



Battlefield conditions: Different environment but the same duty of care

Nursing Ethics

17(5) 636–645

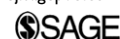
© The Author(s) 2010

Reprints and permission:

sagepub.co.uk/journalsPermissions.nav

10.1177/0969733010373434

nej.sagepub.com



Janet Kelly

University of Hull, UK

Abstract

Using an interpretative research approach to ethical and legal literature, it is argued that nursing in the battlefield is distinctly different to civilian nursing, even in an emergency, and that the environment is so different that a duty of care owed by military nurses to wounded soldiers should not apply. Such distinct differences in wartime can override normal peacetime professional ethics to the extent that the duty of care owed by military nurses to their patients on the battlefield should not exist. It is also argued that as military nurses have legal and professional obligations to care for wounded soldiers on the battlefield, this obligation conflicts with following military orders, causing a dual loyalty conflict. This is because soldiers are part of the 'fighting force' and must be fit to fight and win the battle. This makes them more of a commodity rather than individual persons with distinct health care needs.

Keywords

battlefield, duty of care, military nurses, obligations to care

Introduction

This article offers a critique of the concept of military nurses owing a duty of care to wounded soldiers on the battlefield (where direct contact with the enemy takes place owing to hand-to-hand fighting or where soldiers and the enemy are closely engaged in firing bullets, rockets and grenades at each other). It suggests that the battlefield environment is so unusual that the duty of care, which is normally owed by military nurses to their patients, should not apply. Drawing on analogies between battlefield and emergency civilian health care treatment, the article examines significant differences between military and civilian nursing practice.

The article acknowledges that there are professional similarities between military and civilian nursing practice in general. However, it is asserted that the battlefield health care environment is significantly different from the civilian health care environment because caring for wounded soldiers on the battlefield is detached from traditional support mechanisms,¹ even when compared with administering emergency care or treatment to a casualty in a busy civilian accident and emergency (A&E) department in an inner city on a Friday or Saturday night, or even a localized major incident such as a terrorist attack similar to that of the London bombings in July 2005. In such situations, civilian nurses may be able to call on and expect the assistance of a specialized nurse, modern matron or doctor, although it is acknowledged that this assistance may not always be immediate. Military nurses, however, could be alone and isolated in a bleak Afghan

Corresponding author: Janet Kelly, Department of Professional Health Studies, Faculty of Health and Social Care, University of Hull, Cottingham Road, Hull HU6 7RX, UK.

Email: j.kelly@hull.ac.uk

plain, working in extreme high or low temperatures,² and could also be under enemy fire from missile attacks, all of which make the environment extremely dangerous.³ Moreover, civilian nurses would not have the uncertainty about medical supplies being replenished to the same extent as military nurses.⁴ Accordingly, even though it is acknowledged that giving care and treatment in emergency civilian circumstances is difficult and challenging for civilian nurses,² this article explores the evidence that it is unreasonable for military nurses to owe their patients the same duty of care in the battlefield.

The methodology used is an interpretative research approach with a critical analysis of ethical and legal literature. The article commences by explaining the current legal position of nurses owing their patients a duty of care. It highlights legal and ethical conflicts and constraints among professional regulations, military orders, ethos and command. It explains the differences between military and civilian health care practice. It does this by noting that these differences are due to strategic, clinical and environmental criteria. In doing so, it explains that, despite these differences, military nurses continue to owe all their patients a duty of care. This article compares and contrasts this duty with civilian nurses' duty of care and, throughout, comments upon some ethical differences and difficulties that military nurses can encounter on the battlefield.

The legal position

In English law, all health care professionals, irrespective of whether they are military or civilian, owe their patients a duty of care, regardless of the location or the circumstances in which they give this care.⁵ For military nurses serving overseas, this also means that they owe their patients a duty of care in the battlefield.⁶ This legal principle therefore protects patients because the concept of a duty of care provides an overall framework for the huge variety of situations in which accountability may arise.

