armed Conflict, also sometimes referred to as International Humanitarian law, to be the body of law that governs the conduct of hostilities during an armed conflict. Canada reserves the right to apply its own interpretation of the Law of Armed Conflict to the provision of medical care and the protection of medical personnel in times of armed conflict.
DEU	AMedP-8.19, Chapter 2.2.-2.4.3: The relevance of the remarks to the STANAG isunclear. The remarks (esp. 2.2.2 and 2.3.1) also include legal opinions that do not conform to general international law and are, in any case, not shared by Germany. Since we do not see the relevance of the remarks, the entire section 2.1. – 2.4.3 should be deleted. Chapter 2.2. should thus begin with the contents of the box (MC326/4). Chapter 2.5.11, sentence 1 (“Any abuse […]”): The definition (in Germany’s opinion) is too broad and does not conform to the (correct) definition of the document in Annex D (Lexicon) “Perfidy”. Either the definition of the section from the Lexicon should be used (Germany’s opinion) or sentence 1 should be deleted. Annex D (Lexicon): “International Humanitarian Law” / “Law of Armed Conflict” – According to the definition provided, both terms mean the same thing (ius in bello). One of the two terms (Germany’s opinion) should be deleted or both should be listed under one term in the Lexicon. Annex D (Lexicon): “Non-Combatant”: “Non-Combatant” in the legal sense merely refers to “non-combatants” who are members of armed forces (such as medical personnel), see Article 23, paragraph 2, AP I. The definition provided can (from Germany’s perspective) only be accepted in a colloquial sense, which must be made clear through a phrase such as “in a wider sense” or “for the purposes of this document”.
GRC	ARMY: The STANAG will be implemented according to the degree of integration of EU and Greek legislation to the document.

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CHAPTER 1 INTRODUCTION

1.1. INTRODUCTION

Military healthcare ethics (MHE) refers to the application of ethics - the moral principles governing or influencing conduct[1] - by healthcare personnel working within military contexts.

1.2. CONTEXT

1.2.1. NATO's essential and enduring aim is to safeguard the freedom and security of its members by political and military means, but the Alliance uses its power within the legal and ethical standards of the rules based international order. The authority of the Alliance is underpinned by its moral legitimacy through its core values, objective legality and its demonstration of reputable, ethical and moral behavior. MHE is an extension of this obligation to uphold the ethical standards of the Alliance.

1.2.2. Healthcare personnel are held to additional moral, ethical and legal requirements in the discharge of their duties. They are bound by professional codes that safeguard the wellbeing and dignity of their patients. The military operating environment is increasingly hazardous, complex, uncertain and resource constrained. Healthcare personnel may be presented, often under considerable pressure, with situations that are ethically ambiguous.

1.2.3. It is thus important that NATO healthcare personnel are supported with education, tools and common procedures to effectively analyze each situation and determine an ethically acceptable course of action.

1.3. BACKGROUND

MHE is not new, but there are currently few formal publications that bring together and guide on the numerous topics and issues within this broad subject. This Allied Medical Publication on MHE has been developed in response to a request from the Committee of the Chiefs of Military Medical Services of NATO (COMEDS) to develop a succinct document to advise and guide NATO healthcare personnel and commanders on MHE matters.

1.4. SCOPE

This publication covers the application of MHE across all NATO military healthcare activities. It draws upon numerous military and civilian references but is not an authoritative reference on the relevant law nor the application of healthcare ethics under national jurisdictions. This publication covers the following.

[1] Concise Oxford English Dictionary.

- International law and conventions.
- Ethical principles.
- MHE issues.
- Forums and governance.
- Decision making tools.
- Education and training.

1.5. PURPOSE

The purpose of this publication is to provide a common understanding of NATO's approach to MHE and to guide NATO healthcare personnel in the ethical discharge of their duties. It provides direction on the approaches and tools that should be in place to deliver best practice of MHE on operations. It may also be useful for commanders and planners as a source of information and guidance on MHE related matters, but it is not primarily intended to guide command decision-making.

1.6. APPLICATION

This publication is applicable to all registered healthcare professionals and personnel assigned to healthcare duties, including non-military personnel, employed within a military healthcare system. It also acknowledges the role of combatants with extended healthcare training.

1.7. REVIEW

This document will undergo scheduled review in accordance with AAP-03 by the Custodian and the NATO Military Healthcare Working Group. As an evolving text, proposals for modification are welcomed using the procedure in AAP-03.

CHAPTER 2 INTERNATIONAL LAW AND CONVENTIONS

2.1. INTRODUCTION

This chapter considers some of the related international laws, conventions and principles that have a close relationship with or implications for ethical military healthcare. NATO must operate within a legal framework, defined by applicable national and international law to maintain moral legitimacy.[2] Observing the rule of law is fundamental to NATO's professional military culture and is inherently linked to lawful, moral and ethical behaviors. Healthcare personnel should understand the legal underpinning of NATO activity and the laws that govern healthcare personnel behavior.

2.2. LEGALITY OF THE USE OF MILITARY FORCE

2.2.1. International and national legal frameworks provide the basis for states, or the Alliance, to use military force in situations endangering peace and security. Various mandates, charters and treaties may apply to both provide authority and constraints in different situations across the continuum of competition.[3] These include, for example, the North Atlantic Treaty Article V for individual or collective defense of a NATO nation.

2.2.2. 'Jus ad bellum' refers to a set of principles for a legitimate and justifiable use of force. These are a foundation within the Charter of the United Nations[4] and the North Atlantic Treaty[5].

These principles include:

a. **Proper authority**. A war is 'just' only if waged by a legitimate authority.

b. **Just cause**. The aim of war must not be to pursue narrowly defined national interests, but rather to re-establish a just peace.

c. **Probability of success**. There must be good grounds for concluding that aims of the just war are achievable.

d. **Last resort**. All non-violent options must first be exhausted before the use of force.

2.2.3. Healthcare personnel should be aware of the authority for any military activity that they may be ordered to support.

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[2] AJP-01 para 3.31
[3] See AJP-01 Allied Joint Doctrine 3.31-3.37 for detail on NATO and international law.
[4] Un Charter https://www.un.org/en/about-us/un-charter.
[5] The North Atlantic Treaty. Washington D.C. - 4 April 1949
https://www.nato.int/cps/en/natohq/official_texts_17120.htm

2.3 CONDUCT DURING ARMED CONFLICT

2.3.1. 'Jus in bello' is a term that refers to principles around restraint and conduct during armed conflict:

a. **Military necessity**. This permits only that degree and kind of force required to achieve the legitimate purpose of a conflict, i.e. the complete or partial submission of the enemy at the earliest possible moment with the minimum expenditure of life and resources.

b. **Distinction and non-combatant immunity**. The parties to a conflict must at all times distinguish between civilians and combatants in order to spare the civilian population and civilian property. Neither the civilian population as a whole nor individual civilians may be attacked. Using weapons or methods of warfare that are indiscriminate is forbidden.

c. **Proportionality**. Weapons that are likely to cause superfluous injury or unnecessary suffering are forbidden. The use of force against a legitimate military target must not be excessive. An attack that inflicts harm on protected civilians is only proportionate if it prevents substantially greater harm being caused by the opposing party.

d. **Humanity**. The principle of humanity forbids the infliction of all suffering, injury or destruction not necessary for achieving the legitimate purpose of a conflict.

2.3.2. The principles of jus in bello are the foundation of a military 'code of conduct' and have been progressively enshrined within international humanitarian laws and conventions.

2.4 INTERNATIONAL HUMANITARIAN LAW (IHL)

2.4.1. IHL[6] is part of international law that seeks to limit the effects of armed conflict and is largely enshrined within the Geneva Conventions and Additional Protocols.[7] IHL contain rules that limit barbarity, such as through banned weapons conventions, and that protect people who do not take part in the fighting (civilians, non-combatants, humanitarian aid workers) and those who can no longer fight (wounded, sick, shipwrecked, prisoners of war).

2.4.2. IHL generally only applies during an armed conflict. However, nations may apply IHL and the Geneva conventions to all military activities as a matter of national law or policy.

[6] IHL is also referred to as the Law of War or Law of Armed Conflict (LOAC).
[7] The Geneva Conventions of 1949 and their Additional Protocols - ICRC

2.4.3. NATO has set clear policy that IHL is to apply to all medical activities regardless of the nature of the operation.

