Martin Bricknell reflects on Christianity in conflict medicine and what it teaches us about managing the current pandemic

RELIGION, MORALITY, ETHICS AND WAR

key points

- The pressures on healthcare systems around the world have raised resource and care prioritisation issues similar to those found in the practice of healthcare in conflict situations, from which there is much we can learn.
- Those working in military healthcare have to balance 'dual loyalties' to their healthcare profession, its values and ethics, and to the military and its requirements. This is seen most acutely during times of military conflict.
- For Christians in this situation the ethics, values and loyalties we have to Christ and his Kingdom add a further level of complexity to these 'dual loyalties'.

The COVID-19 crisis has challenged our healthcare system's very fabric and placed enormous burdens on healthcare workers. There have been comparisons between this crisis and healthcare practice in the Armed Forces.[1] As a recently retired military doctor, I believe my reflection on the personal beliefs that have grounded me throughout my career might provide some insights into resilience in crisis medicine.

Military healthcare professionals' practice is grounded in the concept of dual loyalty: loyalty to our healthcare profession and loyalty to the military profession.[2] This 'dual loyalty' has profound implications for the clash of purpose between the professions; the first to save life and the second to wage violence on behalf of our nation, which might involve taking life. At an intellectual level, this clash is resolved through the principles of *'jus ad bellum'* – the legal authority to go to war; *'jus in bello'* – the measures under international humanitarian law to reduce the suffering caused by war; and 'the humanitarian principles' – humanity, impartiality, neutrality and operational independence – which protect humanitarian organisations from harm.[3] Military health services operate at the intersection of these principles. Governments organise military medical services to reduce the harm from war on their military personnel (and other entitled populations such as prisoners). The Geneva Conventions protect medical facilities and personnel, as well as non-combatants. Thus, military medical services exist to mitigate the consequences of warfare, not be party to it. Beyond this, all military health personnel must reconcile this clash personally. Their mere existence within the military medical services could be construed as tacit acceptance of the armed forces' potential role in taking life. I was able to balance this based on my Christian faith that recognises the clash between God and the devil,[4] and that it may be necessary to fight to prevent the imposition of evil (eg World War II against the Nazis). However, I believe that a government's use of violence must be accountable, which lies at the heart of our democratic system.

Dual loyalty extends to healthcare practice within the armed forces, too. There is a fundamental tension between patient-centred practice focussed

on the needs of the individual and a utilitarian perspective that might see health services as a means to achieve maximum productivity of humans within a state system. This is most stark in the application of triage in crises.[5] In an emergency, the usual practice is to treat the most severely sick or injured first based on clinical need. However, if there are insufficient health resources to meet the demand (a mass casualty incident – MASCAL), then prioritisation is based on the 'ability to benefit from treatment' and the interests of the many over those of the individual.[6] Arguably, the NHS approached this situation during the peak of COVID admissions, and it has been implicit in the decision to prioritise treatment for COVID over treatments for certain other life-limiting conditions. Fortunately, I never had to use MASCAL decision-making during my military career. However, I did have to argue for more medical resources on several occasions to prevent this from occurring. To me, it is essential that any system of triage is underpinned by the provision of compassionate care to all patients, even if physical treatments are limited. The CMF File on care and compassion provides an excellent summary of the Christian foundations for this aspect of healthcare.[7]

The most common dual loyalty tensions occur in the occupational health aspects of military healthcare practice rather than emergency medicine. This commonly occurs around confidentiality and the desire of military leaders to understand the health of their personnel.[8] The military requires a high level of physical and psychological fitness due to the combat environment's challenging nature. This varies according to the specific role, with different standards for a pilot, a submariner, and an infantry soldier. Information on the medical fitness for duty of everyone in the armed forces is required to understand how many personnel are not fully fit. Whilst individuals may allow medical information to be shared with their managers, medical staff can also express the impact of a medical condition on functional performance without revealing the condition itself.