Although there is no legal or professional distinction between civilian and military nursing, the law and the Nursing Midwifery Council's (NMC)⁵ professional code is clear: if nurses give care, treatment, or advice to patients they then owe those patients a duty of care.⁷ The duty of care and the legal responsibility begins 'whenever they accept a patient for treatment'.⁸ Thus, it can be argued that the duty of care concept is comprehensive and goes to the very essence of ensuring that it sets clinical boundaries for all health care professionals irrespective of them being either civilian or military. This is so that they remain accountable for their acts or omissions and are liable for the consequences of careless clinical practice and/or behaviour.⁵ The duty of care concept is comprehensive, embracing and wide ranging. It is not, as mentioned by Green,⁹ an 'indivisible phenomenon'.

For military nurses, by the very fact they are deployed on the battlefield giving medical support to soldiers, it is clear that if they come across a wounded soldier who requires treatment they have a legal and professional accountability to that patient.¹⁰ In such an environment, they are duty bound to assist casualties and potential casualties.¹¹ However, the difficulty with legal and professional accountability is that, if it conflicts with military orders on the battlefield it places military nurses in an ethical dilemma about what course of action to take. Thus, military orders and discipline can appear to be almost a physical impediment for a military nurse in deciding what course of action to take.

According to Tschudin, one person can seldom solve an ethical dilemma.¹² Tschudin goes further by saying that problems can be solved whereas dilemmas cannot. This arises when faced with an agonizing choice. For example, such a conflict could occur if a military nurse travelling in a Landrover within a battlefield area has been given prior orders not to leave hard-packed roads owing to landmines. However, the nurse then comes across a soldier lying on a dirt track five metres away, who has just experienced a traumatic amputation of his right leg and arm caused by a landmine. Unexploded mines surround him; he is screaming out in pain and bleeding profusely. The military nurse, as he or she is trained to do, can see the urgency of needing to place tourniquets around the soldier's severed limbs. The nurse wants to start de-mining a path to reach the injured soldier, by lying prone and feeling for mines with bare hands or a thin rod, and gently crawl towards

the soldier to treat him. (This manoeuvre would take approximately five minutes: one metre per minute.) However, military orders on operations¹³ prevent the nurse from doing so; the nurse must wait until personnel with appropriate technical equipment arrive to make a safe passageway. Statistics state that there are 700,000 unexploded mines in Kuwait from the first Gulf War, thus highlighting the reality of this threat.¹⁴ Military nurses' duty to care on the battlefield therefore appears to be constrained by the power of military orders. However, by following military orders (because nurses must adhere to the law) they would therefore breach the NMC code of ethics⁵ by not making the patient their first concern. In addition, they would also not be following the guidelines of the International Council of Nurses *Code of ethics for nurses*, where it advises that nurses' fundamental responsibilities are to alleviate suffering.¹⁵

Although a similar analogy, for example, could be drawn if a civilian nurse, when driving while on duty in the community, witnesses a child struggling in a deep lake but is unable to help because it is too dangerous to do so, the scenario environments are significantly different. This is because, whereas the civilian nurse cannot help because he or she is not able to do so (e.g. the nurse may not be able to swim), the military nurse can help but is ordered from a higher command not to do so. As mentioned by Altun,¹⁶ military nurses must be unquestionably obedient to military orders, which they must follow and accept with the utmost seriousness. However, if on the other hand, the military nurse disobeyed military orders and immediately de-mined a safe passage to the soldier, although there would be no conflict with professional accountability, the nurse would have disobeyed a lawful military command and would perhaps have committed a reckless act under military law that could lead to disciplinary action.¹⁷

Consequently, in relation to the scenario, if the military nurse failed to act by not putting tourniquets around the soldier's severed limbs, it is likely that the soldier would exsanguinate. If the nurse, however, disobeyed military orders and acted by de-mining a safe passageway with the intent of giving treatment to the wounded soldier, by this act the nurse would also assume a duty of care.⁸ Thus, it appears that the law and the NMC's professional code⁵ leave little scope for any dispute because it is clear that the military nurse would owe a duty of care to the wounded soldier in both situations in the context of the scenario.