MC 326/4 NATO Policies and Principles of Medical Support

Compliance with the Law of Armed Conflict and Humanitarian Conventions*. The conduct of medical activities will comply with the rules and spirit laid down by the Law of Armed Conflict*. In circumstances where specific provisions of these Conventions may not be directly applicable, these principles nevertheless define the minimum acceptable standard. Primarily, all sick, injured, shipwrecked or wounded shall be treated without discrimination and solely on the basis of their clinical needs and the availability of medical resources.*

* In this context, law of armed conflict includes the provisions of The Hague and Geneva Conventions that are in force, as well as other applicable conventions. The Geneva Conventions of 1949 are widely accepted as customary international law. Not all NATO Member States have ratified the 1977 Protocols Additional to the Geneva Conventions. However, a number of Articles in the Additional Protocols are considered to be customary international law binding on all Nations regardless of ratification of the Additional Protocols, NATO personnel must follow their respective national laws in addition to the international law applicable to their actions.

2.5. APPLYING HUMANITARIAN LAW AND CONVENTIONS

2.5.1. **Protected status**. Medical units and healthcare personnel are protected within IHL as non-combatants. Protected status should afford them immunity from attack and they are not to be hindered when carrying out medical duties. To be so protected healthcare personnel should be readily identified by uniform/clothing and documentation. They may wear the protective emblem (red cross, red crescent, red diamond). They are required to carry specific documentation identifying themselves as healthcare personnel and therefore non-combatant. Healthcare personnel as non-combatants have an individual and collective duty to comply fully with IHL and not to engage in any activity which would compromise their status as a non-combatant.

2.5.2. **Healthcare personnel in 'combat roles'**. National authorities may wish to employ healthcare professionals in non-healthcare duties such as personnel management or logistics. Such employment may conflict with their 'non-combatant' status. National authorities should consider whether such a role is compatible with the ethical code of their healthcare profession. Healthcare professionals assigned to a military operation in a combatant role should ensure that their legal status is confirmed by a competent body, that they carry appropriate documentation regarding their legal status. Their national professional regulatory body should be informed. Some nations may require the individual to formally suspend their professional healthcare registration for the duration of their employment in a combat role.

2.5.3. **Combatants with extended medical training**. Combatants, regardless of any extended medical training, are not entitled to wear the protective symbol nor carry

identity documents intended for healthcare personnel (non-combatant). They are permitted to use the healthcare skills they have acquired to assist with the treatment of sick and injured.

2.5.4. **Protected status of medical facilities and materiel**. Protective symbols may be displayed to indicate medical treatment facilities and supplies are non-combatant and should therefore be respected and immune from attack. Medical units, such as field hospitals, should be clearly identified, by displaying the protective symbol, and sited an appropriate distance away from combat military installations, to avoid them being targeted. Further detail is contained in relevant STANAGs[8].

2.5.5. **Protection from deliberate attack**. Commanders may (legally) decide to not display the protective symbol, for example to achieve camouflage of a medical facility, or to avoid (illegal) deliberate targeting of healthcare personnel, facilities or transports by an adversary. This does not remove the non-combatant status of healthcare personnel or facilities, but it does render it very difficult for an adversary to distinguish as non-combatant. Commanders and planners must work with medical staff to plan adequate protection for medical facilities and platforms to ensure the safest possible working environment for healthcare personnel and their patients.

2.5.6. **Arming of medical units and personnel**. Healthcare personnel are permitted to carry and use arms for their own defence, or to defend the wounded and sick in their charge, but not to support the collective protection of non-medical facilities and assets.[9] Healthcare personnel sacrifice their protected status if they engage in offensive action[10].

2.5.7. **Civil-Military Interaction**. Healthcare personnel must be aware of the potential impact that military presence may have on the ability of humanitarian organizations to operate in accordance with their humanitarian principles (impartiality, neutrality, humanity and independence) and with the trust of the local population. Healthcare personnel, commanders and CIMIC staff must always act ethically by ensuring their military activity and engagement with civilian organizations or host nation health actors, does not create unintended political tension, attract hostile attacks or disadvantages to the local population in any way. The ICRC document 'Protecting Healthcare: Guidance for the Armed Forces' provided useful guidance on the measures armed forces can take to protect health care workers and to limit the impact of armed conflict on access to, and delivery of, healthcare services[11].

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[8] ATP-79 Orders for the Camouflage of Protective Medical Emblems on Land Tactical Operations (STANAG 2931) and AMedP-1.5 Identification of Medical Materiel for Field Medical Installations (STANAG 2060)

[9] AJP 4-10(C) para 1-51,1-52

[10] Article 21 of GC1 lays down the conditions under which military medical establishments and units covered by Article 19 lose their protection, i.e. if they are 'used to commit, outside their humanitarian duties, acts harmful to the enemy'.

[11] Protecting healthcare: Guidance for the Armed Forces. ICRC 2020 Available at: https://www.icrc.org/en/publication/4504-protecting-healthcare-guidance-armed-forces

Examples include:

a. Arranging transfer of local national patients from military medical facilities to host nation civilian medical facilities.

b. Assisting local healthcare services with advice and mentorship.

c. Assisting local healthcare facilities with access to medications and medical supplies.

2.5.8. **Prisoners of war (POW) and Detainees**. POW and detainees require appropriate healthcare which is the responsibility of the detaining power to provide under IHL[12]. In 1982 the UN General Assembly passed Resolution 37/194 agreeing Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[13]. The UN has issued the 'Istanbul Protocol'[14] which outlines international legal standards and sets out specific guidelines on how to document and conduct effective legal and medical investigations into allegations of torture and ill-treatment. The Istanbul Protocol is the first set of international guidelines for the medical documentation of torture and its consequences.

2.5.9. **Torture, Inhumane and Degrading Treatment**. Healthcare personnel should not only refuse to participate in acts of torture or ill treatment of any person but have a duty to report any such act to appropriate authority. The World Medical Association[15] has affirmed the ethical obligation on physicians to report and denounce acts of torture or cruel, inhuman and degrading treatment and punishments of which they become aware.

2.5.10. **Absolute prohibitions**. There are absolute prohibitions under IHL for the conduct of healthcare personnel and their facilities. These include:

a. A non-combatant engaging in offensive action, such as an assault on a enemy position (providing medical support to the assaulting force is not perfidious, but carrying out offensive action is).

b. Concealing combat capability, such as a combat headquarters or ammunition stocks, within a facility displaying the protective symbol.

[12] "Convention (III) relative to the Treatment of Prisoners of War. Geneva, 12 August 1949"
[13] https://undocs.org/en/A/RES/37/194
[14] OHCHR | Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (2022 edition)
[15] WMA Statement on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment – WMA – The World Medical Association

c. Taking part in, or assisting with, acts of torture or failure to report any such act to an appropriate authority.

d. Conducting medical research on PW and Detainees.

2.5.11. **Perfidy and violations**. Abuse of any of the special protections afforded by the Geneva Conventions is perfidy. States have an obligation to ensure all military personnel are trained to comply with IHL and must punish all violations that occur. Serious violations of the Geneva Conventions are war crimes and could be tried in the International Criminal Court. It is paramount that all healthcare personnel understand the laws and how they apply in military healthcare contexts. Military commanders and planners must also understand that healthcare personnel have obligations under IHL and they must be assisted in fulfilling these obligations. Healthcare personnel shall never be punished for executing their duties in compliance with legal and ethical norms.

2.6. HUMAN RIGHTS LAW AND NATO CROSS-CUTTING TOPICS

2.6.1. Human rights law typically pertains to the obligations of states towards their citizens to protect and promote fundamental freedoms such as freedom from torture and derogatory treatment and the right to health. The World Health Organization Constitution (1946) envisages "…the highest attainable standard of health as a fundamental right of every human being."[16] Rights-based health care requires health policies that are free from discrimination on grounds of race, age, ethnicity or any other factor and requires the fair allocation of resources.

2.6.2. NATO and NATO-led forces will always operate in accordance with human rights law when applicable.[17] Human rights are reflected in several treaties such as the Universal Declaration of Human Rights 1948[18], however different NATO member nations may be bound by different human rights obligations or interpret treaties differently. Regardless of such variations, NATO is committed to ensure that people are minimally impacted by conflict and disaster and to recognize, report and respond to human rights violations.