Dual loyalties are also a factor in questions of uncoerced consent, such as for receipt of vaccinations or antimalarials, or for involvement in medical research. These aspects of dual loyalty have analogies with other medical specialities such as public health and travel health. They have become particularly important as we adjust employment for healthcare workers who are especially vulnerable to COVID-19. I have found the ethical guidance provided by the health regulatory bodies and the medical Royal Colleges and faculties to be extremely helpful in supporting my decision-making in these technical aspects of clinical and organisational practice. Whilst not explicitly based on religious values, many of the underlying principles in Western medical ethics arise from a Judeo-Christian theology of care through compassion-based grace. This is explored in the paper by Cavanaugh[9] and the *CMF File* on Christian views on ethics.[10]

Whichever branch of medicine and the healthcare professions we choose to join, we cannot avoid the possibility of having to make difficult decisions that could have profound implications for our patients. These occur much more frequently and immediately in crises, like the COVID pandemic or war. Such decisions can have a long-term impact on our mental health, especially if the process or outcome goes against our internal values. This can damage our psychological, social and spiritual health, causing 'moral injury'. This term has arisen from the academic literature covering the psychological impacts on soldiers of war and is distinct from post-traumatic stress disorder (PTSD). Whilst both can occur due to the same events, the distinction is important. 'Moral injury' encompasses the much greater complexity associated with conscience-based decisions and actions, whilst PTSD has a narrower psychiatric definition relating to symptoms resulting from exposure to life-threatening incidents.[11] As I have become more senior in my military career, and since transitioning to academic practice, I have spent more time reflecting on the foundations of clinical and organisational decision-making. I found the WHO definition of health as a state of complete physical, mental and social well-being increasingly valuable, but it still misses the spiritual component that truly encompasses the emotional and moral foundations of our identity. Notably, the Armed Forces continue to have chaplains and other faith leaders as an integral part of the welfare services that support military personnel. This spiritual dimension of our health is most at threat when we respond to crises, both personal and societal. The Christian faith provides reassurance during difficult times that the gift of Jesus guarantees us life beyond the present day to eternity.[12]

One of my biggest projects in 2020 has been to develop a tool for teaching military medical ethics to healthcare professionals in the armed forces. This has led me to reflect on my decision-making foundations during my military career, and to a more explicit acknowledgement of my Christian faith's importance as the essence of my spiritual health and resilience during difficult times. As we think about how to support our colleagues during these challenging times, we must explicitly acknowledge the importance of spiritual understanding and values as a significant contributor to our resilience to moral injury.

Martin Bricknell *is Professor in Conflict, Health and Military Medicine at King's College London. He took up this role in 2019 after a full career as a military doctor that culminated in his appointment as Surgeon General of the UK Armed Forces in 2018*

This spiritual dimension of our health is most at threat when we respond to crises, both personal and societal

references (accessed 10/2/21)

1. Watts G, Wilkinson E. What the NHS is learning from the British army in the COVID-19 crisis. *BMJ* 2020;369:m2055 *doi.org/10.1136/bmj.m2055*
2. Olsthoorn P. Dual loyalty in military medical ethics: a moral dilemma or a test of integrity? *BMJ Military Health*. 2019;165:282-283. dx.doi.org/10.1136/jramc-2018-001131
3. Broussard G, Rubenstein LS, Robinson C et al. Challenges to ethical obligations and humanitarian principles in conflict settings: a systematic review. *Int J Humanitarian Action* 2019;4; 15 *doi.org/10.1186/s41018-019-0063-x*
4. Revelation 12:7-10
5. Robert R, Kentish-Barnes N, Boyer A, et al. Ethical dilemmas due to the COVID-19 pandemic. *Ann. Intensive Care* 2020;10:84. *doi.org/10.1186/s13613-020-00702-7*
6. Pingree, CS, Newberry, TR, McMains, KC, & Holt, GR. Medical Ethics in Extreme and Austere Environments. *HEC forum: an interdisciplinary journal on hospitals' ethical and legal issues*, 2020;32(4):345-356. *doi.org/10.1007/s10730-020-09405-9*
7. Fouch S. Care and Compassion. *CMF File* 50. 2013. *cmf.li/3aaqydl*
8. Ethics toolkit for armed forces doctors. *BMA*. 8 September 2020. *bit.ly/2Z6losn*
9. Cavanaugh TA. Relating Hippocratic and Christian Medical Ethics. *Christian bioethics: Non-Ecumenical Studies in Medical Morality*, 2020;26(1):81-94 *doi.org/10.1093/cb/cbz017*
10. Stone D. Christian views on ethics. *CMF File* 3. 1998. *cmf.li/2NeBjlU*
11. Kinghorn W. Challenging the Hegemony of the Symptom: Reclaiming Context in PTSD and Moral Injury, *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 2020;45(6):644-662, *doi.org/10.1093/jmp/jhaa023*
12. 2 Corinthians 4:8-15