However, this article suggests that, in spite of the law and the regulation from the NMC, military nurses should not owe a duty of care that is subject to legal negligence when in a battlefield environment. The main reason for this, as will be discussed in detail, is owing to the battlefield being a distinct hostile environment. As mentioned by Beam,¹⁸ the battlefield is 'the antithesis of the ideal medical setting'. It is more violent than a civilian A&E department. It is noisy, chaotic, in a constant state of flux and unpredictable. 'There are simply no comparable situations in the civilian sector, despite frequent comparisons to inner-city emergency rooms on "any Saturday night"' (p.371).¹⁸

Military nursing practice: its distinctness

Strategic differences

Gross¹⁹ explains that during war and on the battlefield military nurses treat individual soldiers as an essential part of the 'fighting force' so that they can be fit to fight. Soldiers are therefore seen more as a commodity to win battles and wars rather than individuals with distinct health care needs. As such, according to Kowtow,²⁰ the battlefield can force military nurses to perform duties that are clearly not always in a patient's best interests if they have to follow military orders first. This is supported in a different article by Gross,²¹ where he states that 'on the battlefield, military healthcare is an adjunct of war, it does not speak to saving the lives of soldiers as an end in itself, but of salvaging their lives so they can fight'. This emphasizes a clear difference between an emergency civilian situation either within or outside a hospital and the battlefield. This is because, unlike military nurses, in accordance with their professional code civilian nurses would need to 'make the care of people' their 'first concern' even in an emergency (p.1).⁵ Thus, military nursing in an

organization that is involved in fighting can seem contradictory to the values and beliefs of civilian health care professionals.²²

Gross²¹ goes on to explain that, in the battlefield, salvaging lives in order to maintain manpower and military capability is of paramount importance. For civilian nurses, salvaging lives is equally their goal but, for different reasons, they would 'promote the health and wellbeing of those in their care'.⁵ Moreover, on a wider scale, whereas civilian health care is directed towards saving life, military health care offers a legitimate framework for taking life in war.²³ Gross¹⁹ also states, 'During war, healthcare personnel do not treat individual soldiers "qua discrete" patients but as components of a *fighting force*: a living, collective entity'. This is because in choosing a particular course of action military personnel are governed by an enforced 'command structure', which expects its soldiers to carry out tasks that are more demanding compared with civilians.²⁴

Both Gross²¹ and Kottow²⁰ highlight the different ethical and moral concept that military nurses have of patient care when compared with civilian practice. Furthermore, they illustrate how military nurses act differently in war when they are compared with civilian nurses. Civilian nurses caring for wounded soldiers would not consider their patients (i.e. the soldiers) as a 'fighting force'. They would 'treat people as individuals and respect their dignity' (p.2).⁵ They would care for patients according to the severity of their wound or illness, not based on whether that individual was required to fight a decisive battle. Moreover, they would give nursing care in an atmosphere that allows individualized patient care for the attainment of patient autonomy and fulfilment of self-determination.²⁵

However, the courts are keen to allow the military to remain autonomous and detached from civilian norms.²⁶ Gross's²¹ article therefore highlights that the military nurse owing a duty of care to a patient on the battlefield may be seen as an unnecessary constraint because it is secondary to winning the battle and the war. This is because, as Tripodi²⁷ mentions, soldiers (this includes military nurses) are equipped through basic training to act without later thinking of the moral or legal repercussions of their decisions. In other words, an army's existence is not to adhere to normal peacetime social expectations such as a military nurse automatically acquiring a duty of care when giving treatment to a patient on the battlefield. 'The military objective must override the interests of the individual'²⁸ so that they are 'fit to fight' before being accorded personal needs and individualized health care.¹⁹ Thus, the critical ethical difference between civilian and military health care practice in the battlefield is that the military need is primarily to provide care to achieve and maintain battle readiness.

Fit to fight

There are two reasons why military nurses consider soldiers to be part of the 'fighting force' so that they must first be fit to fight before being viewed as patients with individual health needs.

First, the existence of an army and its aim in a conflict is to 'fight and decisively win its nation's wars'.²⁹ Thus, it is crucial that military nurses ensure that soldiers are fit to fight and win the battle decisively before acknowledging the individual needs of their patients. This article accepts that this notion may be morally repugnant to civilian nurses and contradict the entire principles of health care.³⁰ However, if winning the battle was not important, it can be questioned why should an army with military nurses exist in the first place? A state or country should not lose sight of this 'fit to fight' concept by placing constraints on those military personnel who fight and aspire to achieve this aim and those who give military nursing care.

