UK MILITARY NURSES' EXPERIENCE OF ETHICAL DECISION-MAKING ON DEPLOYMENT: A REFLEXIVE THEMATIC ANALYSIS.

by

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ABSTRACT

Background:

Military nurses are frequently exposed to complex, dangerous situations and trauma on a scale their civilian colleagues are unlikely to ever experience. Additionally, the role of the military nurse on operations is constantly redeveloping due to advances in healthcare, education, and responsibility as well as the changing character of conflict and deployment profiles. The unfamiliar situations and complex environments encountered in evolving combat and humanitarian operations, combined with advances in practice, means that deployed military nurses are increasingly likely to become more involved in, or lead, ethical decision-making (EDM) in military treatment facilities. The researcher conducted a PhD study which aimed to explore how military nurses experienced EDM, with the research question “How do UK military nurses experience ethical decision-making on combat and humanitarian deployments?” This was in a bid to determine how best to practically prepare this unique professional group for the future deployed ethical landscape.

Methods:

This qualitative study analysed the narratives of 30 semi-structured interviews with serving and retired miliary nurses, whose experiences spanned a period from the 1950s to the 2020s. A Reflexive Thematic Analysis of the data was undertaken according to the principles of Braun and Clarke. Line-by-line analysis immersed the researcher in the data, and codes were openly generated as analysis progressed. The coding and theme development constantly evolved throughout the analysis to ensure they remained true to the data, prioritised participants’ voices, and maintained academic rigour. Two broad themes, the first with a sub-theme, were developed.

Findings:

The first theme is: ‘Doing the right thing’, with a sub-theme relating to the utility of written codes and guidelines as a handrail to ethical nursing practice. The second theme is: ‘The deployed context influences the EDM of military nurses’. The study

demonstrated that military nurses felt very strongly about the importance of quality EDM and ‘doing the right thing’, even if they could not always be as involved in the process as they would have liked. Opinion was divided as to whose responsibility it is to make ethical decisions in both the military and healthcare professional contexts, reporting hierarchy as a monolithic barrier in many cases. Participants felt that in the deployed military space, EDM is inevitably messier and more complex than in their ‘firm base' practice in the NHS. This is due to additional complicating ethical factors such as issues of dual loyalty conflict, scarce resource allocation, two-tiered care, impartiality, and interoperability with international colleagues. Military nurses regarded the good character expected of a nurse, a solid ‘moral architecture’ (including a healthy dose of moral courage), and their identity as military nurses (which was sometimes confused) as the cornerstones of ethical practice, and which governed their internal ‘moral compass’. There was also varying reliance on written codes and guidelines as an ethical handrail, from something to slavishly adhere to, to something to ignore in favour of their own judgment.

Conclusions:

To the best of the researcher’s knowledge, this is the first empirical study examining UK military nurses’ understanding and experience of EDM across a wide chronological and operational range. The deployed context influences the EDM of military nurses who are constrained from adhering to peacetime ethical principles, which international legal and ethical frameworks tell them they should, by the “*big and decisive hammer*” of military necessity (Gross and Carrick, 2013, p.5). There is confusion amongst participants in resolving the duality of their professional roles as nurse and serviceperson, which should be distinct, but pragmatically cannot. Some also appear to believe that they exhibit a higher level of moral sensitivity than their doctor colleagues, making them indispensable in the collegial EDM process. Pre-deployment training has been identified as the weak link in preparing military nurses to experience deployed EDM, and ethics education in the Defence Medical Services needs to be ‘front-loaded’ to rectify this. Use of the MOD’s Four Quadrant Approach as an EDM tool, in combination with case-based learning rooted in real-world experience, has been identified as the optimal method of achieving this.

DEDICATION

This thesis is submitted in memory of my father, Brian Brockie, who passed away in May 2021. If it wasn't for him encouraging me to study at this level, I might never have started. He'd have been proud of me for finishing it, and exceedingly smug too!

I would also like to dedicate this work to the memory of my father-in-law, Tony Douglas, who passed away in January 2023. He would also have been proud.

ACKNOWLEDGMENTS

I would like to begin by thanking my participants, without whom this study could not have been conducted. They all spoke with courage, were open and honest with me (sometimes brutally so!) and I have learned so much from them. They recounted and unburdened themselves of some of the most difficult ethical situations from their deployed practice. Many of them had never spoken of these to anyone before, in some cases holding onto the bad feelings for decades, which could not have been easy or nice. However, I hope in the end, it proved as cathartic an experience for them as it was for me!

My family deserves a special mention here, as for the past eight years they have had to put up with me in the various states of moodiness, alarm, distraction, panic, and mental absence that the emotional roller-coaster of undertaking a PhD study is prone to cause. Thank you to Iona, Conor, and Struan for their support and encouragement, but none more so than my amazing wife Nikki. Despite her insanely busy job in the NHS, and her non-voluntary status as a PhD widow, she always found the time to offer words of support and practical action like making sure I remember to eat and drink, all while spinning many other plates. Not to forget a relatively new addition to the family, thanks also go to Bonnie, the family puppy who loves hugs and has been co-opted as my therapy dog in recent weeks! I love you all.

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TABLE OF CONTENTS

ABBREVIATIONS AND DEFINITIONS

2TC – Two-tiered care

4QA – Four Quadrant Approach

ANP – Advanced Nurse Practitioner

CBL – Case-based learning

CCAST – Critical Care Air Support Team

CDM – Clinical decision-making

CPERS – Captured persons

DLC – Dual loyalty conflict

DMD – Deployed Medical Director

DMS – Defence Medical Services

DS – Directing staff

ED – Emergency department

EDM – Ethical decision-making

EWS – Early Warning Score

HCP – Healthcare practitioner

HOSPEX – Hospital exercise (for Unit pre-deployment assessment and validation)

ICU / ITU – Intensive Care Unit / Intensive Therapy Unit

ICW – Intermediate care ward

IED – Improvised explosive device

IHL – International Humanitarian Law

MERT – Medical Emergency Response Team

MHCP – Military healthcare practitioner

MOD – Ministry of Defence

MODREC – Ministry of Defence Research Ethics Committee

MRoE – Medical rules of eligibility

MSO – Medical Services Officer (a non-medical administrator)

MTF – Military treatment facility

NATO – North Atlantic Treaty Organisation

NCO – Non-commissioned officer

NHS – National Health Service

NMC – Nursing and Midwifery Council

PDT – Pre-deployment training

RTA – Reflexive thematic analysis

SRA – Scarce resources allocation

WMA – World Medical Association

TABLE OF RELEVANT STUDY PARTICIPANT DEMOGRAPHIC DATA

Anonymised participant number	Service	Serving / retired during fieldwork	If retired, length of time since leaving Service	Sex / Gender	Nursing speciality / other roles worked on deployment	Ranks in which deployments were experienced	Operational tours experienced (Area served in, and tour frequency)
P001	Army Reserve	Retired	0-10 years	Female	Operating Theatres	Commissioned Officer	Afghanistan, x 2
P002	Royal Navy	Retired	0-10 years	Female	ED	Junior NCO and Senior NCO	Iraq, x 2; Afghanistan, x 1
P003	Army Reserve	Serving	N/A	Male	Wards; Trauma Nurse Coordinator	Commissioned Officer	Afghanistan, x 2; Kenya, x 1
P004	Regular Army	Serving	N/A	Female	Medical / surgical wards	Junior NCO and Commissioned Officer	Iraq, x 1; Afghanistan, x 1
P005	Army Reserve	Serving	N/A	Male	Mental health	Commissioned Officer	Iraq, x 1; Afghanistan, x 1
P006	Regular Army, then Royal Navy	Retired	0- 10 years	Male	Mental health; G5 Medical Liaison Officer	Senior NCO and Commissioned Officer	Bosnia, x 1; Kosovo, x 1; Iraq, x 1; Afghanistan, x 1
P007	Royal Air Force	Retired	20-30 years	Male	Medical / surgical wards; Primary care; ANP	Junior NCO and Senior NCO	Gulf War 1 (Bahrain) x 1
P008	Regular Army	Serving	N/A	Male	Wards; ED; Apheresis lead nurse	Junior NCO and Commissioned Officer	Iraq, x 1; Afghanistan, x 1; Sierra Leone x 1; South Sudan, x 1
P009	Reg Army	Serving	N/A	Female	Medical / surgical wards; Infection control nurse	Junior NCO and Senior NCO	Iraq, x 3; Afghanistan, x 1
P010	Regular Army	Retired	0-10 years	Female	Medical / surgical wards; Regimental Nursing Officer (forward Role 1 care in lieu of a doctor); ED; Healthcare governance lead; Senior Officer	Commissioned Officer	Gulf War 1 (Bahrain) x 1; Bosnia, x 3; Iraq, x 1; Afghanistan, x 3
P011	Royal Navy	Retired	10-20 years	Female	Medical / surgical wards; Primary care;	Junior NCO, Senior NCO, and	Kenya, x 1; Iraq x 2 (one in a maritime role, one on