2.6.3. **Cross-cutting topics**. NATO has identified the following cross-cutting topics to reinforce its institutional narrative on human rights. All healthcare personnel should be aware of these topics, their role and ethical responsibility to recognize, respond and report violations.

- Protection of civilians.
- Children and armed conflict.
- Cultural property protection.
- Women, peace, and security.

[16] World Health Organization Human rights (who.int)
[17] AJP-01 Allied joint Doctrine Para 3.44
[18] Universal Declaration of Human Rights | United Nations

- Conflict-related sexual violence.[19]
- Combatting trafficking in human beings.
- Sexual exploitation and abuse.
- Building integrity (this could include corruption and wrongful allocation of medical resources).

Further details on the cross-cutting topics can be found in AJP-01 Allied Joint Doctrine and throughout NATO doctrine.

2.7. NATIONAL LAW AND PROFESSIONAL REGULATION

Healthcare personnel have a duty to comply with their respective national laws and national professional regulations. National bodies have ultimate authority regarding the regulation and sanction of healthcare practitioners including those working in military contexts. Whilst national laws and professional regulations have primacy, there is a requirement for national authorities to inform NATO of any variance between their laws/professional regulation and international codes/laws.

[19] AMedP on the medical response to conflict-related sexual violence is in development.

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CHAPTER 3 PRINCIPLES OF MILITARY HEALTH CARE ETHICS

3.1. INTRODUCTION

Military healthcare personnel are required to act ethically, and commanders at all levels have a responsibility to both enable them to do so, and to hold them accountable for their behavior. Ethical and moral considerations underpin the law and reflect operational decision-making and military conduct to ensure moral legitimacy.

3.2. ETHICAL PRINCIPLES IN HEALTH CARE

Beauchamp and Childress's four principles are widely cited as the fundamental basis of medical ethics[20], and are frequently used to guide ethical decision making in health care:

a. **Autonomy** – the right of patients to control decisions about their healthcare. This is the basis of 'informed consent'.

b. **Beneficence** – The duty of healthcare providers to ensure that patients benefit from healthcare as well as to prevent and to remove harm from patients.

c. **Non-maleficence** – The duty of healthcare providers to ensure interventions to patients' health do not cause harm, either through acts of commission or omission.

d. **Justice** – Fairness in the allocation of resources or as Aristotle said, "giving to each that which is his due." There are a number of mechanisms for 'just' allocation of resources, such as:

(1) to each person an equal share;
(2) to each person according to need;
(3) to each person according to effort;
(4) to each person according to contribution;
(5) to each person according to merit; and
(6) to each person according to free-market exchanges.

[20] Beauchamp and Childress Principles of Biomedical Ethics 6th Edition

3.3 INTERNATIONAL CODES OF ETHICS

3.3.1. There are numerous international codes of medical ethics:

a. **Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies (ICMM, ICRC, WMA, ICN, FIP)**
https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies
This is the most prominent internationally agreed set of ethical principles applicable to armed conflict and NATO medical support activities. It is not formally adopted by NATO, but all healthcare personnel working in the military context must be familiar with it and understand the principles.

b. **International Code of Medical Ethics** (World Medical Association)
https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/
For members of the medical profession worldwide.

c. **International Council of Nurses (ICN) Code of Ethics for Nurses**
https://www.icn.ch/system/files/2021-10/ICN_Code-of-Ethics_EN_Web_0.pdf

d. **International Pharmaceutical Federation** (**FIP) Statement of Professional Standards**. Codes of ethics for pharmacists
https://www.fip.org/file/1586

e. **Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies (ICRC, 2020)**
https://www.icrc.org/en/publication/4104-health-care-danger-responsibilities-health-care-personnel-working-armed-conflicts
Provides additional guidance on legal and ethical duties for all healthcare practitioners (including those in the armed forces) during humanitarian emergencies.

3.3.2. Whilst these codes offer excellent guidance on medical ethics, none currently fully address the dilemmas of MHE presented by the requirement to consider military necessity (for example, the requirement to ensure adequate resource to achieve the mission), or the dual loyalty owed by military healthcare personnel both to their patients and to their commanders and comrades.

3.4 NATIONAL CODES OF ETHICS

Allies and partners of NATO will have national codes of ethics. These may be produced by national professional regulatory bodies or by the military medical service. Healthcare ethics will be influenced by national cultures and perspectives. In working together as an Alliance, nations and NATO organizations must be prepared to understand each other ethical positions. Communication and understanding are key to

working together. It is recommended that forums are established to facilitate the solving of ethical differences, see Chapter 5.

3.5. NATO CODE OF MILITARY HEALTHCARE ETHICS

3.5.1. At this time, NATO does not have a Code of Military Healthcare Ethics. Instead, healthcare personnel and units are to apply NATO policy, doctrine and standardization agreements alongside the international and national laws, codes and regulations that will apply to them. Nations providing medical contributions are responsible for the coherence and compliance of their national clinical standards, practices and procedures with relevant agreed common policies and guidelines.

3.5.2. **NATO Core Values and Staff Code of Conduct**. All NATO personnel, organizations and units will act with the highest ethical standards in mind and will uphold the core values of the Alliance:

- Individual liberty
- Democracy
- Human rights
- Rule of law

The NATO Code of Conduct is a set of principles and rules that guide the behavior of NATO staff and members. It is intended to be applicable to the staff working environment rather than operations, but it is indicative of the standard of behavior expected by NATO:

- Integrity
- Loyalty
- Accountability
- Impartiality
- Professionalism

3.5.4. **MC 326 'Principles and Policies of Medical Support'**. This policy sets the standards and principles that must be applied in the delivery of medical support to Alliance military activities. The policy makes important statements regarding MHE and must be applied in all NATO medical activities, including the healthcare principles, which must be followed in all NATO medical support activity:

- Compliance with the Law of Armed Conflict and Humanitarian Conventions
- Medical Ethics and Legal Constraints
- The Primacy of Clinical Need.
- The Universal Provision of Acute Emergency Care
- Medical Confidentiality
- Patient Welfare

3.5.5. **Allied Joint Medical Doctrine**. The Allied Joint Medical Doctrine portfolio of AJPs, AJMedPs and AMedPs span all topics related to the planning and delivery of health and medical support. Throughout the doctrine, guidance may given on the standards and ethical approaches expected in particular clinical or military situations, and this guidance should be considered authoritative and is to be applied with judgement.

CHAPTER 4 ISSUES IN MILITARY HEALTH CARE ETHICS

4.1. INTRODUCTION

This chapter discusses and offers guidance on aspects of health and medical support in military contexts that could present particular ethical frictions or dilemmas for healthcare personnel.

4.2 HEALTHCARE IN THE MILITARY CONTEXT

4.2.1. Many aspects of policy within a military health system have ethical implications, often concerning dual loyalty. Whilst this lies within the responsibility of national authorities, such policy can influence the culture and expectations of healthcare personnel ~~MHP~~ when assigned to NATO roles and missions.

4.2.2. There are several challenges presented to healthcare personnel working within a military context which are different from those faced in most clinical settings. Some examples include:

a. A legal obligation to provide care for captured enemy combatants, the numbers and medical requirements of whom are very difficult to predict.

b. A working environment that may present real, or potential, physical and psychological hazards and threats. Military healthcare personnel may have to deliver care under tactical conditions, such as wearing personal protective equipment, emissions control, rapid mobility and so on, that may interrupt or impact quality of care.

c. A requirement to carefully manage limited medical resources during conflict across numerous distinct patient groups (own forces, captured enemy forces, local nation civilians etc).

d. A potential ‘dual loyalty’ of perceived or real pressure from commanders to prioritize the military mission over needs of the patient, for example to treat less serious casualties ahead of more serious casualties so that they can return to duty quickly.

4.3 DUAL LOYALTY

4.3.1. MHE is characterized by the issue of ‘dual loyalty’. Dual loyalty is the term used to describe the loyalty military healthcare personnel have towards both their patients and to their colleagues and organization. Healthcare personnel can experience ethical dilemmas when trying to balance these potentially conflicting loyalties and do the best

for each.[21] For example, healthcare personnel must act impartially and provide care to those most in need. There may be an instance where this requires treatment of an enemy combatant ahead of a close friend or colleague. Despite a strong loyalty to their own force, the healthcare professional must uphold their professional ethical principles and prioritize based solely on clinical need.