Second, for the British Army, wherever a service person is serving, military law and discipline must underpin operational effectiveness,³¹ which, at its highest level, achieves the military intent of the government of the day. This could be to win the war or to maintain peace. The military Commander's intent is then mirrored in this concept. Thus, operational effectiveness takes precedence and is the British Army's ultimate objective before everything else. On the contrary, however, this article acknowledges that operational effectiveness

is perhaps not a consideration or issue that front line civilian nurses in the NHS are preoccupied with to the extent that owing a duty of care to their patient becomes secondary. Operational effectiveness has a rather different interpretation in the NHS context: it is to ensure that civilian nurses provide equally high quality patient care while, alternatively, military nurses' high quality patient care must ensure that soldiers are 'fit to fight'.^{5,32} The legal mandate for providing high quality care is found in the National Health Service Act 2006.³²

Military discipline

Although military nurses owe their patients the same duty of care as civilian nurses, these nurses are different. This is because they more readily adapt their clinical skills to any situation and have a different disciplinary code,³³ even though these differences are due to what Beam¹⁸ comments on as a predisposition of military medical personnel to obey military orders and a closed hierarchical military rank structure that does not allow orders to be questioned by subordinates. Military nurses, by the adoption of military rank and following military orders, the wearing of combat uniform, the carrying of arms and the undertaking of general military training are, according to Bassett,³⁴ 'of the military'. This makes military nurses soldiers first, who are subjected to military discipline, and nurses second. Thus, discipline is the 'backbone' that promotes efficiency in the armed forces and involves military nurses following military orders.³¹

Although it may be argued that civilian nurses have the same distinctness in terms of civilian uniform, a hierarchical structure (albeit less authoritarian than the armed forces), and an internal training structure, military nurses nonetheless remain different as they also have diverse expectations placed upon them and more demands.³⁵ For example, military nurses are on duty 24 hours a day and they are sometimes ordered to attend military duties outside their normal clinical duty working hours while wearing military uniform.³⁶ For instance, a military nurse could be caring for a patient on the battlefield and then be on guard duty at a medical establishment and carrying a loaded weapon during the night.

Furthermore, although civilian nurses must equally follow civilian orders, a civilian order is more patient focused than a military one. Harper³³ argues that this is one of the main differences between military and civilian medical services because it demonstrates a significant distinction between which duty should take precedence over the other. For civilian nurses there is no doubt that patients' health care needs are paramount and come first.⁵ However, for military nurses the situation is less straightforward because operational effectiveness takes precedence. This raises the question of the legal and ethical conflict of interest arising when military nurses, who are soldiers first, can be acting legally and ethically in one sense only by compromising legality and acting unethically in the other!³⁷ This is because it is legally right to follow a military order and legally wrong not to do so,³⁸ a dilemma that civilian nurses do not experience because they are accountable only to the NMC.

Toner³⁹ remarks that a sword dominates military ethics, with the importance of following military orders being a priority. This means that achieving operational effectiveness is a feature that every military nurse must accept and anything after that, such as nurse autonomy or patients' self-determination, is secondary, a concept that would be clearly unacceptable for civilian nurses. For example, one could not imagine a civilian administrator in an A&E department during an emergency ordering where and when civilian doctors or nurses must treat patients. However, in striving to achieve operational effectiveness in the battlefield, a nursing obligation to treat casualties must be weighed against the military obligation to win the battle, a notion that civilian nurses would not even have to contemplate. Furthermore, in the battlefield, military orders become a 'third party' in that they can sometimes interfere with what Enemark²³ comments on as the 'dyadic doctor-patient relationship' or nurse-patient relationship. A fundamental difference is that third-party intervention would not normally occur or affect the civilian relationship between nurses and patients, especially in an emergency environment.