					Sexual health / GUM; ANP	Commissioned Officer	the ground); Afghanistan, x 1
P012	Regular Army, then Army Reserve	Retired	0-10 years	Male	ED; Senior Officer; various command roles	Commissioned Officer	Bosnia x 1; Kosovo x 1; Iraq x 1; Afghanistan x 1
P013	Regular Army, then Army Reserve	Retired	0-10 years	Female	ITU	Junior NCO, Senior NCO, Commissioned Officer	Bosnia x 2; Kosovo x 1; Iraq x 2; Afghanistan x 2; Sierra Leone x 1
P014	Regular Army	Retired	10-20 years	Female	ED	Commissioned Officer	Bosnia x 1; Iraq x 3; Afghanistan x 1
P015	Regular Army	Retired	10-20 years	Male	Burns & Plastics	Senior NCO	Gulf War 1 (Bahrain) x 1
P016	Royal Air Force	Retired	60-70 years	Female	Operating Theatres	Commissioned Officer	Cyprus x 1 (during the Suez crisis)
P017	Royal Air Force	Serving	N/A	Female	ED and Pre-hospital care; ANP; Trauma Nurse Coordinator; Nurse MERT practitioner	Commissioned Officer	Afghanistan x 3; Kenya x 3
P018	Royal Navy Reserve	Serving	N/A	Female	Operating Theatres	Senior NCO	Multiple deployments at sea; Iraq x 1; Afghanistan x 2
P019	Royal Navy	Serving	N/A	Female	ED; ANP	Commissioned Officer	Afghanistan x 3
P020	Regular Army (in a fighting role), then Army Reserve as a nurse	Retired	0-10 years	Male	Medical / surgical ward; Paediatrics	Commissioned Officer	Afghanistan x 1 as a nurse; Previous tours in a combat Regiment in a fighting role
P021	Regular Army	Serving	N/A	Male	Medical / surgical wards; Senior Officer; various command roles	Senior NCO; Commissioned Officer	Afghanistan x 2; Kenya x 2; other tours x 4 (locations redacted to maintain anonymity)

P022	Royal Air Force	Serving	N/A	Female	ITU; ANP; MERT nurse; CCAST nurse	Commissioned Officer	Middle East x 1 (location redacted to preserve anonymity); Bosnia x 1; Iraq x 1; Afghanistan x 1
P023	Regular Army	Retired	0-10 years	Female	ITU	Commissioned Officer	Iraq x 2; Afghanistan x 3
P024	Royal Navy	Retired	10-20 years	Male	Medical / surgical wards	Junior NCO; Senior NCO	Falklands Conflict x 1; Gulf War 1 (Iraq) x 1; Kosovo x 1
P025	Royal Air Force	Serving	N/A	Female	ED	Junior NCO; Senior NCO	Afghanistan x 4
P026	Army Reserve	Retired	0-10 years	Male	Medical / surgical wards; Regimental Nursing Officer; ED	Junior NCO; Commissioned Officer	Gulf War 1 (Saudi Arabia) x 1; Iraq x 2; Afghanistan x 1
P027	Royal Air Force	Retired	10-20 years	Female	ED and Pre-hospital care	Commissioned Officer	Iraq x 1; Afghanistan x 1
P028	Royal Navy	Retired	0-10 years	Female	ITU	Junior NCO; Senior NCO	Iraq x 2 (once in a maritime role, once on the ground); Afghanistan x 2; Sierra Leone x 1
P029	Royal Navy	Serving	N/A	Male	ITU	Junior NCO; Senior NCO; Commissioned Officer	Afghanistan x 1; South Sudan x 1
P030	Regular Army	Retired	10-20 years	Female	Medical / surgical wards; Sexual health / GUM	Junior NCO; Senior NCO	Gulf War 1 x 1; Afghanistan x 2; Kenya x 2

TABLES AND FIGURES

Chapter 1

INTRODUCTION

It was a series of five combat deployments spanning 2001-2014 (once to Kosovo, twice to Iraq, and twice to Afghanistan) which gradually stimulated my interest in the ethical decision-making (EDM) process I experienced in various deployed military treatment facilities (MTF). Pre-deployment training (PDT) before these operational tours aims to physically and professionally prepare all military healthcare professionals (MHCP) for operational deployment outside the UK. I have experienced PDT myself as both a deploying nurse and as a member of the Directing Staff (DS). DS are experienced MHCPs who have just returned from operations, whose role is to assess, validate and assure the soon-to-deploy MHCPs as competent to practice, both clinically and militarily. Accordingly, I know that nurses are told by the DS that they will have a clear voice in ethical decisions made in relation to the patients they are caring for. However, in my experience 'on the ground', the reality is somewhat different. Doctrinally, the responsibility for ethical decisions taken within the MTF rests with a single individual - the Deployed Medical Director (DMD), who is typically a senior doctor (Greaves, 2019).

I was in the operating theatre in Afghanistan one morning with my hands inside the open chest of a gravely wounded indigenous allied soldier, physically helping to keep him alive, when a DMD-led 'command huddle' (interestingly, not an 'ethical huddle') involving three senior doctors took place away from the operating table to decide his fate. Following his discussion, the DMD returned to the operating table, peered into the patient's chest, and almost nonchalantly made a motion drawing his hand across

his throat while saying ‘Yeah, sack it’. In other words, it was communicated to us that we should stop what we were doing and in effect allow the patient to die in front of us. There was no indication of the reasoning for this decision, and when I asked the anaesthetist why we were abandoning the patient, the reply was ‘because that’s what the grown-ups have decided, so shut up and get on with it’. This left me and the rest of the care team at the operating table disbelieving, stunned and angry. This specific issue precipitated a significant episode of discomfit and upset in the care team, including me. This was characterised by increased stress, feelings of guilt, anxiety, difficulty in sleeping and a lingering feeling of ‘betrayal’ by the chain of command. Such a decision, taken by others with no buy-in from the team delivering immediate care, is very difficult to rationalise.

I have had long experience with this frustrating doctrine in practice, and observed the same routine taking place many times each week during my deployments. Command huddles were justified to the rest of the care team, who were directly involved in caring for the patient, on the basis that they may be emotionally compromised by being ‘too close’ to the decision and should therefore not be involved in the EDM process. Following the command huddle, they would then ‘announce’ their decision and required actions to the rest of the care team without wider discussion.

Consistent use of this method of EDM made me (and anecdotally until this study, many others) feel progressively disenfranchised and demoralised, and as if I had no voice within the care team. We could not therefore act as the vulnerable patient’s advocate and in their best interests as professional and personal moral and ethical obligations demand, as we were habitually excluded from the EDM process.

However, it was that incident in the operating theatre which prompted my interest in healthcare ethics and drove my aspiration to explore the issue of military nurses' involvement in, attitudes towards, and experience of EDM in the context of deployed MTFs. To fully examine these areas, detailed inquiry into other military nurses' experiences was necessary.

Serving as a military nurse is demanding, exposing nurses to complex ethical dilemmas (Finnegan et al., 2016a), and presents multiple challenges beyond those faced in peacetime NHS practice when providing care in an operational environment (Finnegan et al., 2016b; Meyer et al., 2021). Military nurses continue to follow in the footsteps of their forebears in the 19th and 20th centuries, delivering care across a wide spectrum of deployed operations in combat and humanitarian (including disaster and epidemic response) contexts (Sadhaan et al., 2022). This is often undertaken in austere conditions in volatile or hostile regions, and at great personal risk. However, changes have taken place over the last decade or so in the nature of the roles and responsibilities of military nurses. Included in this is an increase in the level of education and training they receive to deliver advanced practice.

Operational healthcare is organised by the Defence Medical Services (DMS) through its Operational Patient Care Pathway, which categorises its MTFs from Role 1 to Role 4 and places them along the route of casualty evacuation (Greaves, 2019). These provide different capabilities to deployed forces, with each level of care located sequentially farther away from the fighting and scaled up in capability and size at the cost of reduced mobility. Role 1 provides primary healthcare, immediate first aid, and initial triage at the front line, while Role 2 is located several miles away

from the fighting and provides damage control surgery and resuscitation. Role 3 is usually located much farther away from the front line, and is served by a network of air and road transfers. It is typically part of a much larger, well-defended contingency operating base, like Camp Bastion in Afghanistan, which was approximately the size of the UK town of Reading (Ibid.). Role 3 provides a full deployed hospital service with e.g., some definitive surgical treatment, advanced scanning capabilities, and critical care services. Role 4 care is currently provided by the Royal Centre of Defence Medicine at the Queen Elizabeth II hospital in Birmingham.

Several partner nations of the UK, such as Australia, Canada, and the US have long been deploying autonomous advanced nurse practitioners (ANP)[1] closer to the front line in nurse-led MTFs at Role 1 and Role 2 in lieu of doctors (O'Neill and Luther, 2013). The UK DMS, by contrast, operates a consultant-led care model for its provision of operational healthcare. Despite employing credentialled military ANPs in military units embedded in NHS trusts across the UK, no operational role currently exists for an ANP in the DMS while scoping work is being undertaken to establish one (MOD, 2024a).

One key factor influencing this decision will be the ongoing shortage of front-line doctors, meaning that military nurses have the potential to soon become more involved in front-line clinical and ethical decision-making than ever before. This could come as something of a shock to this group of professional nurses, as even in recent years, nurses have been found to be uncomfortable articulating or discussing ethical

[1] The DMS often refers to this role as 'Advanced Clinical Practitioner' as it is inclusive of Allied Health Professionals like physiotherapists and paramedics.

issues (Small, 2018), reluctant to participate in the EDM process (Storaker et al., 2019), or have simply been excluded from this process (Flannery et al., 2020; Gjessing et al., 2023). Moreover, Arends et al. (2022) state that hospital nurses are typically less involved with EDM than they would like. With these statements in mind, it can be argued that a culture shift in the DMS is required to ensure that military nurses are fully prepared to effectively meet the challenges that EDM on deployment presents. This is especially true in the context of remaining operationally effective and consistently achieving the best possible outcomes for their patients.