4.3.2. Healthcare personnel must also apply disciplined judgement to all situations. They might, for example, be under legal orders not to intervene in the emergency care of the local population. This might be due to heightened local tensions and interference by the military could lead to eruption of violence causing far more harm. In this situation the healthcare personnel must understand their military ethical obligation to minimize harm.

4.3.3. Whilst dual loyalty might present ethical dilemmas, there should be no instance where healthcare personnel are put in a situation of being unable to act in line with their conscience. Pressure to act unethically, witness of illegal or unethical activity or illegal orders must be recognized, challenged and reported (Chapter 5).

4.4. MEDICAL RULES OF ELIGIBILITY (MRoE)

4.4.1. MRoE are put in place to control access to a medical treatment facility (MTF). They list patient groups that are eligible for certain types of care within that facility.[22] MRoE are necessary to ensure the limited resource of a MTF is used appropriately. Without MRoE an MTF might be overwhelmed and not be able to fulfil its intended role within the medical plan and put forces at unacceptable risk. MRoE might also legitimately control access to a facility for security reasons.

4.4.2. MRoE remove the need for healthcare personnel to make a judgement for every patient that seeks treatment. The MRoE make a fair distinction between groups of patients (e.g. NATO forces, contractors, local population), without any discrimination in terms of gender, religion and so on. Once determined to be eligible (akin to determining if the MTF owes a duty of care) all patients are handled with complete impartiality.

4.4.3. Through the MRoE, the commander has the authority to limit the availability of military medical support to third parties, however, acute emergency treatment of life-threatening conditions normally must not be denied within the capability/capacity of the medical resources deployed.[23] Healthcare personnel might encounter grey areas in the MRoE or feel they are not ethical. Having good leadership and decision-making frameworks in place will help healthcare personnel navigate these situations.

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[21] See Cecil B Wilson Dual Loyalty World Medical Journal Vol 70 No3 Nov 22 4-8

[22] AJMedP-1 Allied Joint Medical Planning Doctrine describes the medical planning process that assesses the potential Population at Risk (PAR) for military health support and the determination of MRoE. AJMedP-8 Allied Joint Medical Doctrine for Military Health Care describes the standards of medical care to be provided on NATO missions.

[23] MC 326/4 para 17

4.5. TRIAGE AND MASS CASUALTY (MASCAL) SITUATIONS

4.5.1. Triage is used to determine the prioritization for treatment and MEDEVAC of patients in need of emergency care. These decisions should conform to the provisions of the Common Article 3 of the Geneva Conventions and the primacy of clinical need as laid down in MC 326/4 (see below). However, the decision-making process will also need to recognize the circumstances of each casualty (such as population group) for both the type of clinical care provided and the destination for medical evacuation.

The Primacy of Clinical Need. Clinical need is to be the principal factor governing the priority, timing and means of a patient's medical care and evacuation.

4.5.2. When the actual or expected casualty load exceeds the local medical capacities and capabilities, medical commanders may declare a MASCAL situation. MASCAL plans will be in place, with actions for both the medical and non-medical staff to respond to the situation. The medical response may include do not necessarily treat the most badly injured first, but instead uses available resource to treat as many casualties as it can, noting that the most seriously injured may not survive regardless of the amount of resource allocated. MASCAL is designed to do 'the most for the most' rather than the 'utmost for the most badly injured' – a so called 'utilitarian' approach.

4.5.3. Detailed procedures for Triage and MASCAL are contained in AMedP-1.10 Medical Aspects in the Management of a Major Incident/ Mass Casualty Situation. It is beneficial for healthcare teams to 'role play' triage and MASCAL scenarios so that ethical differences of opinion can be discussed and resolved.

4.6. NON-MILITARY POPULATIONS

4.6.1. The principle of universal provision of acute emergency care means that military medical facilities have a duty to provide, without discrimination, life, limb and function preserving care to all who need it, within the resources available. AJMedP-6 Allied Joint Civil-Military Medical Interface Doctrine provides further detail about the ethical approaches that must be taken when providing any form of treatment or services to local civilian populations. This includes cultural sensitivity and not providing care that exceeds standards appropriate to the local health system.

4.6.2. Healthcare personnel may feel challenged by witnessing significant unmet humanitarian need in the local population and being restricted from helping by the MRoE. It is important that healthcare personnel at all ranks understand the rationale for MRoE. Healthcare personnel should understand that providing short term, overly sophisticated medical treatments without any provision of follow up care may not be ethical.

4.6.4. The offer of healthcare services to local population groups must never be to gain access for the purpose of intelligence gathering or to gain combat advantage. There must be genuine healthcare benefit for medical activity to be ethical. Conducting

activity for disingenuous purposes may cause mistrust of healthcare providers and lead to significant harm to the local population and wider mission.

4.7. CONSENT

4.7.1. **Informed consent**. Obtaining informed consent from patients for any examination or healthcare intervention, if they can do so, is essential even in a military context. If a patient is unable to consent by reason of being unconscious or lacking the capacity to consent, the healthcare professional must act in the patient's best interests. This may not necessarily be easy to determine. If time permits, legal advice should be sought. Informed consent requires a free decision-making process. In the military context, healthcare personnel should be mindful of the potential for military personnel to feel obliged to give consent. This may be due to differences in rank, fear of punishment or simply wishing to do their duty.

4.7.2. **Preventive Medicine**. A key element of force health protection may include provision of medical countermeasures and prophylaxis, such as nerve agent pre-treatment and antimalarial chemoprophylaxis. These are medicines given to healthy individuals in anticipation of exposure to a threat. It is essential that these are only dispensed following careful risk-benefit analysis and must be with fully informed consent. Nations may have different policies regarding the use of such measures for scientific, cultural or political reasons. For example, vaccination against certain biological agents is recommended by several NATO countries. National policy will deal with such issues; NATO should be informed of any such differences.

4.7.3. **Refusal of treatment / consent**. If an individual declines to accept a recommended preparation, commanders have an obligation to ensure that an individual's choice does not endanger the mission or the rest of the force. If an individual declines to accept such an intervention (such as vaccination) their commander may decide to deploy the individual in a restricted role.

4.7.4. **Conscientious objection**. Healthcare personnel may have a conscientious objection to certain healthcare interventions or healthcare policies. For example, this could be objection to administering operational vaccines due to severe side-effects, or refusal to conduct non-essential examinations for the participation in a potentially harmful activity (such as boxing). Professional bodies typically allow healthcare practitioners freedom of clinical practice in accordance with their conscience, religious and moral views. However, this should typically be managed by referring the patient so that they are not disadvantaged. In a military context healthcare personnel may have less freedom to express individual views or deviate from policy. It may also not be possible to refer a patient to another healthcare professional, particularly on operations. It is best practice to have mechanisms in place for healthcare personnel to express their views, challenge policies and plan mitigations ahead of time (see Chapter 5).

4.8. CONFIDENTIALITY AND PRIVACY

4.8.1. **Confidentiality**. Patients are entitled to expect that their medical information will be confidential between them and healthcare personnel unless there is an overriding reason for confidentiality to be broken. Such cases may include public health risk (such as a service person having a notifiable disease which they are unwilling to have disclosed) or those presenting a significant risk to themselves or others (such as a dangerous paranoid delusion) or a risk to national security. The aggregation of health data (including genetic data) within military health information systems may require specific oversight to ensure the use of such information is compatible with the individual's rights of consent and confidentiality.

4.8.2. **Occupational health**.[24] Occupational health care encompasses assessing military personnel's fitness for military occupations or deployment on operations. It also involves screening for and managing occupational related illnesses or injuries. Healthcare personnel have a duty to ensure that a patient is fit for their role and to assist with minimizing avoidable risk. Healthcare personnel have an obligation to advise commanders on any risk and mitigations that are required but need to do so with sensitivity to patient confidentiality and without disclosing an individual's specific medical details. This may potentially create dual loyalty challenges.

4.8.3. **Public Health**. Public Health reporting of significant diseases and medical conditions of operational relevance is vital to safeguard the health of the Force. Sharing of medical information between national contingents within NATO forces is essential in prevention and rapid control of disease outbreaks. Reporting of such incidents may potentially create dual loyalty challenges. All data collection should be planned, and data used for a specific purpose. AMedP-4.1 Deployment Health Surveillance provides guidance on NATO health surveillance processes.