Clinical differences

Gross²¹ also comments about patients having limited rights on the battlefield. Here, he emphasizes that in the American armed forces it is an offence for soldiers to refuse medical treatment that would subsequently render them unfit for duty.⁴⁰ In English law, 'even when his or her own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it'.⁴¹ Nevertheless, although in English law every competent adult is entitled to refuse medical treatment, even if they could die, in the British armed forces, refusing medical treatment could equally be seen as wilful neglect of their military duty, even on the battlefield. According to the Armed Forces Act 2006,⁴² an act or omission to aggravate or prolong any injury is considered an offence. Clearly, refusing medical treatment on the battlefield would delay the soldier returning to fight.

Other clinical differences arise from the evacuation chain of casualties. Owing to the unpredictability of warfare, this chain can never be guaranteed to work. Moreover, on operations, large numbers of clinical personnel may attend the same casualty at different points in the treatment chain.⁴³ This can make the evacuation chain longer than what it would be in a civilian hospital and delay treatment.⁴⁴ In particular, this can delay critical treatment in the 'golden hour':

The first 60 minutes following a serious injury is known as the 'Golden Hour'. Seriously injured casualties correctly resuscitated and treatment begun in a definitive care facility during this vital time will be given the best chance of survival with minimum long-term disability. Of those victims of major trauma who die, two-thirds will have suffered major head or other central nervous system injuries about which little could have been done that would have altered the inevitable outcome. However, two-thirds of the remaining fatalities would be preventable if the casualty were to receive appropriate medical management in this 'Golden Hour'. The majority of preventable deaths at the scene occur because of inadequate airway management. The rest occur because of inadequate management of ineffective breathing or inadequately treated shock following haemorrhage.⁴⁵

Even more lives can be saved by adequate treatment during the 'platinum 10 minutes':

Recently, the Army medical community rediscovered that even more important than the Golden Hour was the first 10 minutes after a traumatic injury. The first 10 minutes is now being called the 'Platinum 10'.⁴⁶

Although a delay in emergency treatment can be equally problematic, for example, when rescuing a drowning child, nonetheless, providing essential care on the battlefield is clearly deemed more dangerous. As mentioned by Callan⁴⁷ and Murdock,⁴⁸ to prevent death, trauma patients must receive definitive care within these two crucial timescales. Moreover, as stated by Hess and Holcomb,⁴⁹ when military physicians treat patients from the battlefield 'who require massive transfusion [blood] four to five times the frequency seen in civilian practice' the situation can become more problematic. Hodgetts et al.⁵⁰ highlight this difference further when they explain that injury caused by ballistic weapons generates significantly more damage than the blunt trauma commonly seen in a civilian A&E department, and that profuse bleeding is the main cause of death on the battlefield. Consequently, the traditional ABC (airway, breathing and circulation) management is now replaced by training military nurses to adapt to '<C>ABC management where C stands for dealing with catastrophic haemorrhage'.⁵⁰

Environmental differences

Localized environmental differences are also significant. Unlike civilian health care professionals working in a stable and often relatively safe environment, military nurses work in the battlefield in total isolation from medical assistance. They do not have access to the same emergency facilities to summon assistance. They can be fatally injured at any time when giving treatment to their patients. They also work in extreme hot and cold conditions without heating or air conditioning, and in harsh temporary and mobile facilities without any

reinforcements to assist or relieve them.⁵¹ Even civilian nurses and others attending major incidents outside the safety of their hospitals do not experience such conditions. If they are outside the hospital, the environment to this extent does not impede them. Although many civilian nurses work alone in the community and in sparse rural areas where mobile phone reception can be extremely poor, they are still never totally isolated in terms of communication and dangerous terrain such as landmines to the same degree as military nurses can be isolated in the battlefield. They do not, for example, ever have a minefield to circumvent before reaching a casualty. Thus, caring for wounded soldiers on the battlefield carries awesome responsibility and requires courage.⁵²

These harsh environments are not, according to Griffiths and Jasper,²² 'ring fenced', meaning that the battlefield is no longer static; instead it is fluid and movable given the use of modern weapons. For example, in the deserts of Iraq and Afghanistan, Colonel Tim Hodgetts, a military A&E consultant at the local field hospital, commented that 'the clinical routine was regularly interrupted by ballistic missile warnings for incoming SCUDs [tactical ballistic missiles developed by the Soviet Union during the Cold War and exported widely to other countries], or chemical attack alarms'.⁵³ The threat of chemical attack would have entailed all personnel wearing their nuclear, biological and chemical warfare charcoal suit and putting on their respirator within nine seconds. This makes treating casualties almost impossible owing to the degradation (i.e. physical exhaustion) of the human body caused by the charcoal clothing.