The Nursing and Midwifery Council (NMC) Code of Conduct for nurses in the UK (hereafter referred to as 'the Code') exists to dictate, with input from the public, the professional standards which all nurses must uphold (NMC, 2018). It speaks broadly of acting as the patient's advocate, though more in the sense of upholding the law and acting in the patient's best interests when they are lacking capacity. The only decisions mentioned in the Code are those decisions made by qualified nurses to delegate tasks to other suitably qualified and experienced colleagues, rather than speaking to any ethical element of the decision-making process itself. It does mention the need to seek assistance from more experienced or qualified colleagues when it is in the patient's interests to do so. This is an ethical dimension of patient care, and a moral virtue identified in a study by Conroy et al. (2021) – recognising and not exceeding your limits of competence; an excess or deficiency of which, like any moral virtue, could lead to an adverse outcome for both nurse and patient. The Code also details the actions a nurse must take to protect vulnerable or 'at risk' patients.

The only time that ethics is explicitly referred to in the Code is in ensuring that any published material a nurse produces to advertise their professional services must be accurate, responsible and ethical so as not to mislead the public (NMC, 2018). The need to always act with honesty and integrity is a directive aimed squarely at upholding the values of the profession in the face of public scrutiny, rather than acting with these values in mind with the expressed purpose of participating in the EDM process. This makes the Code difficult to both interpret and strictly adhere to, as although it does offer some *implicit* ethical guidance, it has limitations in that it does not appear to offer any *explicit* rules or regulations to nurses guiding them in how to approach, rationalise, make or justify any ethical decisions they might have to make during their practice.

The Code uses statements vaguely exhorting virtuous practice such as ‘treat people with kindness, respect and compassion’. There is also evidence of the tacit acknowledgment of (for example) deontological and principlist ethics in statements that nurses must ‘act in the best interests of people at all times’ with the requirement to ‘respect a person’s right to accept or refuse treatment’ (NMC, 2018). These are all based on the NMC’s view of what is right. However, this is not practical or helpful for military nurses preparing for, or on deployment, as there are contextual factors in these circumstances which the Code may not have considered. For example, there will be times in which military necessity dictates that nurses, as MHCPs, must act contrary to their professional guidelines or personal codes of ethics in the interests of the State (Hooft, 2019). So, although military nurses ought to act ethically in the same way as their peacetime practice, the context of deployment could make this problematic. Military nurses are bound to follow orders from their chain of command,

which may be non-medical, and which may clash with their professional guidelines or instincts. Therein lies the classic military nurse dichotomy (as it also does for other MHCPs): a consistent dual loyalty conflict.

On deployment, situations often occur where casualty rates in an MTF are overwhelming, and the military conditions are unclear or novel; with associated lack of precedent or experience from which to draw comparisons. My own experience has demonstrated that nurses may feel that they lack the necessary resources and education to effectively address the ethical issues pertaining to their patients. As previously stated, the Code is often no practical help in this case. Perhaps consequently, there has been a call for increased emphasis on education and awareness training in appropriate ethics and values in both undergraduate nursing and medical curricula, and in the DMS, to improve critical thinking in this field (See e.g., Kotzee et al., 2016; Kang, 2017).

However, no consensus exists regarding the optimal method of transferring the theoretical skills learned in formal education or pre-deployment training to apply to practical healthcare EDM ‘on the ground’. There is also no consensus on how best to promote sound ethical practice of military nurses in both their peacetime NHS and deployed practice environments (Mills and Bryden, 2010). Therefore, there is a need to explore military nurses’ own perceptions of how EDM is experienced and undertaken, to inform optimal preparation of military nurses to deploy. This study is also based in part upon my own varied experience of deployed EDM as a military nurse.

Aim of the study

The aim of this study is to examine the phenomenological (lived) experience of military nurses who have deployed to MTFs in challenging and austere conditions on combat or humanitarian missions. The intent is to gain a deeper comprehension of how military nurses understand, navigate, and process the EDM to which they have been exposed or involved in. This is to identify any critical themes that may have implications for military nursing, such as how nurses understand the process of EDM in such situations and how prepared they feel to manage or cope with it in the context of operational service, away from their routine work at home embedded within the NHS.

Research question

'How do UK military nurses experience ethical decision-making on combat and humanitarian deployments?'

The research question above positions the focus of the study on my participant's experiences, but I also acknowledge that the analysis will inevitably be influenced by my position as both the researcher and as a military nurse with similar deployed experience to my participants. This will be discussed more fully in the chapter on research design, which discusses Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2022) as the selected analytic approach to answer this research question. There is a gap in established knowledge which the evidence from this study is well placed to address, as will be demonstrated in the literature review in the next chapter.

Objectives

1. Identify military nurses' perceptions and experience of what EDM is and how it is conducted, incorporating the beliefs and core values which shape this.

2. Examine the influence of the deployed context on military nurses' experience of EDM.

3. Analyse and present the data generated in coherent themes using RTA, critically discussing and situating the data against current opinion in the literature.

4. Present conclusions derived from the findings and discuss implications for military nurses in future deployed nursing practice.

Layout of the thesis

This thesis consists of six chapters. Chapter one presented an introduction to military nursing and the DMS. It also detailed my own experience of EDM in the operational context, and explained my motivation, aims, and rationale for conducting this study to further investigate the topic of EDM in military nursing. Chapter 2 details the findings from the narrative literature review. This explores nurses' perceptions, both military and civilian, of multiple facets and contexts of EDM in nursing practice. Chapter 3 explains the methodology for the study, from describing the research paradigm to detailing the methods used in the fieldwork. It will also discuss the underpinning philosophical and theoretical approach through which the data were analysed. Other methodologies which were considered and discarded will also be presented. Chapter 4 presents a reflexive thematic analysis of the findings of the qualitative study, which used semi-structured interviews to determine the deployed experience of EDM of 30

UK military nurses. Two main themes were developed, one with a sub-theme, and are presented sequentially. The first theme is ‘Doing the right thing’, and its sub-theme is ‘Codes and guidelines as an ethical handrail’. The second theme is ‘The deployed context influences the EDM of military nurses’. Chapter 5 draws on findings from the literature review, and utilises the wider literature to discuss them in the context of the synthesised findings of the study. It presents the discussion thematically for ease of reference, similarly to the findings chapter. Chapter 6 offers the conclusion to this thesis. This includes detailing novel contributions of this study to the field of healthcare ethics in military nursing and the implications, the identified need for further research, strengths and limitations of the study, and a reflective account of the analytic approach used (RTA).

Chapter 2

LITERATURE REVIEW

In accordance with the previously stated research question and study objectives, this chapter presents a review of the literature around EDM in both the military and civilian nursing contexts, and nurses' experience of it. I selected this topic for study because as stated in the objectives for this thesis, I wanted to identify and understand other military nurses' perceptions of EDM and their place in the process, particularly in the deployed operational context. Snyder (2019, p.333) tells prospective researchers that "*building your research on and relating it to existing knowledge is the building block of all academic research activities, regardless of discipline*." Thus, a review of the pertinent literature is an indispensable part of any research project. It is my intention through this literature review therefore to justify my topic selection, highlight its importance in nursing and more specifically military nursing, and demonstrate the original contribution that this study makes to the field of healthcare ethics in military nursing.

A literature review serves firstly to demonstrate what has already been learned in the field of study. Secondly, in so doing, it justifies studies designed to fill gaps in the established knowledge found by researchers. Thirdly, it informs a deeper understanding of the topic and helps to identify the key issues (Hart, 2005). There are many ways to conduct a literature review in academic work, but I have elected to undertake a narrative review for this study. A narrative literature review is "*a synthesis of information and existing literature in relation to a focused topic*" (Agarwal et al., 2023, p.1162), incorporating the experience and expert opinion of the writer,

and is a popular method to present a review of evidence in the field of healthcare (Ibid.). This is ideal for qualitative research as it summarises "*current understanding on a topic together with implications for future research*" (Ibid.) without trying to be reproducible. This means that narrative reviews are subjective and unique to the writer. Should another writer attempt to reproduce a qualitative narrative review on the same topic, the outcomes and conclusions would likely look very different.

Narrative reviews differ from systematic reviews (SR), which are "*focused on answering a single question*" (Bettany-Saltikov and McSherry, 2024, p.5). SR are ideal for reviewing quantitative research using statistical evidence from e.g., randomised controlled trials. They are often lauded as the gold standard (See e.g., Brackett and Batten, 2020) and the most scientifically rigorous method of reviewing evidence in healthcare (Sataloff et al., 2021). However, they have also been criticised due to concerns about bias affecting the quality of the SR (See e.g., Moore et al., 2022). Indeed, the Cochrane organisation has even developed a database of a sub-genre of SR, the umbrella, overview, or meta-review (a review of a review) to retrospectively assess and address the quality of previous SR (Pollock et al., 2024). Quality in a literature review consists of several key features. These include demonstrating appropriate breadth and depth of understanding, academic rigour and consistency, clarity and brevity, and effective critical analysis with synthesis of ideas (Hart, 2005). SR are now normally undertaken according to the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' (PRISMA) guidelines (Page et al., 2021), which are used to assess their quality and reproducibility.

Conversely, Baethge et al. (2019, p.1) refer to a narrative review as "*an attempt to*

summarize the literature in a way which is not explicitly systematic", making the format vary depending on the writer (Agarwal et al., 2023). Indeed, in agreement with the authors of the last two papers in all but terminology, Kraus et al. (2022) refer to this format as a 'non-systematic literature review' (non-SLR), as they are conducted without following any systematic procedure. This makes it difficult to assess the quality and reproducibility of a narrative or non-SLR, as they are not compatible with the critical assessment tools designed for SR e.g., PRISMA guidelines.