4.8.4. **Medical intelligence**. Medical intelligence is not to be used as a vehicle for gathering combat intelligence[25] or informing combat planning. There are particular ethical risks in the intelligence assessment of biomedical sciences, capabilities of adversaries and the implications for research, weapons development, and human protection/enhancement including the exploitation of health-related 'big data' such as genomics. AJMedP-3 Allied Joint Medical Doctrine for Medical Intelligence provides further guidance on the use and limitations of medical intelligence within the wider intelligence function.

4.8.5. **Remote Care and Telehealth**. Remote care and telehealth allow separation between the MHP and patient by distance and time. It is now commonplace due to improvements in information connectivity and changed behaviours during the COVID-19 pandemic. The technology is particularly useful in the military environment. This potentially poses ethical issues around consent, confidentiality, data sharing, record-keeping, clinical responsibility, use for personal medical data for research, and data

[24] AJP4-10(C) para 2-35
[25] AJP 4-10(C) para 1-51

ownership. The World Medical Association declaration of Taipei provides a source of international guidance on this topic.[26]

4.8.6. **Privacy**. All patients should expect their privacy to be respected. This can be difficult within military treatment facilities; however, care should be taken by healthcare providers to ensure that patients are given adequate privacy particularly from visitors – including VIP and senior officers - to the facility. Patients should not be subject of media coverage or photography without their consent. MTFs should have policies in place for this.

4.8.7. **Dignity**. All patients are to be treated with dignity both in life and death. This includes recognition of cultural, religious, gender, disability and age-related needs where practically feasible.

4.9. MEDICAL RESEARCH

4.9.1. Medical Research and any research on human participants must always be ethical. Oversight of medical research should be maintained by a governance framework, such as an appropriate research ethics com (HE)mittee. The ethical risks within medical research is heightened in military populations due potential coercive influences within the hierarchical military environment. All research should comply with the principles of the Nuremberg Code.[27]

4.9.2. **Biological and Chemical Agents**. Medical research has been used to derive defence measures against biological and chemical weapons.[28] Whilst this is permissible ethically, it is not permissible to use medical research or biomedical science knowledge in the development of biomedical or chemical weapons, which are illegal under the Chemical Weapons Convention and Biological Weapons Convention.[29]

4.9.3. **Human Performance Enhancement/Augmentation**. There is significant interest globally, particularly in a military context, regarding research into Human Performance Enhancement or Human Augmentation. Human Enhancement (HE)[30] can be described as the natural, artificial, or technological alteration of the human body to enhance physical or mental capabilities. HE includes pharmaceuticals, genetic modification or bioengineered implants both internal and external to the human body. There are numerous emerging ethical, legal and moral issues, such as provision of informed consent, associated with HE which are very likely to confront healthcare

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[26] WMA Declaration of Taipei on Ethical Considerations Regarding Health Databases and Biobanks. 4 Jun 2020 At: https://www.wma.net/policies-post/wma-declaration-of-taipei-on-ethical-considerations-regarding-health-databases-and-biobanks/

[27] Nuremberg Code - Wikipedia

[28] Declaration of Helsinki – WMA – The World Medical Association

[29] Chemical Weapons Convention | OPCW en.wikipedia.org/wiki/Biological_Weapons_Convention

[30] Buchanan, Allen. "Ethical Issues of Human Enhancement". *Institute for Ethics and Emerging Technologies*.

personnel in the near future. These issues will affect both research and implementation of HE[31].

4.9.4. **Prisoners of war (POW)**. It is absolutely prohibited under IHL and humanitarian law to conduct research on persons deprived of their liberty including POW.

[31] Development, Concepts and Doctrine Centre. (2021). Human Augmentation - The Dawn of a New Paradigm. At: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/986301/Human_Augmentation_SIP_access2.pdf

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CHAPTER 5 GOVERNANCE, COMMITTEES AND FORUMS

5.1 INTRODUCTION

Commanders are accountable for their actions and the actions of those under their command.[32]

5.2. REPORTING CONFLICTS OF INTEREST

5.2.1. Nations have a duty to highlight any conflict of interest between national laws or professional regulations and NATO operational policy, doctrine and STANAGs including this one.

5.2.2. There is also a responsibility for NATO commanders and healthcare personnel to report and refer any apparent or potential conflicts to national authorities. Chapter 1, Section 3 of AJP-4.10(C) Allied Joint Doctrine for Medical Support lays out the responsibilities between NATO commanders and national authorities for medical support.

5.3. REPORTING VIOLATIONS AND CONCERNS

5.3.1. **Whistleblowing**. Procedures should be in place within all healthcare facilities for healthcare personnel to report any unethical behaviors they witness. Healthcare personnel must be able to report unethical behavior without fear of punishment or victimization.

5.3.2. **Reporting violations and illegal activity**. All healthcare personnel have a duty to report illegal orders and any violations of law, conventions or codes of conduct. All personnel must therefore be clear on how and to whom they are to report.

5.4. GOVERNANCE AND BEST PRACTICE

5.4.1. **Team training**. It is best practice for healthcare teams to rehearse situations in which ethical dilemmas may arise and ensure suitable plans and approaches are agreed.

5.4.2. **Audit**. It is best practice to regularly review how teams have managed ethical decision making and identify any lessons for future improvement. Use of an agreed decision-making framework (see Chapter 6) can improve the quality and consistency of healthcare decision-making in complex situations.

[32] AJP-01 Allied Joint Doctrine Para 3.38

5.5. ETHICS COMMITTEES AND FORUMS

5.5.1. **NATO Ethics Committee**. NATO policies and procedures for health and medical support may have ethical implications. NATO requires an MHE forum to discuss policy issues related to MHE and may share examples of good practice within nations with members. It is recommended that the establishment of such a forum is considered by COMEDS.

5.5.2. **National MHE committees**. It is suggested that nations may wish to consider how ethical dimensions of medical policy are resolved, including the mechanisms for consultation with professional and regulatory bodies that control the license to practise of military healthcare personnel. This may require the establishment of a formal ‘defence military healthcare ethics’ committee.

5.5.3. **Ethics forums on operations**. Operational medical teams should consider the establishment of an ethics forum to regularly review policies and rehearse team response to ethical dilemmas. It is particularly important that this is done in multinational facilities so those from different nations understand different perspectives within the team.

5.5.4. **Research ethics committees**. As discussed in Chapter 4, medical research and any research involving humans, should be assessed for approval by an ethics committee.

CHAPTER 6 DECISION-MAKING IN MHE

6.1. INTRODUCTION

Many decisions in military healthcare ethics (MHE) lie at the interfaces of law and professional ethics without absolute answers. Ethical decision-making requires the analysis and balancing of different perspectives.

6.2. OVERVIEW

6.2.1. This chapter describes a framework for the analysis of dilemmas in MHE. It is designed to enable military healthcare personnel to reach a decision that complies with the law, their professional standards, and their military duties. It specifically includes the wider perspectives that reflect the nature of health care practice in the military environment including the additional complexity of dual loyalty.

6.2.2. The framework is derived from the Sokol 4 Quadrants model[33], the Humanitarian Health Ethics Tool[34] and the framework taught at Military Medical Ethics course hosted by the ICMM Centre of Reference for Education on IHL and Ethics[35]. This framework has been evaluated with multiple international audiences and is recommended by the COMEDS MHC WG.

6.3. USING THE FRAMEWORK

6.3.1. It is recommended that complex problems are considered by an appropriately experienced team including representatives of the range of clinical professions within a military health care team, one or more legal advisers, and representatives from the military command.