Concluding comments

This article has discussed and exposed legal and ethical dilemmas, which can create dual loyalty conflict.⁵⁴ It has also highlighted the difficulties for military nurses facing this dual role conflict; that is, that of soldiers/nurses having to obey military orders while also having to follow professional codes of practice.⁵⁵

Military nursing is significantly different from civilian nursing, and even more so on the battlefield⁵⁶ because caring for wounded soldiers in this environment is detached from traditional support mechanisms.² However, in spite of this distinctiveness, legally, military nurses continue to owe a duty of care to their patients. This article has also highlighted that military nursing is deemed to be secondary to achieving operational effectiveness, which is to achieve whatever military objective has been given by the government of the day. This could be to win a decisive battle, the war, or to achieve peace if deployed on a peace-keeping mission.

Best⁵⁷ remarks that a 'medical readiness mission' supports military necessity, which is to ensure that soldiers are fit to fight. It is therefore clear that the primary role of military nurses is to maintain the readiness of combat soldiers to ensure that they are fit to fight and, if necessary, to kill the enemy during war.⁵⁸ As discussed, this can cause a distinct ethical dilemma for military nurses. In one sense, they are as described by Matthews⁵⁹ as having two roles: that of healer in doing no harm and that of a 'security agent' in preparing a soldier to inflict harm on another person. This dual role and being a servant to two masters can be problematic. For a professional body such as the NMC to have an effective code of ethics for determining acceptable behaviour, it must have sole responsibility for its members.⁶⁰ This perhaps is not possible for military nurses because, even though they are responsible and accountable to the NMC and owe all their patients a duty of care,⁷ military orders and law primarily govern their actions. However, as Witting⁶¹ points out in his analysis of the concept of a duty of care, the courts would be willing to examine the impact that a duty of care could have on a party as long as the argument was sufficiently robust and was in the administration of justice.

To draw a clear distinction between civilian and military nursing it must be seen that such clear differences in wartime can override normal peacetime professional ethics. This, however, creates ethical dilemmas for military nurses on the battlefield. 'An action may be legal but unprofessional, exposing a healthcare professional to action by his/her Statutory Regulatory Body.'⁵⁵ Thus, following military orders and maintaining operational effectiveness can make following professional codes of practice and owing a duty of care to

patients in the battlefield more difficult. This is a view shared by London,⁶² who stresses that health care ethics very often yields to the ‘acquiescence to military demands’, so acknowledging friction between achieving the military mission and adequately caring for casualties on the battlefield.

This article has also concluded that the limited colonization of military law by civilian norms should remain distant.²⁶ In other words, the duty of care owed by military nurses to their patients who have been injured in the battlefield is constrained and thus questionable under existing ethical and legal parameters. It could be argued that civilian norms in the battlefield cannot be colonized and are thus incompatible with the reality of war and, in particular, with the battlefield environment.

Perhaps, as stated by Hallgarth,⁶³ the ‘painful truth’ may be that, when practising nursing in the battlefield and ‘when the stakes are sufficiently high’, to allow patients the same duty of care relationship as they would have with civilian health care professionals is not practicable or reasonable in such hostile conditions and is too onerous a legal task for military nurses.

Conflict of interest statement

The author declares that there is no conflict of interest.