However, rigorously assessing quality and reproducibility are not typically major concerns in a non-SLR. This is because they are designed to:

> "*weave together relevant literature based on the critical evaluations and (subjective) choices of the author(s) through a process of discovery and critique (e.g., pointing out contradictions and questioning assertions or beliefs)*" (Ibid., p. 2581, their parentheses).

This makes them unique to each researcher as alluded to above. Despite the criticism levelled at non-SLRs, they are also acknowledged as an important tool in healthcare education and represent a good way to discuss relevant elements of a specific topic being researched (Jahan et al., 2016). They also allow a researcher flexibility and breadth of coverage in their review of the literature (Byrne, 2016). Non-SLRs are therefore heavily influenced by the researcher's professional exposure, expertise, and experience to provide a deductively reasoned and balanced overview and critique of literature relevant to the proposed research topic (Frederiksen and Phelps, 2018), highlighting existing 'scholarly contentions' in the field and supporting generation of a research question (Ibid.).

A literature search around the topic of EDM in nursing and military nursing was

conducted through database sources optimised for nursing and medical literature, which were PUBMED, MEDLINE, CINAHL, and ProQuest, all of which offer institutional access for University of Birmingham students. These yielded so-called 'white literature' primary sources such as books and original peer-reviewed academic and research papers, and secondary sources such as systematic reviews of evidence. In addition, researchers are increasingly recognising that 'grey literature' may also offer positive contributions to an academic literature review (Adams et al., 2017). Grey literature consists of independently or organisationally published or unpublished work e.g., theses and dissertations or reports, which is not subject to the traditional peer-review process. 'Grey evidence' is useful because it can help to reduce publication bias and may offer alternative viewpoints or niche, specialist data which is not available in a literature review using commercial databases of publications (Adams et al., 2016). Accordingly, a manual search using Google Scholar's Advanced Search function was also utilised, as it has been cited as a useful and powerful tool for identifying grey literature from across the internet and is recommended for use as a supplement to an academically conventional literature review of primary and secondary sources (Haddaway et al., 2015).

I initially aimed to limit the literature search in the databases listed above to publications from 2015 to the present, as all offer a date range function to control the search results. The same date range restriction was also initially applied in Google Scholar through its advanced search function. This was sufficient for sourcing broad literature related to EDM in civilian nursing, as there is a great deal of recent information available in this field. However, there is an almost complete lack of relevant evidence in the field of EDM in UK military nurses. There is also limited

recent evidence from the international military nursing perspective, and in some specific aspects of EDM. Therefore, it was necessary to expand the date range as far back as 1996 to include some older and niche area papers in the narrative review to get as clear a picture as possible of what is already known. There are also some seminal and influential texts within the white literature which are older than the preferred date range, but which were included because of their importance and academic standing in the field. Natural language database search terms and stem words were used either in isolation or in combination across all databases with Boolean operators AND, OR, and NOT to link, select between, or exclude search terms. Other Boolean operators i.e., parentheses, asterisks, and quotation marks were also used as appropriate to focus, expand, or limit results.

The PUBMED database was searched using established MeSH (Medical Subject Headings) terms through the MeSH website's advanced search function, e.g., (Nursing Ethics OR Professional Ethics) AND Military Nursing AND Decision Making. CINAHL and MEDLINE databases were searched using the online EBSCOhost advanced search function, again utilising Boolean operators and stem words e.g., nurs* AND (ethic* OR moral*) AND military* AND (decision* OR dilemma). The asterisk operator is useful as it allows the researcher to expand their search beyond the stem word used to include different spellings, word variations, or extensions. For example, the stem word Nurs* searches the databases for publications including the terms nurs OR nurse OR nursing OR nurses OR nursing care OR nursing staff. The ProQuest database was searched in much same way as CINAHL and MEDLINE through its advanced search function, which helpfully also has an option to specify the search results to display only peer-reviewed sources. Complementing the search

methods described above were key author and citation searches. Lists of references from significant papers, especially those from the limited field of EDM in military nursing, were also examined to identify further potentially relevant evidence.

Considerable literature of relevance to the specifics of, and situations surrounding, nurses' experience of EDM in the hospital-based civilian nursing context was found, much of which was international (e.g., much of it originated in the US and Scandinavia). However, there is limited empirical evidence or theoretical contribution relating to the same topic in deployed military nursing practice. Furthermore, what little there is also appears to originate from outside the UK (e.g., the US and Australia). This represents a gap in the current knowledge in the field of military healthcare ethics as they pertain to UK military nurses. This narrative literature review is intended to help fill that gap by providing deeper insight into nurses' understanding and experience of EDM processes, which are also of relevance to military nurses, and generate new knowledge in this field. This study is occurring during a critical period of advanced role development for military nursing (Paxman, 2023) which will increasingly see military nurses act as 'ethical gatekeepers', or decision-makers in future deployed MTFs. It can therefore be argued that any contribution my study makes to the limited body of knowledge in this little-studied field in military healthcare ethics will represent important and original input and could be of significant benefit to the MOD and the nurses who serve within it.

A narrative review of the literature relating to EDM in nursing practice

As already acknowledged, there is a great deal of evidence in the literature about nurses' experience of and attitude towards EDM in the civilian context. There is much

less so in the military context. To frame this study in the context of the current literature, and to identify the gaps in knowledge it may address, it is necessary to examine both cultural contexts - civilian and military - as there are key cultural differences between these groups of nurses. This distinction is important, because as Cerit and Dinç (2012, p.202) state, "*how nurses respond to ethical problems varies by professional experience, autonomy and competency, [and] social and cultural factors can influence nurses' professionalism and ethical decision-making."* It is also important to note that there is no consensus in the literature upon which ethical principles, theories, or moral perspectives nurses' decisions should be based.

Regardless, nurses are still confronted every day with ethical problems, and are expected to make ethical decisions (Nora et al., 2016). However, the complex nature of healthcare situations and ethical or moral dilemmas may influence nurses' EDM. The golden thread of this literature review, and indeed this thesis, is military nurses' experience of EDM, and examining the factors which can influence this. I have organised this narrative literature review under several sub-headings, as nurses' experience of EDM is related to a diverse range of concepts and theories. However, some of these concepts and theories are subtly interrelated, and as such there is some inevitable crossover in each section below. In examining nurses' experience of EDM, a good starting point is to examine the nature of EDM, and that of ethical dilemmas, which often initiate the EDM process.

The nature of EDM and ethical dilemmas

EDM is widely accepted by scholars as a systematic process of moral judgement and moral reasoning involving conscious, intentional, and deliberative thinking (Zhong,

2011; Treviño et al., 2006). However, there is also some suggestion in the literature that emotion and 'intuition' have a role to play in EDM (see e.g., Haidt, 2001 for a description of his social intuitionist model). The concepts of moral judgement and moral reasoning and how they influence EDM, and the place of emotion and intuition in EDM, will be explored in greater detail below. However, a central component of EDM is the concept of the ethical dilemma.

The definition of an ethical dilemma in the bioethics literature is contested, but according to Braunack-Mayer (2001, p.98) they are generally defined "*in terms of conflict and choice between values, beliefs and options for action.*" This is supported elsewhere in the literature by Thompson et al. (2006), reinforced by Haahr et al. (2020) who define an ethical dilemma as a situation where competing values mean that a choice or decision on the ethically optimal course of action to take must be made. Other authors say that sometimes this choice will be unpalatable, but any action this choice drives will inevitably have consequences, which could be good or bad (Jiménez-Herrera, 2023; Agazio and Padden, 2024).

However, there is evidence of a lack of conceptual clarity in deciding what constitutes an ethical dilemma for nurses. This conceptual clarity is further obscured because the terms 'morals' and 'ethics' are used interchangeably by some bioethicists (See e.g., Singer, 1993; Banks and Gallagher, 2009), who argue that this is right. Others have distinct views on what constitutes each. For example, Harley (2007) states that ethics is simply the study of moral behaviour, a basic decision on what the moral agent views as right or wrong, good or bad. This is in direct contrast to Seedhouse (1998) who described moral reasoning and ethical action. Another opinion is that

ethical action is underpinned by moral values (See e.g., Fry and Johnstone, 2002; Thompson and Dowding, 2002).

Rainer et al. (2018) report that the ethical dilemma as a concept has been well explored in the literature, and states that they are universally prevalent in nursing practice. Yet despite acknowledging that improving education in resolving ethical dilemmas must be addressed globally to protect patients and nurses, there is little in the way of practical guidance to help nurses achieve this (Ibid.). The process of prioritising the competing values and beliefs etc. needed to make a decision in an ethical dilemma, i.e., EDM, is influenced in nurses on multiple levels. For example, Suhonen et al. (2018) describe these influences as: (i) the macro, or strategic level (e.g., matters of public health or health policy), (ii) the meso, or organisational level (e.g., financial concerns from employers such as the MOD or NHS), and (iii) the micro, personal, or individual level of the patient, their family, or the nurse. One thing is clear in the literature - ethical dilemmas occur frequently in nursing practice and tend to present multifaceted challenges (Sillero Sillero et al., 2023).