6.3.2. Wherever possible, the process and decision for complex and contentious issues should be formally recorded.

6.3.3. The framework follows four Steps:

Step 1 - Identify the problem
Step 2 - Analyse

[33] Sokol DK. The “four quadrants” approach to clinical ethics case analysis; an application and review. Journal of Medical Ethics 2008;34:513-516.
[34] Hosted at: https://humanitarianhealthethics.net/humethnet/commentaries/resources/hheat/. An academic paper describing the tool is: Fraser, V., Hunt, M., De Laat, S., & Schwartz, L. (2015). The Development of a Humanitarian Health Ethics Analysis Tool. Prehospital and Disaster Medicine, 30(4), 412-420. doi:10.1017/S1049023X1500480X and
[35] ICMM Center of Reference for Education on IHL and Ethics. Website: https://www.melac.ch/

Step 3 - Fuse
Step 4 - Decide

6.3.4. The process for each step is summarized below.

6.4. STEP 1 – IDENTIFY THE PROBLEM(S)

- Briefly state the **Scenario**
- List the **Issues** that arise from the scenario
- Identify **Critical Information** required and **Assumptions** to be made

This Step is intended to orientate the decision-making group to the problem and to allow the problem to be clarified in order to determine the exact ethical issue and the issues that arise. This stage also includes confirmation of critical information required and any assumptions that will form the foundations of the decision.

6.5. STEP 2 – ANALYSE

Patient: What are the views of the Patient? (and 'patient group')? How do 4 principles of: Autonomy, Beneficence, Non-maleficence and Justice apply? Other perspectives?	**Legal:** Is scenario covered by IHL, Geneva Conventions, military law, other law? Other perspectives?
Clinical: What is the clinical diagnosis, prognosis, treatment options? Is this scenario covered by professional regulation or guidance? What are the views of individual members of the clinical team? Other perspectives?	**Societal/Military:** Is there a military necessity? Is this scenario covered by military regulation or military perspective? Is this scenario covered by public health or societal ethics? Other perspectives?

This Step considers the problem from 4 perspectives: patient; clinical; legal; and societal/military. This reflects the breadth of perspectives that impact on the practice of military healthcare personnel within a military context. It is expected that the relative balance of these perspectives will depend on the exact problem, not every question will be relevant, and additional questions may need to be considered.

a. **Patient**. This quadrant covers the perspectives of patients and their representatives (spouse, wider family, legal advocate). This is the perspective

in which Beauchamp and Childress's four principles of ethical health care are most likely to apply.

b. **Clinical**. This quadrant covers the perspectives of the clinical team covering all professional groups involved in clinical decision-making. It is also the perspective that should capture any guidance provided by regulatory or professional bodies.

c. **Legal**. This quadrant covers the legal perspective including International Humanitarian Law, national law or military law. In contentious cases, it is recommended that this perspective is provided by a qualified lawyer.

d. **Societal/Military**. This quadrant covers wider, non-clinical perspectives. It includes the ethical perspectives of public health, occupational health and preventive medicine. This quadrant might also consider if the principle of 'military necessity' gives a 'military commander' the authority to order the military medical services to undertake an activity that would be legal but may not be easy to reconcile ethically (such as controversial adjustment to MRoE).

6.6. Step 3 – FUSE

- Summarise conclusions
- Insert citations to key reference sources for your analysis
- Determine the exact Decision(s) to be made

This is the culminating step. The conclusions from the analysis of perspectives should be summarized and key references cited. This will determine the exact decision(s) to be made.

6.7. Step 4 – DECIDE

- **What is your Decision**?
- **Why** (can you justify it)?
- **Residual uncertainly**, need for review?

The final step clearly articulates the decision and is the record listing the key reasons for making that decision. This may include a record of areas of enduring uncertainly and any planned review of the decision.

6.8. The framework for MHE analysis is shown at Annex A with a worked example at Appendix 1.

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CHAPTER 7 TRAINING AND EDUCATION

7.1. INTRODUCTION

It is essential that all healthcare personnel on NATO or NATO led operations are familiar with their legal and ethical responsibilities. Professional healthcare education will provide a general background in healthcare ethics, however there is a need for specific MHE training to ensure the differences in the military context are understood.

7.2. EDUCATION AND TRAINING REQUIREMENTS

7.2.1. **Law of Armed Conflict** (**LOAC)**. States are responsible for ensuring all military personnel are trained in LOAC. Requirements are set in STANAG 2449 ATrainP-2 Training in the Law of Armed Conflict.

7.2.2. **Minimum standard training for NATO personnel**. STANAG 2249 AMedP-8.3 Training Requirements for Health Care Personnel in International Missions requires healthcare personnel to have the ability to identify and handle general and medical ethical problems during missions[36].

7.2.3. **NATO MHE indicative education curriculum**. NATO member nations will provide training and education in MHE to a varying standard. Annex B provides an indicative training curriculum that nations may wish to use to deliver MHE education to healthcare personnel within their military health services. It is recommended that this curriculum evolves based on the experiences of NATO members and organizations.

[36] AMedP 8.3 paragraph 3.2. MODULE 2 – Multinational Relations and Medical Ethics

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ANNEX A MILITARY HEALTH CARE ETHICS ANALYSIS FRAMEWORK

STEP 1 – IDENTIFY THE PROBLEM(S)

- Briefly state the **Scenario**
- List the **Issues** that arise from the scenario
- Identify **Critical Information** required and **Assumptions** to be made

STEP 2 – ANALYSE

Patient: What are the views of the Patient? (and 'patient group')? How do 4 principles of: Autonomy, Beneficence, Non-maleficence and Justice apply? Other perspectives?	**Legal:** Is scenario covered by IHL, Geneva Conventions, military law, other law? Other perspectives?
Clinical: What is the clinical diagnosis, prognosis, treatment options? Is this scenario covered by professional regulation or guidance? What are the views of individual members of the clinical team? Other perspectives?	**Societal/Military:** Is there a military necessity? Is this scenario covered by military regulation or military perspective? Is this scenario covered by public health or societal ethics? Other perspectives?

Step 3 – FUSE

- Summarise conclusions
- Insert citations to key reference sources for your analysis
- Determine the exact Decision(s) to be made

Step 4 – DECIDE

- **What is your Decision**?
- **Why** (can you justify it)?
- Residual uncertainly, need for review?

APPENDIX 1 OF ANNEX A - WORKED EXAMPLE OF MHE ANALYSIS FRAMEWORK[37]

Disclaimer:

This is an example of how to use the framework. Different considerations may lead to other conclusion, which should therefore not be considered a definitive single conclusion to the problem.

Step 1 – **IDENTIFY THE PROBLEM(S)**

- Briefly state the **scenario:** *You are commanding a NATO field hospital deployed in a conflict zone. The NATO force is sustaining significant numbers of casualties on a daily basis and your Intensive Care Unit (ICU) is continuously either close to capacity or full. You currently have 2 empty ICU beds. When ICU capacity is reached, more hazardous NATO military activities require to be suspended, or the NATO Commander is obliged to take risk that wounded NATO personnel may not receive the ICU care they require.*
- *A local national child, with airway burns, caused by the stove in her home exploding, has arrived at the front door of your hospital and will require immediate ICU care to survive. There is no other ICU facility in the country.*
- List the **issues** that arise from the scenario:
  - *Duty to injured child (saving life) vs duty to Commander and NATO force* (*preserving ICU capacity to enable Mission to proceed unhindered*)
  - *Potential effect on local permissiveness and cooperation if refusing to act to save lives of local population*
  - *Morale and potential moral injury to clinical staff if a salveable life is lost*
  - *Personal values*
- **Critical information Required** (**CIR**) and **Assumptions** to be made:
  - ***CIR** – what are Medical Rules of Eligibility (MRoE) in relation to treatment of Local National emergencies? Are MRoE subject to change, and how?*
  - ***CIR** - What is current threat assessment to the NATO force?*
  - ***CIR** - What level of risk of loss of ICU capacity is the NATO Commander prepared to tolerate?*
  - ***Assumption** – Child will die without ICU care. There is no ICU care available elsewhere in the country*
  - ***Assumption** – The child is likely to survive with ICU care*
  - ***Assumption** – The ICU cannot increase its capacity*
  - ***Assumption** – The NATO Commander will accept your recommended Course of Action*

[37] Derived from the kcl Department of War Studies MHE 'playing cards', specifically the 4 of Clubs

- ***Assumption*** *– Unless contrary information becomes available, NATO forces are likely to sustain new ICU requiring injuries in the next 36 hours*

Step 2 – **ANALYSE**

Patient: What are the views of the Patient? (and 'patient group')? How do 4 principles of: Autonomy, Beneficence, Non-maleficence and Justice apply? Other perspectives?	**Legal:** Is scenario covered by IHL, Geneva Conventions, military law, other law? Other perspectives?
Clinical: What are the clinical diagnosis, prognosis, treatment options? Is this scenario covered by professional regulation or guidance? What are the views of individual members of the clinical team? Other perspectives?	**Societal/Military:** In there a military necessity? Is this scenario covered by military regulation or military perspective? Is this scenario covered by public health or societal ethics? Other perspectives?