References

1. Southby JR. Nursing ethics and the military. In: Beam TE, Sparacino LR (eds). *Military medical ethics*, vol. 2. Washington, DC: Borden Institute, 2003, p.661–86.
2. Fry S, Harvey RM, Hurley AC, Foley BJ. Development of a model of moral distress in military nursing. *Nurs Ethics* 2002; 9: 373–87.
3. Kligman A, Kupermintz H. Response style and self-control under SCUD missile attacks: the case of the sealed room situation during the Gulf War. *J Trauma Stress* 1994; 7: 415–26.
4. US Department of the Army. *Combat health support in stability operations and support operations* [Field manual]. Washington DC: DA, 1997, p.8–42.
5. Nursing and Midwifery Council. *The code: standards of conduct, performance and ethics for nurses and midwives*. London: NMC, 2008.
6. *R v. Bateman* [1925] All ER Rep 45 at 49
7. Nursing and Midwifery Council. *Duty of care* [Advice sheet]. London: NMC, 2008.
8. *Cassidy v. Ministry of Health* [1951] 1 All ER 574 at 586
9. Green S. Coherence of medical negligence case. *Med Law Rev* 2006; 14(1): 1–14.
10. Tschudin V, Schmitz C. The impact of conflict and war on international nursing and ethics. *Nurs Ethics* 2003; 10: 354–67.
11. Williams PT. To kill or not to kill: a question of wartime ethics. *Nurs Ethics* 1996; 3: 150–6.
12. Tschudin V. *Ethics in nursing: the caring relationship*, second edition. Oxford: Butterworth-Heinemann, 1992.
13. *Armed Forces Act 2006*. Norwich: The Stationery Office, 2006, s. 2 (3).
14. Bajec I. Post Gulf War explosive injuries in liberated Kuwait. *Injury* 1993; 24: 517–20.
15. International Council of Nurses. *Code of ethics for nurses*. Geneva: ICN, 2000.
16. Altun I. Innovation in behaviour patterns that characterize nurses. *Nurs Ethics* 2008; 15: 838–40.
17. *Armed Forces Act 2006*. Norwich: The Stationery Office, 2006, s. 12 (1) (a) and (b).
18. Beam TE. Medical ethics on the battlefield: the crucible of military medical ethics. In: Beam TE, Sparacino LR (eds). *Military medical ethics*, vol. 2. Washington, DC: Borden Institute, 2003, 369–402.
19. Gross ML. *Bioethics and armed conflict: moral dilemmas of medicine and war*. Cambridge, MA: MIT Press, 2006.
20. Kottow MH. Should medical ethics justify violence? *J Med Ethics* 2006; 32: 464–7.
21. Gross ML. Why treat the wounded? Warrior care, military salvage, and national health. *Am J Bioethics* 2008; 8(2): 3–12.