According to the American Nurses' Association (2015), ethical dilemmas are distinct from moral dilemmas. Moral decision-making is influenced by personal values and / or religious beliefs, and EDM requires choosing 'right or wrong' from two or more equally ethically valid choices. They also point out that virtue ethics is an ethical tradition concerned with the individual's character and others' perceptions of it as the central component of ethical reasoning when making ethical decisions (Ibid.). Somewhat contrarily Rainer et al. (2018) say that virtue ethics directly applies to nurses when there are no existing guidelines to steer, drive, or guide decisions, and

that decision-makers should rely strictly on their own values despite earlier stating that this would be considered a strictly moral endeavour and not within the realms of ethics. Interestingly, their review (Ibid.) reveals some international comparisons in how nurses approach EDM. US nurses were reported to be mainly principles-based in their decision-making, in contrast to Chinese nurses whose decisions were virtue-based, and Japanese nurses who appeared to favour responsibility-based decision-making.

Haidt (2001) says that moral judgment is based on a 'reflex' feeling, or 'intuition', that something is right or wrong and requires no reasoning or reflection. This suggests that EDM could be said to be more instinctual or habitual in nature (though perhaps not in the Aristotelian virtue ethics sense). If this is so, it could then be argued that the everyday EDM which takes place in every nursing interaction is a 'lower order' or 'background' level of EDM which requires little in the way of conscious deliberation. This is because it is a way of acting and a routine part of nursing practice inculcated in all nurses from the beginning of their education. For example, a study of oncology nurses by Raines (2000) concluded that this group regularly experienced, on average, 32 different types of ethical dilemmas, with many of these events occurring daily. They were related mainly to pain management, cost containment, and immediate quality of life considerations which were assessed as relatively easy to process due to the constant exposure.

The bigger issues which face nurses may then be the extraordinary ethical dilemmas, or 'higher order' level of EDM which require deliberative and critical thinking. These dilemmas typically have roots in normative ethical theories such as deontology,

consequentialism, or virtue ethics. In the context of making an ethical decision, they are therefore concerned with what is e.g., right and wrong, or good and bad etc. in practice and policies (Vogelstein and Colbert, 2020), or in other words, the criteria of basic moral standards. These ethical dilemmas are well described in the literature and many focus on the speciality group they belong to, e.g. intensive care, emergency, or primary care nursing. There is also a mix of qualitative and quantitative approaches used to study them and the associated effects on nurses, utilising a broad range of moral concepts, normative ethical theories, and methodologies which will be explored in greater detail in a later section. Having discussed the nature of EDM and ethical dilemmas in relation to how nurses experience EDM, it is necessary to examine nurses' perception of their place in the EDM process to situate this in context.

Perceptions of nurses' place in EDM

Some authors consider the relationships nurses form with their patients an important consideration in EDM. For example, Zeilinger et al. (2025, p,1) state that "*nurses play a critical role in the continuum of patient care, often spending more time with patients than any other healthcare professionals.*" According to Bustin et al. (2024), this makes them the most consistent healthcare professional (HCP) presence in the hospital-based caring process. Moreover, the feelings and emotions engendered by and intimately linked with these relationships are also an important facet of EDM in nursing. This leads to a relationship of a "*very special nature"* (Jiménez-Herera, 2023, p.1) developing between nurse and patient which Inocian et al. (2021) refer to as 'authentic'. Consequently, nurses get to know their patients well and typically bear witness to the pain, suffering and overall experiences of their patients during their

hospitalisation. This causes "*very diverse feelings when these are related to making decisions about ethical issues*" in patient care (Jiménez-Herrera, 2023, p1).

Due to this, Cerit and Dinç (2012) state that the nurse has a special place in the EDM process, and it is essential that nurses are involved in it as a matter of course. However, in addition to the place of feelings, emotions, and relationships in nurses' EDM, the same authors go on to argue that professional considerations also underpin nurses' EDM. They state: "*ethical decision-making is requisite for being a professional, and it is interrelated with professional competency and autonomy, [making it] important to investigate [in] nurses"* (Ibid., p.201). In addition to this, it has been suggested that nurses are also professionally accountable for the ethical decisions they make (See e.g., Hamilton and Gallagher, 2020).

EDM is experienced and perceived in different ways by different professional groups, as well as in different speciality areas and countries. In the Intensive Care Unit (ICU) for example, most literature on EDM is based around a specific set of concerns. These are typically the ethical issues which arise in the end-of-life phase when decisions must be made about withdrawal or withholding of active life-sustaining treatment, and the move to a palliative care pathway. This may be down to the fact that the ICU is usually the inpatient care area in any hospital with the highest mortality rate, which in the US in the year 2018-19 ranged from an average of 10% to 29% depending on age, co-morbidities and illness severity (Society of Critical Care Medicine, 2021). The aggregated ICU mortality rate in the UK in the year 2019-20, by comparison, is 14.5% (ICNARC, 2022). The ICU in a deployed MTF is also the clinical area in which ethical decisions of this nature are most frequently discussed

and taken, so many findings in civilian studies will be relevant in the deployed context.

Gallagher et al. (2015) conducted a study across five countries (Brazil, England, Germany, Ireland and Palestine) examining end-of-life decision-making practices of intensive care nurses in these different cultures and contexts. They concluded, as it has long been known, that doctors and nurses approach EDM differently. For example, Robertson (1996) found that nurses are likely to feel more serious consequences of their decisions than doctors when dealing with an ethical dilemma. This is principally due to the nature of the close relationship formed between nurse and patient and the associated emotional bond, as previously alluded to. Doctors were often described as distant and considered themselves 'one step removed' from any ethical violations or transgressions (Ibid.). One reason suggested in the literature for nurses feeling ethical tension around decision-making is that doctors often make ethical decisions without involving nurses, e.g., to withdraw care, but nurses are then tasked with operationalising their decisions, with which they might not agree (See e.g., Haahr et al., 2020). Rainer et al. (2018, p.3447) suggest that virtue ethics is of relevance in this phenomenon because nurses are more concerned with character when relying on their own moral values to guide decision-making, stating:

> "*When nurses disagree with physicians' clinical decisions, this is a source of ethical conflict or dilemma under virtue ethics because the nurse is not the person making decisions, but the person who executes on those decisions*."

This has been the case for a long time and may be a key factor in nurses developing moral distress through cumulative moral injury. For example, in an integrative review of the literature, Aljabery et al. (2024) found that nurses experience moral injury when

compelled to follow doctor's decisions which are not consistent with their moral values, or what they believe to be in the patient's best interests. Nurses may also take matters into their own hands in exercising their moral judgment and making ethical decisions rather than breach their moral values by 'following doctor's orders'. For instance, in one international empirical study, the researchers found that although disagreements in decision-making between doctors and nurses were usually resolved in the doctors' favour, nurses would sometimes ignore these decisions and instead do what they thought was right for their patients (Gonçalves et al., 2019). This, in effect, prioritises their own moral values above other HCPs (i.e., those, one could argue, with the responsibility for making those ethical decisions) and avoids the associated moral injury.

Another international study showed that while doctors *have* the responsibility of withdrawing life support, i.e., making the decision, nurses *take* the responsibility of enacting it (Tingsvik et al., 2025). A further study found that nurses are the professional group most likely to have to enact 'do not resuscitate' orders (Ntseke et al., 2023). It is therefore unsurprising that this heavy responsibility can engender the typically reported feelings of anger, powerlessness, and frustration (Arends et al., 2022; Morley et al., 2020a), or guilt and shame (Čartolovni et al., 2021) associated with moral distress in nurses. It is also known that civilian nurses working in intensive care units around the world employ a range of coping mechanisms and strategies to manage their role in the EDM process in end-of-life care (Adams et al., 2011). These include acting as 'information broker' to improve communications and coordination between the medical team, the patient, and their family, as 'supporters' to provide emotional support to families to help them rationalise the decision-making process,

and as an ‘advocate’ in end-of-life EDM for all parties, helping all to see the wider picture (Ibid.).

Gallagher et al. (2015) add to this debate by concluding that nurses engage in ‘negotiated reorienting’, a way of transitioning from curative care to comforting care using two core practices, ‘consensus seeking’ and ‘emotional holding’. Consensus seeking sees nurses help, or coax, doctors to make withdrawal decisions in cases where a patient has clearly reached the end-of-life-stage of care despite maximum medical support, by painting an honest picture of the situation (Ibid.). They also help families to understand the situation through ‘information cueing’ and ‘voice enabling’ - in other words, to know the reality. They then employ these practices consistently until consensus is achieved. Emotional holding relates to the nurses’ practice of using various strategies to emotionally support families by prioritising time spent talking with them (time-space creation), giving hints or using religious measures to make families realise their relative is near death; or by ‘bending the rules’ to ensure that grieving families can stay together in a private space. Some of these reasons may be why Deshpande et al. (2006) found that nurses are considered more ethical than any other hospital employees. However, it is unlikely that these practices will be of any practical use to military nurses. Soldiers deploy on combat and humanitarian operations without accompanying family, and seeking next of kin input is not always straightforward due to clinical urgency and operational constraints on external communications during casualty incidents.

Ferrand et al. (2003) conducted a quantitative study in France examining the perceptions of ICU nurses and doctors involved in the EDM process in end-of-life

care. They concluded that existing EDM processes were regarded as satisfactory by 73% of doctors, but by only 33% of nurses. >90% of both groups believed that EDM should be collaborative, but only 50% of doctors and only 27% of nurses believed that nursing staff were involved. This study also found that fear of litigation (they referred to decisions to forego life-sustaining treatment) was the biggest barrier to quality EDM and moral reasoning for doctors. Nurses, in contrast, reported that the lack of interdisciplinary collaboration was their biggest barrier to the same. Close multidisciplinary team collaboration, particularly in close-knit clinical areas like the intensive care environment, is ethically necessary and has been shown for some time to improve patient outcomes (See e.g., Baggs et al., 1999; Higgins, 1999). Failure to do so can lead to team conflict, job dissatisfaction and burnout for nurses (Arries, 2005). However, I could not identify any studies in the military context which either support or contradict these findings.