Patient:
Patient unable to express a view but is clearly in need of lifesaving treatment
Patient Group (Father is local clan chief) are vociferous requesting treatment
Autonomy – assume patient wishes to live
Beneficence – saving a life is beneficent
Non-Maleficent – Failing to easily save a life is maleficent but so would be removing ICU capacity from an at-risk NATO force
Justice – Injured people can reasonably expect to be helped by others but the resources in place were provided specifically for NATO and will not be in place when NATO departs. Healthcare personnel have a duty to save life.
Legal:
IHL and NATO policy (MC 326/4) states: The Universal Provision of Acute Emergency Care. Although the Operational Commander has the authority to limit the availability of military medical support to third parties, acute emergency treatment of life-threatening conditions normally must not be denied within the capability/capacity of the medical resources deployed.
WMA states that care should be provided without discrimination but this runs contrary to MRoE, which are not illegal.

Clinical:
The child has significant airway burns and without being intubated and ventilated and receiving ICU care will die. There are no realistic alternative lifesaving treatments.
Professional guidance would indicate this is a clinical emergency and requires appropriate treatment.

Societal/Military:
There is a military necessity to maintain ICU capacity to support the NATO force, however it is not possible to accurately predict when NATO will sustain casualties requiring ICU care or how many will be sustained.
Societal ethics would not make an adverse distinction towards a child versus a soldier (in fact a child is likely to receive more intensive therapy for a given situation)
In Public Health terms the health of the NATO population is being preferentially advantaged to the detriment of the local population.
There may be significant adverse media and political perceptions of NATO fails to provide treatment in this case
The Commander may pause hazardous military activity when ICU is at capacity; this may lose NATO the tactical initiative.

Step 3 – **FUSE**

- *Summarise conclusions*
  - *Failing to admit the child to ICU will result in her death*
  - *Although the Operational Commander has the authority to limit the availability of military medical support to third parties, acute emergency treatment of life-threatening conditions normally must not be denied within the capability/capacity of the medical resources deployed.*
  - *The situation has the potential to either erode local permissiveness and create adverse media coverage, or alternatively restrict local NATO military activity depending on the course of action chosen.*
  - *This situation may potentially result in moral injury to those involved.*
- *Insert citations to key reference sources for your analysis*
  - *NATO MC 326/4*
  - *NATO MHE STANAG*
- *Determine the exact Decision(s) to be made*
  - *A decision is required on whether to admit the child to the field hospital ICU or not*

Step 4 – **DECIDE**

- ***What is your Decision**? Recommend that the child may be admitted to the field hospital ICU. This is conditional on the NATO Commander acknowledging that when ICU reaches capacity, a suspension of hazardous military activities for the NATO force may be required, or else wounded NATO personnel may not receive the ICU care they require.*

- ***Why*** *(can you justify it)? This is a balance of risk. A life will be lost otherwise.*

- *Residual uncertainly, need for review?*
  - *What is the actual current threat to the NATO force?*
  - *How could extra ICU capacity be generated?*
  - *How will this action impact on consent of local population?*
  - *Would treating the patient help the overall Mission?*
  - *How might this situation be avoided in the future?*

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ANNEX B INDICATIVE MHE EDUCATIONAL CURRICULUM

KEY REFERENCES

- **Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies**. ICRC et al (2015). https://www.icrc.org/en/download/file/21341/icrc_ethical_principles.pdf
- **AJP 4.10(C) Allied Joint Doctrine for Medical Support**. NATO (2018)
- Geneva Conventions and their Additional Protocols. The Geneva Conventions and their Commentaries (icrc.org)
- **Protecting healthcare: Guidance for the Armed Forces**. ICRC (2020). Protecting healthcare: Guidance for the Armed Forces | International Committee of the Red Cross (icrc.org)
- **Health Care in Danger: The Responsibilities of Health-Care Personnel Working in Armed Conflicts and Other Emergencies**. ICRC. (2020). HCiD - Resource centre (healthcareindanger.org)

OVERVIEW

1. This indicative curriculum is designed to meet the Training Objective (TO) 'Understand Military Healthcare Ethics in order to practice health care ethically in the military setting'. This TO may be inserted into health professional courses delivered to members of NATO. Subordinate Enabling Objectives (EO) are separated into military operations (1.0) and professional practice (2.0). The EOs under 1.0 focus on knowledge, skills and attitudes for the operational environment. The TOs under 2.0 focus on general professional practice across the wider military health system.

2. The curriculum shows in **Bold** those Enabling Objectives (EOs) that should be taught to all personnel; in *Italics* those TOs that should be taught to middle grade leaders; and in normal font, a small number of TOs that should be taught to specific professional groups.

TRAINING OBJECTIVE: **Understand Military Healthcare Ethics in order to practice health care ethically in the military setting**

ENABLING OBJECTIVE 1: Understand the Laws of Armed Conflict (LOAC) and International Humanitarian Law (IHL) as applied to military health care personnel during military operations.

1.1. **Undertake LOAC training to comply with military service standards**.

1.2. **Identify the components of military service LOAC training that particularly apply to healthcare workers**.

1.3. **Identify the provisions within the Geneva Conventions and other International Humanitarian Law that apply to military healthcare workers**.

1.4. **Demonstrate the application of LOAC/IHL in the care of individual patients in the following categories: national military patients, international military patients, civilians, enemy combatants, non-state armed actors, criminals**.

1.5. **Describe the application of LOAC/IHL in the conduct of military medical units during conflict**.

1.6. *Prepare a teaching session on LOAC/IHL for ORs/junior NCO health professionals*.

1.7. *Prepare a teaching session on LOAC/IHL for senior NCOs/OF1-3 health professionals*.

ENABLING OBJECTIVE 2: Understand ethics in military health care as applied to professional practice as a healthcare worker (service personnel and civilians) within NATO.

2.1. **Interpret the ICRC et al Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies and other key references as applied to clinical professional practice for operations**.

2.1.1. **Demonstrate the ethical application of Triage in military medical practice**.

2.1.2. **Demonstrate the ethical application of Entitlement to care/Medical Rules of Eligibility in military medical practice**.

2.1.3. **Describe the additional responsibilities and arrangements for the provision of healthcare to specific populations under LOAC/IHL:**

children, women, disabled, non-native speakers, different religions, and cultures.

2.1.4. **Describe the use of the Protective symbol such as the Red Cross by healthcare personnel, ambulances, and medical facilities, including identity documentation**.

2.1.5. **Describe the authorities and limitations for the 'arming of healthcare personnel' under the Geneva Conventions and the restrictions of the use of force by healthcare personnel**.

2.1.6. *Understand the ICRC Healthcare in Danger project (http://healthcareindanger.org/), WHO Attacks on Healthcare Initiative (https://www.who.int/activities/stopping-attacks-on-health-care) and the WHO Violence Against Healthcare Workers project (https://www.who.int/violence_injury_prevention/violence/workplace/en/) and the duties of healthcare professionals*.

2.1.7. **Describe the application of ethical principles to standards of clinical practice on operations**.

2.1.8. **Describe the specific duties of healthcare personnel in regard to prisoners, captured enemy personnel, and detainees**.

2.1.9. Demonstrate the medical examination of a captured person (all doctors and nurse practitioners) and record-keeping.

2.1.10. **Describe the specific prohibitions of actions/behaviours by healthcare personnel under LOAC/IHL**.

2.1.11. **Demonstrate a process for making decisions in ethically uncertain circumstances on operations**.

2.1.12. *Describe the roles of a Commanding Officer, Senior Medical Officer, Senior Nurse (or equivalent national roles) in the ethical leadership of military medical units*.

2.2. **Understand the duties and potential conflicts associated with the duality of professions between the armed forces and healthcare workers**.

2.2.1. **Describe the general principles of medical ethics**.

2.2.2. **Identify national sources of policy, procedures, and general information on military medical ethics**.