22. Griffiths L, Jasper M. Warrior nurse: duality and complementarity of role in the operational environment. *J Adv Nurs* 2007; 61: 92–9.
23. Enemark C. Triage, treatment, and torture: ethical challenges for US military medicine in Iraq. *J Military Ethics* 2008; 7: 187–201.
24. Sandin P. Collective military virtues. *J Military Ethics* 2007; 6: 303–14.
25. Rossow-Kimball B, Goodwin D. Self-determination and leisure experiences of women living in two group homes. *Adapt Phys Activ Q* 2009; 26: 1–20.
26. Rubin GR. United Kingdom military law: autonomy, civilisation, juridification. *Mod Law Rev* 2002; 64: 36–57.
27. Tripodi P. Peacekeepers, moral autonomy and the use of force. *J Military Ethics* 2006; 5: 214–32.
28. *Re Post Traumatic Stress Disorder Group Litigation. Multiple Claimants v. Ministry of Defence* [2003] EWHC 1134 at 2.c.12
29. Westhusing TS. Equality within military organizations. *J Military Ethics* 2006; 5: 5–11.
30. Crowe C, Hardil K. Nursing and war: transforming our legacy. *Can Nurse* 1991; 87: 291–302.
31. SO1 Leadership and Development. *Soldier management: a guide for commanders*. Sandhurst: Royal Military Academy, 2004, p.50.
32. *National Health Service Act 2006*. Norwich: The Stationery Office, 2006.
33. Harper P. Different skills, different attitude, same duty of care. *Br J Nurs* 2006; 15: 537–9.
34. Bassett A. *Guns and brooches: Australian Army nursing from the Boer War to the Gulf War*. Oxford: Oxford University Press, 1997.
35. Moore BA, Reger GM. Clinician to frontline soldier: a look at the roles and challenges of army clinical psychologists in Iraq. *J Clin Psychol* 2006; 62: 395–403.
36. Ministry of Defence. *Queen's regulations for the Army* (Part 8: Medical, dental and health – Part 9: Dress). London: Her Majesty's Stationery Office, 1975, J5.362.
37. Yeo M. Integration of nursing theory and nursing ethics. *ANS Adv Nurs Sci* 1989; 11(3): 33–42.
38. *Armed Forces Act 2006*. Norwich: The Stationery Office, 2006, parts 11–13.
39. Toner C. Military service as a practice: integrating the sword and the shield approaches to military ethics. *J Military Ethics* 2006; 3: 183–200.
40. Bureau of Medicine and Surgery, under the authority of the Secretary of the Navy. *Manual for the Medical Department of the United States Navy*. Washington, DC: Government Printing Office, 1914, paras 2085, 3413.
41. *St Georges's Healthcare NHS Trust v. S, R v. Collins and others, ex parte S*, [1998] 3 All ER 673
42. *Armed Forces Act 2006*, Part 1 (Offences), s. 16 – Malingering (1) c).
43. Ministry of Defence. *Joint medical doctrine* (Joint Warfare Publication 4-03). Shrivenham: Joint Doctrine and Concepts Centre, 2007, paras 120, 122.
44. MacFarlane C. Emergency thoracotomy and the military surgeon. *Aust N Z J Surg* 2004; 74: 280–4.
45. Haworth M. *Motorsport rescue. The golden hour*. <http://www.haworth21.karoo.net/The%20Golden%20Hour.htm> (2006, accessed May 2010).
46. Bukowski CW. The Platinum 10: 2nd BCT, 101st Airborne improves medical training to help save lives. *Infantry Magazine* 2006; (July–August). http://findarticles.com/p/articles/mi_m0IAV/is_4_95/ai_n17154164/ (2006, accessed May 2010).
47. Callan v. Extrication of the seriously injured road crash victim. *Emerg Med J* 2005; 22: 817–21.
48. Murdock DB. Trauma: where's there no time to count. *AORN J* 2008; 87: 322–32.
49. Hess JR, Holcomb JB. Transfusion practice in military trauma. *Transfus Med* 2008; 18: 143–50.
50. Hodgetts TJ, Mahoney PF, Russell MQ, Byers M. ABC to <C> ABC: redefining the military trauma paradigm. *Emerg Med J* 2006; 23: 745–6.
51. Kraemer LA. A military twist to the profession of nursing. *Medsurg Nurs* 2008; 17: 275–7.
52. Rajecki R. Rescuing soldiers. *RN* 2009; 72(2): 36,39.
53. Hodgetts TJ. Personal view: a day in the life of an emergency physician at war. *Emerg Med J* 2004; 21: 129–30.

54. Coleman S. The problems of duty and loyalty. *J Military Ethics* 2009; 8: 105–15.
55. Ministry of Defence. *Medical support joint operations*, second edition. Shrivenham: Joint Doctrine and Concepts Centre, 2007, para. 112.
56. Kennedy TE, Hill E, Adams NR, Jennings B. A conceptual model of army nursing practice. *Nurs Manage* 1996; 27: 33–6.
57. Best R. *Military medical care: questions and answers*. Congressional Research Service. <http://www.washingtonpost.com/wp-srv/nation/documents/walter-reed/RL33537.pdf> (2007, accessed May 2010).
58. Tricarico DJ. Readiness – meeting the air force mission. *Today's Surg Nurse* 1998; 20: 41–6.
59. Matthews RS. Indecent medicine: in defense of the absolute prohibition against physician participation in torture. *Am J Bioethics* 2006; 6(3): W34–W44.
60. Hedahl M. Blood and blackwaters: a call to arms for the profession of arms. *J Military Ethics* 2009; 8(1): 19–33.
61. Witting C. Duty of care: an analytical approach. *Oxf J Legal Stud* 2005; 25(1): 33–63.
62. London AJ. Threats to the common good. *Hastings Cent Rep* 2003; 33(5): 17–25.
63. Hallgarth MW. Bioethics and armed conflict: moral dilemmas of medicine and war [Book review]. *J Military Ethics* 2007; 6: 83–4.