Dierckx de Casterlé et al. (2008) argue in their meta-analysis of nine studies examining EDM in nurses from across four countries (US, Belgium, Switzerland, and Japan) that nurses often relied on Kohlberg's conventions as their primary decision-guiding criteria, rather than a patient-centred philosophy. As a result, they concluded that most nurses are ill-prepared to address ethical dilemmas. Kohlberg's seminal work detailing his cognitive-structural framework (Kohlberg, 1976) defines six stages of moral development within three phases - the pre-conventional, the conventional and the post-conventional.

In the pre-conventional phase nurses have yet to come to understand and uphold ethical conventions, and fear of punishment or hope of reward guides their

reasoning. In the conventional phase, nurses tend to base their reasoning and decisions on an over-rigid application of social norms, rules, or laws (Kantian deontology) (Ibid.). In this phase, loyalty and conformity guide their behaviour - reflection on the patient's place in their EDM is largely absent. Those in the post-conventional phase understand society's demands and conventions but tend to formulate their own ethical principles, borne from experience, to blend in with these. When a dilemma occurs, bringing these two into competition, post-conventional nurses will judge by personal principle rather than by convention (Ibid.). Dierckx de Casterlé et al. (2008) amended Kohlberg's framework to add a patient care dimension to the post-conventional phase, which focuses on nurses' commitment to promoting patient well-being.

Guiterrez (2005) found that nurses acknowledge that barriers to ethical practice exist and actively compromise their ability to engage in quality EDM. Torjuul and Sorlie (2006) found that frequently cited contextual factors which create such barriers to ethical practice include inadequate time, constraints generated by the organisation including financial obligations, low staffing, and heavy workload. These constraints translate easily into the military context. Newly qualified nurses are also casualties of context, as they have been reported to base their actions regarding EDM practice on 'ethical codes' during their early days of practice, falling into Kohlberg's (1976) conventional phase, before succumbing to pressure to conform to organisational demands and constraints (Ham, 2004). The same could be said for military nurses in their early practice or first deployment, though only based on my knowledge and experience, as I cannot find any evidence which supports this in the literature.

There is some evidence of nurse leaders' impact on the EDM process and ethical environment or culture within an organisation. Nurse leaders have a large part to play in creating a healthy work environment for their staff, which includes establishing an environment which fosters sound ethical behaviour. Kearney and Pengue (2012, p.36) state that this would go some way towards reducing or eliminating the "*conflict experienced by nurses who want to take the correct course of [ethical] action, but are fearful of retribution or blame by those in authority.*" Nurse leaders also have a pivotal role in providing nurses with opportunities to increase their ethical awareness and competence (Poikkeus et al., 2014), while Laabs (2012) states that increased ethical education and awareness may increase nurses' confidence to make ethical decisions. It has been suggested that nurse leaders should enable their nurses to reflect on and use ethically grounded arguments and ethical values such as patient dignity in their clinical work and EDM, including cultural considerations (Rejnö and Berg, 2015). In addition, Alabay et al. (2015) consider creation of honest dialogue between nursing staff and nursing leaders to be vital in achieving better ethical awareness and competence.

Much of the existing literature on the effect of leadership on nurses' EDM is focused on the intensive care environment, where matters of end-of-life care and admissions decisions dominate ethical discussions (Robert et al, 2020). This has been compounded, especially for nurses whose views are not always taken seriously in this regard by clinical leaders, by the Covid pandemic (Morley et al., 2020b). Storaker et al. (2019) provide one of the few examples of a study examining the nurse's place in EDM in a non-intensive care setting, in this case on an adult general ward. They describe the lack of leaders' interest and engagement with the nursing workforce,

who felt compelled to rely on basic routines of care with little regard for specific ethical demands on the role. They also reported that nurses were "*engaged in decisions made for the patients, but they seemed unable to understand their role in participating in the [ethical] decision-making process*" (Ibid., p.719). They posit that nurses lack knowledge of the words required to fully participate in the EDM process and so instead choose to remain silent.

This may also have been attributed in part to the commonly held view of an asymmetrical power balance between nurses and physicians, where nurses' autonomy in decision-making is compromised through their historically subordinate role to doctors, leaving them with the overall impression of an unequal partnership (Pursio et al., 2021). This is a scenario where nurses are portrayed as choosing obedience over critical thinking, and simply assume it is the job of the doctor to make ethical decisions including those involving nursing assessments such as nutrition and fluid balance etc. However, there is no suggestion in the literature as to how a balancing of the perceived power differential would be achieved, or help nurses to determine ethical priorities and resolve ethical dilemmas (Pavlishy et al., 2012).

Despite the evidence supporting a interpersonal and professional base for EDM, it has been noted that nurses do not always recognise that even the smallest nursing intervention has ethical implications, and that awareness of this needs to improve to promote patient good, do the right thing, and limit harm (Robichaux et al., 2022; Haahr et al., 2020). This awareness of the intrinsically ethical nature of nursing practice is important, because it is a component of moral sensitivity (i.e., the ability to see the moral dimensions of a situation), which is in turn both a component of EDM

and a necessary precursor to moral agency and moral action (Milliken and Grace, 2017). However, the level and method of ethical education delivery in nursing curricula varies between countries, states, and even institutions (Ibid.). This makes standardisation of ethical awareness in pre-registration education problematic, and also limits opportunities to develop moral sensitivity, turning this issue into a vicious circle. This is despite Grace (2018) arguing that it is an obligation of the profession to ensure that nurses understand the moral and ethical base of their practice. Complicating this issue further, it is argued that "*regardless of the type of ethics education provided, nurses still lack confidence in their ability to articulate their ethical concerns consistently and effectively*" (Ibid., p.126). This section explored perceptions in the literature around the nurses' place in the EDM process, and introduced some issues and barriers around nurses' ethical awareness and engagement. Following on from this, it is prudent to examine the support and utility (or lack thereof) offered by normative ethical theories and moral principles as they pertain to ethical education and enabling EDM in nursing.

Ethical theory in support of nurses' EDM

There are several schools of ethical thought which may have significant philosophical and practical relevance in underpinning and assisting, or equally hampering, the EDM process for nurses. Among these approaches, all of which I have experienced during my time as a military nurse, are deontological, consequentialist, and virtue ethics as mentioned above, as well as principlist ethics. Conroy et al. (2021) argue the case for the prime importance of the Aristotelian model of virtue ethics in EDM in the clinical space. This proposes that making consistent ethically 'wise' decisions (or the least 'unwise' decisions) relies on the consistent application of *moral virtues*

through engagement of one's judgement and reasoning in the form of *intellectual virtues* (particularly *phronesis,* or practical wisdom*)*, rather than applying explicit rules and regulations. Indeed, in his translated interpretation of Aristotle's (2002) *Nicomachean Ethics*, Sachs proposes that according to Aristotle, the only practical path to achieving ethically effective action is through consistent and prudent application of moral virtues.

EDM in nursing practice has been described as informed and strongly supported by normative bioethical approaches (Chambliss, 1996), as alluded to above. Such approaches may be characterised as rule-based, e.g., deontology, or act-centred, e.g., utilitarianism, which is a branch of consequentialist ethical theory. This may also include using easily available EDM frames of reference such as local clinical policies or the NMC Code (2018) as a handrail for ethical guidance. It might also include using the 'best interests' argument to weigh up the ethical factors to make a decision on a patient's behalf. However, Benner et al. (2008a) argue that reducing ethics education for nurses to simply learning ethical principles by rote is insufficient to form the basis of everyday ethical behaviour. This is echoed by Grace (2018) who agrees that while ethical principles may prove useful in navigating the nuances of a complex ethical situation, it is the nursing profession's wider goals and perspectives which should guide everyday EDM, even if these do, ironically, also broadly respect the normative ethical principles of autonomy, beneficence, non-maleficence, and justice.

Others advocate a more person-oriented, contextual, or agent-centric approach within the spheres of nursing practice and education, such as virtue ethics and a popular feminist theory, the so-called 'ethics of care' (Howe III, 2019; Armstrong,

2007). With nursing recognised as a traditionally female-dominated profession (Masibo et al., 2024), Copeland (2019, p.4) comments that the 'ethics of care' are particularly appropriate for nursing practice because *"this approach to ethics brings into focus the values and virtues historically associated with women*", rather than reliance on rules and universal principles. This may include making value decisions based on what the chosen actions will say about that nurse's character, what a virtuous (in the neo-Aristotelian sense) nurse would do in an ethically challenging situation, or balancing collaboration and conflict to achieve the 'interconnectedness' to aid decision-making between all parties in the way that the 'ethics of care' promotes. In this way, nurses' EDM can be measured against the teachings of the traditional schools of normative ethical theory, but only after the exercise of initial internal moral reasoning (often described as a moral compass) before proceeding with a selected course of moral action (Zhong, 2011). This section established that normative ethical theory and moral principles or values can actively, or passively, guide nurses' EDM. Next, it is reasonable to examine in more detail some of the moral concepts and other factors already alluded to in this literature review which may influence nurses' EDM. This is because it will draw nurses' subjective experience of EDM, through their character and values, together with normative ethical theory and moral concepts such as reasoning and judgment to offer a wider perspective on their ethical action.