2.2.3. **Describe your professional/ethical responsibilities in routine clinical practice within a NATO and national context in regard to: confidentiality, consent, reporting medical fitness to work, prescribing/administration of force health protection measures, record keeping, information sharing, relationships with patients, conflicts of interest, conduct of medical research, refusing treatment, seeking alternative/non-standard treatment, national security, safeguarding, practice within competence/training**.

2.2.4. **Give examples of potentially unethical/unlawful commands that might be given to a healthcare provider**.

2.2.5. *Describe the arrangements within your nation and NATO for the ethical oversight of service evaluation and health research*.

2.2.6. *Describe the ethical risks associated with the use of national and NATO military health capabilities for resilience activities (e.g. vaccination of civilians, augmentation to civilian health services).*

2.2.7. Complete an example of a national application to a Research Ethics Committee.

2.2.8. Describe how NATO reviews the introduction of novel/new medical practice/devices/pharmaceuticals.

2.3. **Describe how you would access advice in support of your ethical healthcare practice**.

2.4. **Describe how you would raise concerns regarding the application of ethical principles by your colleagues or the superior chain of command**.

2.5. *Demonstrate how you would address an example of unethical practice by a subordinate*.

2.6. **Discuss examples of failures by healthcare professionals to comply with ethical standards**.

Key:

BOLD – to be taught to all personnel

Italics – to be taught on career development courses JNCO/junior officer

Normal – to be taught to specific groups (listed in brackets)[i]

ANNEX C LEXICON PART 1 – ACRONYMS AND ABBREVIATIONS

C

CIR	Commander's information requirement
COMEDS	Committee of the Directors of Medical Services

E

EO	Enabling Objective

F

FIP	International Pharmaceutical Federation

I

ICMM	International Committee of Military Medicine
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross
ICU	Intensive Care Unit
IHL	International Humanitarian Law

K

L

LOAC	Law of Armed Conflict

M

MASCAL	Mass Casualty
MC	Military Committee
MEDEVAC	Medical Evacuation
MHC WG	Military Health Care Working Group

MHE	Military Healthcare Ethics (Not NATO agreed)
MRoE	Medical Rules of Eligibility
MTF	Medical Treatment Facility

N

NCO	Non-Commissioned Officer

O

OCHA	UN Office for the Coordination of Humanitarian Affairs
OR	Other Ranks

P

POW	Prisoner of War

S

STANAG	Standardization Agreement

T

TO	Training Objective

U

UN	United Nations

W

WHO	World Health Organisation (UN)
WMA	World Medical Association

ANNEX D LEXICON PART 2 – TERMS AND DEFINITIONS

A

B

C

Consent (Informed Consent): The process by which a patient learns about and understands the purpose, benefits, and potential risks of a medical or surgical intervention, including clinical trials, and then agrees to receive the treatment or participate in the trial.
(Medical Definition of Informed consent (medicinenet.com)

Confidentiality: Confidentiality in the medical setting refers to "the principle of keeping secure and secret from others, information given by or about an individual in the course of a professional relationship,"1 and it is the right of every patient, even after death.
(*BMJ* 2008;336:888)

D

Dual Loyalty: Clinical role conflict between professional duties to a patient and obligations, expressed or implied, real or perceived, to the interest of a third party such as an employer, an insurer or the state (military) that can violate patient's rights.
(This term and definition only applies to this publication. Source: World Medical Association)

F

H

Healthcare personnel: The persons assigned on a permanent or temporary basis, exclusively to defined healthcare purposes or to the administration of medical units or to the operation or administration of medical transports. Modified from NATO Agreed term Medical Personnel for the purpose of this document to refer to all healthcare including nursing and dental personnel.
(This term and definition only applies to this publication).

I

Intelligence: The product resulting from the directed collection and processing of information regarding the environment and the capabilities and intentions of actors, in order to identify threats and offer opportunities for exploitation by decision-makers.
(NATO Agreed)

International Humanitarian Law: regulates relations between States, international organizations and other subjects of international law. It is a branch of public international law that consists of rules that, in times of armed conflict, seek – for humanitarian reasons – to protect persons who are not or are no longer directly participating in the hostilities, and to restrict means and methods of warfare. In other words, IHL consists of international treaty or customary rules (i.e. rules emerging from State practice and followed out of a sense of obligation) that are specifically meant to resolve humanitarian issues arising directly from armed conflict, whether of an international or a non-international character.
(NATO Agreed (term only) Source ICRC).

L

Law of Armed Conflict: The body of international law that regulates behaviour during armed conflict (jus in bello to limit its negative effects, applies not only to governments and their armed forces, but also to armed opposition groups
(NATO Agreed (term only) Source: OED)

M

Medical Personnel: The persons assigned on a permanent or temporary basis, by a Party to the conflict, exclusively to defined medical purposes or to the administration of medical units or to the operation or administration of medical transports.

Notes: The term includes:

- medical personnel of a Party to the conflict, whether military or civilian, including those described in the First and Second Conventions, and those assigned to civil defence organizations;
- medical personnel of national Red Cross (Red Crescent, Red Lion and Sun) Societies and other national voluntary aid societies duly recognized and authorized by a Party to the conflict;
- medical personnel of medical units or medical transports.

(Source: derived: Protocols Additional to the Geneva Conventions of 12 August 1949)

Medical Research: The term "health research," sometimes also called "medical research" or "clinical research," refers to research that is done to learn more about human health. Health research also aims to find better ways to prevent and treat disease. Health research is an important way to help improve the care and treatment of people worldwide.
(What is Health Research? - Participating in Health Research Studies - Research Guides at Harvard Library)

Medical Rules of Eligibility. For the prupose of this publication, taken to mean the mechanism determining which patient groups are entitled to receive which treatments and/or evacuation within a medical treatment system, based on their background situation such as: NATO forces, adversaries, local civilians and contractors. This

enables matching of resources to patient demand to avoid medical facilities being overwhelmed.
(Not NATO Agreed. Source AJP-4.10C, please refer for further details)

Medical Intelligence: A specialized intelligence product derived from medical, bio-scientific, epidemiological, environmental and other information related to human or animal health. Notes: This intelligence product, being of a specific technical nature, may require medical expertise throughout its processing within the intelligence cycle.
(NATO Agreed)

Medical Support: A function encompassing the full range of medical planning and provision of medical and health services to maintain the force strength through disease prevention, evacuation, rapid treatment of the diseased, injured and wounded, their recovery and return to duty.
(NATO Agreed)

Military Health Care: Measures and activities to sustain or restore the health and the fighting strength of all military personnel from enlistment to retirement through the full spectrum of military duties in garrison and on deployment.

Military Healthcare Ethics: The study and application of moral principles to all aspects of health care delivered within an operational or military context.
(This term is a new term and definition and has been processed for NATO Agreed status via terminology tracking file [TBC])

Military Healthcare Personnel: Within this AMedP, the term 'military healthcare personnel' is used in place of the NATO Agreed term 'medical personnel' to highlight military status and the applicability to personnel working in all health care roles.

Moral Injury: Moral injury is the social, psychological, and spiritual harm that arises from a betrayal of one's core values, such as justice, fairness, and loyalty. Harming others, whether in military or civilian life; failing to protect others, through error or inaction; and failure to be protected by leaders, especially in combat—can all wound a person's conscience, leading to lasting anger, guilt, and shame, and can fundamentally alter one's world view and impair the ability to trust others.
(Not NATO Agreed: Source Psychology Today)

N

Non-Combatant: a person who is not engaged in fighting during a war, especially a civilian, army chaplain or army doctor.
(Not NATO Agreed. Source: Oxford English Dictionary)

P

Perfidy: deceitfulness; untrustworthiness
(OECD).
Acts inviting the confidence of an adversary to lead him to believe he is entitled to, or is obliged to grant, protection under the rules of international humanitarian law applicable in armed conflict, with intent to betray that confidence, constitute perfidy.
(ICRC). Perfidy | How does law protect in war? - Online casebook (icrc.org)

Population at Risk: A group of individuals exposed to conditions which may cause injury or illness.
(NATO Agreed)

S

T

Triage: The dynamic process of sorting multiple casualties and/or patients, based on severity of illness or injury, to systematically prioritize treatment and evacuation within a resource-constrained environment.
(Modification in progress TTF 2012-0206)

U

W

INTENTIONALLY BLANK

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