Moral concepts and other factors influencing nurses' EDM

There are many moral concepts detailed in the literature around the subject of EDM. However, from reviewing that body of work, I have identified that the most relevant moral concepts to discuss in nurses' experience of EDM, for the purposes of this

thesis, are moral reasoning, judgment (including value judgments), action, and sensitivity. For example, Grace et al. (2024) state that a nurse's moral reasoning and subsequent moral actions are based on the subjective and subconscious elements which form their 'conscience', and advocate conscientious objection as a decision-making mechanism to avoid breaching their moral values. Indeed, Barlow et al. (2018) believe it is best to situate the term 'moral reasoning' within the context of an individual's personal and professional beliefs and values.

The context of military nursing, i.e., the patient population, environment of care delivery, and typical injury profiles is very different from that encountered in civilian nursing. This is likely to have an impact on military nurses' moral reasoning, not least as some elements of nursing in the deployed military context have been referred to as activity "*contrary to the beliefs and values that underpin healthcare*" (Griffiths and Jasper, 2008, p.92). However, these authors continue to state that research into the nature and essence of military nursing has been largely ignored (Ibid.). What is certain is that all cultural groups have a set of moral values and beliefs which influence their choices and behaviour, and which are subject to continuing revision and refinement (Carter and Klugman, 2001).

The literature demonstrates a complex interplay between EDM as a rational process and as one which is emotions-based. However, Miner and Petocz (2003) state that though both processes involve cognitive activity, the gravitas of EDM is distinct from routine or emotions-based decision-making due to the involvement of moral judgement and the moral justification required for the decision. A seminal paper by Kollemorten et al. (1981) suggests that a clinical decision can become an ethical

decision when a nurse (as the moral agent) bases their actions on a value judgement. Indeed, according to Prendeville and Kinsella (2022), personal values and moral judgement are indivisibly linked, hence the contracted term ‘value judgment’. Cerit and Dinç (2012) state that value judgments are made based on non-scientific premises.

The principle of basing a moral agent’s actions on a decision made using a value judgment is in keeping with two of the most common ethical theories observed in Western healthcare. According to Kollemorten et al. (1981, p.67) a value judgement is used to assess “*either the consequences of a decision [consequentialist ethics] or the extent to which the duties of the [nurse] and the rights of others are fulfilled or protected [deontological ethics]*”. A value judgement is therefore subjective and unique to each nurse. If we accept that value judgments are made based on non-scientific premises, then nurses are relying on their personal, internalised moral values and ethical code, which are intrinsic to their character, to support their EDM process. This is in keeping with Kohlberg’s (1976) ‘post-conventional phase’ of moral judgment. This makes it easy to see why character and moral values as part of a nurses’ identity, combined with moral sensitivity and their own ideas of the nature of EDM, represent cornerstones of nursing practice. This is important because nurses, as alluded to above, deal with issues which have ethical implications every day, in every patient interaction, no matter how small (Benner, 2003; Haddad and Geiger, 2023).

Barlow et al. (2018) argue that in the context of nursing practice, rule-based approaches to moral reasoning and EDM fail to capture the importance of emotion in

moral reasoning. Emotion in moral reasoning, and ultimately in EDM, is also apparently important to military nurses as described in a study conducted by Rivers and Gordon (2017). They reported that their participants' emotions were strong when faced with EDM in practice, ranging from feeling as if they were losing themselves in a world that just keeps moving around them to anger at what they faced. They identified several themes which characterised this emotional response, including:

- Feeling alone or unsupported to make critical decisions under pressure.
- The sheer scale of death, devastation and loss in a conflict which they felt keenly, and for which they were entirely unprepared.
- The chaos that surrounded them which prompted a state of fear and indecision akin to a kind of 'mental stasis'.

In the words of one of their participants, "*You cannot freeze up. Indecision kills, you have to make a decision - do something! If that doesn't work, do something else*" (Ibid., p.S103). This appears to suggest that in a combat or humanitarian disaster context, the emphasis for these nurses shifts away from rule-based principles to act-centred or agent-centric principles. The premise here seems to be along the lines of 'it does not matter what you do, even if it is wrong, but just do *something* and keep trying until you get it right'. This is certainly not people-oriented and seems to challenge adherence to normative ethical theories in deployed EDM.

As discussed above, there are many conflicting factors which have the potential to influence the EDM of nurses, and by extension military nurses. This might best be expressed as ethical conflict. Falcó-Pegueroles et al. (2016) describe ethical conflict as a complex construct involving nurses being unable to follow their personal codes

of ethics due to (i) internal or external obstructions (moral distress), (ii) lack of recognition of values and ethics (moral uncertainty), (iii) difficulty in choosing between two or more valid moral values or courses of ethical action (moral dilemma), and (iv) a feeling of being unable to cope with immoral acts perpetrated by others (moral outrage). Pishgooie et al. (2019) relate the negative effects of ethical conflict in the clinical environment not only to the individual, but also to the wider profession, besides its impact on the EDM process. Ethical conflict, therefore, is a barrier to the EDM process and is derived from the ethical responsibilities that come with a career in clinical nursing (Falcó-Pegueroles et al., 2015).

Studies (See e.g., Corley et al., 2005; Cavaliere et al., 2010) have demonstrated that ethical conflict on the individual nurse's level may cause adverse effects such as frustration, anger, discomfort, and a diminishing sense of moral integrity which can erode their self-esteem and / or coping strategies and mechanisms (moral distress). Extrapolated to the wider professional level, ethical conflict can interfere with effective interpersonal or interdisciplinary communication, reduce coherent teamwork, undermine leadership, and may lead to underperforming or abandonment of services and increased voluntary outflow from the nursing profession (See e.g., Pauly et al., 2009; Rushton and Penticuff, 2007). This phenomenon has also been linked with burnout and emotional fatigue in nurses (Wlodarczyk and Lazarewicz, 2011). With the issue of power differential caused by disproportionate rank and professional nursing experience in the military context as described above, it may seem as though ethical conflict is an expected part of military nursing service.

Finally, it is important to explore the deployed context in which military nurses

operate, and offer an appraisal of the limited relevant literature. While this literature offers diverse perspectives on military nurses' experience of working on various combat and humanitarian missions, it also highlights the lack of specific evidence relating to UK military nurses' experience of EDM in this context.

The military context and nurses' EDM

In the deployed military context, Kenny and Kelley (2019, para. 4) are of the opinion that "*most theory learned in nursing programs is 'thrown out the window' when it collides with the reality of war*." They also state that because of the context and conditions in which military nursing is practiced, and the consequent fact that nursing practice may by military necessity breach conventional professional values, ethical concerns are of greater importance than in the civilian context (Ibid.). Storaker et al. (2019) state that there are grounds to believe that demands for nurses to be ever more deeply involved in EDM will increase, based on the modern healthcare climate of rapid change and growing complexity. This rings especially true for military nursing with the steadily evolving character of warfare, continuous development of advanced front-line medical equipment and training, and life-saving techniques.

For example, the recent trend towards large-scale, enduring international military campaigns like Iraq and Afghanistan have given way to a more streamlined, modern deployment profile. This typically advocates much shorter, more focused operations which use the smallest medical footprint possible. They incorporate new innovations and technologies, such as the adoption of Intermediate Care Ward (ICW) principles in MTFs across multiple platforms (i.e., on land and at sea). ICWs provide a service closer to that of a traditional high dependency unit, which allows military nurses to

care for patients with a higher clinical dependency. The intent is to reduce patient admissions to the ICU, which in turn allows deployed ICUs to be smaller and exert less ‘pull’ on shared resources. Another example is deploying forward a nurse-led Role 2 capability (which is a damage control resuscitation facility) with advanced nurse practitioners, a concept which some of the UK’s North Atlantic Treaty Organisation (NATO) partners and international allies have already successfully achieved as described above. In these roles, ICW nurses and Role 2 ANPs would be acting as ethical gatekeepers closer to the forward edge of the battle area than ever before.

There are several papers about military nurses’ experience in war and humanitarian disaster operations. Most were written by academics rather than the nurses themselves, but they are almost exclusively focused on military nurses from outside the UK - predominantly the US. They also focus on issues of training or clinical practice, or were anti-war, rather than focusing on ethical issues. For example, a concept analysis conducted by Fink and Milbrath (2023) included 50 papers which met their inclusion criteria. Only four focused solely on UK military nurses, examining their clinical practice (Byers, 2010), values and characteristics (Finnegan et al., 2016b), experience of war (Griffiths and Jasper, 2008), and an argument against war (Tschudin and Schmitz, 2003). A further two papers included military nurses as part of an international coalition, or a comparison of experiences of war (Kenward and Kenward, 2015; Ma et al., 2021). Some of these papers will be discussed in more detail below.

Professor Janice Agazio has published extensively in the field of military nursing, and

more specifically ethics in military nursing, but has written many of her papers in a descriptive style. An example is a paper in which the authors have written about ethical issues encountered by military nurses during wartime in purely descriptive phenomenological terms (Agazio et al., 2016). This is a factual piece, detailing ethical issues encountered rather than discussion of the EDM process and the nurses' experience or perceptions of it. There is no deep analysis, and only superficial conclusions are drawn. Another paper related to the specifics of ethical issues and dilemmas encountered in wartime US nursing practices (Agazio and Goodman (2017). They conducted a secondary retrospective analysis of two previous descriptive studies, attempting to organise the ethical issues emerging from the data using the International Council of Nursing Code of Ethics as a framework. They did this to better understand how nurses define, assess and manage the ethical situations they encounter in wartime nursing practice, which is similar to the aims of my study. They advocated EDM in military nurses that best promotes outcomes in accordance with nursing ethical codes.

A paper has since been published, advancing the latter work above, again examining moral conflicts and ethical issues experienced in wartime by a group of US military nurses (Agazio and Padden, 2024). This was published long after my fieldwork had been completed and I was nearing completion of this thesis. They again had similar aims to my study and reported close thematic similarities in their findings to my own in UK nurses. However, they focused more on moral distress, coping mechanisms, and post-deployment reintegration of nurses on their return to the US than on nurses' experience of and their place in the EDM process. Other authors have observed symptoms in military nurses returning from operational deployment which they have

linked to compassion fatigue and burnout (Kelly, 2010), Post-Traumatic Stress Disorder (Middleton, 2009), and moral distress (Wilson et al., 2020).

Rivers and Gordon (2017) wrote a descriptive secondary analysis of three other papers, comparing nurses' experiences of combat and humanitarian deployments. They identified limited ethical dilemmas such as dual loyalty conflict but focused more on describing an account of the perceived emotional effects these operations were having on the US military nurses interviewed. There was only one reference to the EDM process, in relation to the importance of emotions in moral reasoning. Gross (2004) believes that due to the uniqueness of the battlefield (the austere environment, the cultural differences, and its distinctive nature), ethical issues experienced by military nurses may be even more pronounced in this context.

Other international studies included a phenomenological study of the lived experience of Nursing Officers from the Australian Defence Force perspective, which was descriptive in nature and simply reported on their views on their role, adjustment to the environment, pre-deployment training, leadership and team working (Conlon et al., 2019). It did not analyse or synthesise their experiences, nor address any ethical issues around decision-making. Another study (Scannell-Desch and Doherty, 2010) used Colaizzi's phenomenological method (a descriptive / interpretive model) to examine the lived experience of nurses in Iraq and Afghanistan 2003 to 2009. Again, this was broadly descriptive and did not focus on EDM.

One Canadian nurse (Haynes-Smith, 2010) wrote a personal account of her lived experience in a war zone, but this was focused on her emotional response to the combat environment and the work she undertook rather than her experience of EDM.

One paper which specifically examined EDM and ethical dilemmas in the military context was unfortunately focused on the military anaesthetist, trauma surgeon, and physician points of view, not on nurses (Kondro, 2007). A U.S. Navy nurse wrote a grounded theory paper on the humanitarian nursing challenges on board a US Navy hospital ship following a tsunami response in 2004 (Almonte, 2009). While largely descriptive, she does comment on the lack of preparedness for ethical conflicts, citing the 'playing God' choice of which children to treat with their finite time and resources.

There were only a few relevant UK studies highlighted in the literature search. Kenward and Kenward (2015) published a paper on the coping strategies used by UK and US military nurses in conflict situations (not necessarily ethical conflict) in Iraq and Afghanistan. They used thematic analysis to exploit the data and draw their conclusions. Griffiths and Jasper (2008) used a grounded theory approach to examine the nature of the dual role of military and nursing service in an environment of war, specifically in the melding of personal, professional and organisational values and standards to identify the effect this had on the nursing role. They concluded that the duality of professional nurse and professional warrior is proudly embraced by military nurses, and that "*further research is needed to explore the essence of the caring role within a conflict zone from military and civilian perspectives*" (Ibid., p.92), which this study may address.

In a UK-based paper, Draper and Jenkins (2017) systematically researched the ethical challenges experienced by UK MHCPs in Sierra Leone during the Ebola Viral Disease outbreak in 2014, although it did not focus on nurses specifically. The results

showed that many MHCPs expected their Ebola Treatment Facility in Kerrytown to be overwhelmed with patients, and many experienced ethical tensions when the opposite was true. Empty beds presented a major ethical issue when the obvious need outside their walls was great. This was felt especially keenly by those staff who professed humanitarian motivations for their deployment. Other ethical issues included work avoidance because of worry of disease transmission, separating and isolating patients from loved ones to die alone, and the use of cameras to observe patients to avoid too much time nursing in the 'hot zone'. It also highlighted normative ethical dilemmas like 'should we use our only ventilator in a case of suspected Ebola when we cannot replace it?', or 'who can we treat?' (based on the Medical Rules of Eligibility). I, with a colleague, created learning materials from this study as part of a European COST (Committee on Scientific Cooperation) action on disaster bioethics (Hale and Brockie, 2016) under the supervision of Professor Heather Draper (Warwick Medical School, Chair of Biomedical Ethics). These have since been extensively used by NGOs and military healthcare teams in deployed healthcare ethics workshops.

This chapter presented a narrative review of the literature to explore what is known about EDM in nursing and follows a 'golden thread' of nurses' experience of it, both military and civilian. I found that there is a lack of evidence in the literature which specifically relates to UK military nurses' experience of EDM in combat and humanitarian deployments. This is unfortunate, especially given the huge amount of lived operational nursing experience gained in extensive deployments over the last few decades in e.g., the Balkans, Iraq, Afghanistan, Sierra Leone, and South Sudan. It represents a critical gap in existing knowledge and DMS corporate memory which

this study aims to fill. Now, between major deployments, is the ideal time to take note of the lessons learned and investigate the ethical experiences of military nurses to better prepare them for future deployments (Agazio and Padden, 2024). It is important to me to avoid regression and advance military nurses' ethical awareness, moral sensitivity, and moral agency.

The next chapter explains this study's research design, including the selected research paradigm, methodology, and the methods used.

Chapter 3

METHODOLOGY

Research paradigm

A research paradigm is comprised of four constituent parts - ontology, epistemology, axiology, and methodology (Lincoln and Guba, 2000). Succinctly paraphrasing Thomas Kuhn, Orman (2016, p.47) states the simple premise that a philosophically supported research paradigm is "*an intellectual framework which makes research possible*". More explicitly, Kaushik and Walsh (2019, p.1) state that a paradigm is based on the "*shared generalizations, beliefs, and values of a community of specialists regarding the nature of reality and knowledge*", while Cresswell and Plano Clark (2011) suggest the term 'worldview' as a synonym.

A research paradigm encompasses a researcher's ontological and epistemological position and underpins the research design, framing the methodology and methods considered most useful to the researcher to meet their aims (Scotland, 2012). Indeed, according to Junjie and Yingxin (2022, p.10), a research paradigm is selected based on "*the understanding of people's knowledge and reality and lays the foundation for all philosophically based scientific research."* Two of the most common research paradigms used in the social sciences, for example, are positivism and interpretivism (Ibid.), the latter of which I have selected as my research paradigm. Interpretivism has its intellectual and philosophical roots in the works of several prominent philosophers (Burrell and Morgan, 1985). For example, Chen et al. (2011, p. 130) state that "*the seeds of interpretivism can be traced back to the ideas of Immanuel Kant*", who articulated its early ontological and epistemological

foundations (Ibid.). Weber (1949) and later Dilthey (1976) were concerned with bridging the gap between idealism and positivism and understanding the difference between natural and cultural science, creating and then developing the idea of 'interpretive sociology'.

I have chosen to follow an interpretivist research paradigm because it is the most appropriate approach for meeting the aims of my study. This is because the core purpose of interpretivist qualitative research is to gain better understanding of subjective human experience, and individuals' interpretation of the world around them, from the position of the individual being studied rather than the researcher (Kivunja and Kuyini, 2017; Burrell and Morgan, 1985). Participants' voices are prioritised in qualitative interpretivist research, but unlike in a positivist paradigm the researcher's own experience and theoretical sensitivity (insight) is still valued (Braun and Clarke, 2023). This means that interpretivist qualitative research is subject to a 'double hermeneutic' (Smith et al., 2012), with the researcher intersubjectively 'meaning making' during the analysis phase (Larkin and Thompson, 2012), or interpreting participants' interpretation of their own remembered experience within the research interaction (Montague et al., 2020). It is this process which necessitates a reflexive approach so that the researcher can remain aware of their position and potential influence on the analysis. Indeed, Clancy (2013, p.12) states: "*It is crucial to undergo a process of reflexivity [in qualitative research] to provide a credible and plausible explanation of participants' accounts and avoid assumptions.*"

This double hermeneutic and reflexive process is well explained by Smith et al. (2012) in their book about Interpretative Phenomenological Analysis. However, it is

also integral to Braun and Clarke's (2022) Reflexive Thematic Analysis (RTA) approach, which I adopted. In a pertinent comment on researcher subjectivity and the importance of reflexivity in qualitative, interpretive phenomenological research, van Manen (1990, p.20, his emphasis) says, "*subjectivity means that we are strong in our orientation to the object of study* ***in a unique and personal way*** *- while avoiding the danger of becoming arbitrary, self–indulgent, or of getting captivated and carried away by our unreflected preconceptions.*" Supporting this, Braun and Clarke (2021) go further, stating that researcher subjectivity in data analysis methods is essential while still incorporating reflexivity. This is because *"themes cannot exist separately from the researcher - they are generated by the researcher through data engagement mediated by all that they bring to this process (e.g. their research values, skills, experience and training)"* (Ibid., p.39; their parentheses).

The research aimed to study the lived experience of serving and retired military nurses in relation to the EDM they were exposed to, involved in, or observed during their operational deployed service. In doing so, I hoped to gain a deeper understanding of how prepared they felt to navigate this complex process. This was to investigate if there were any critical themes which might have implications for defence nursing which could improve preparedness training for EDM prior to deployment. Below, I describe and justify my use of a qualitative study design, discussing the theoretical framework of my research paradigm and stating my ontological, epistemological, and axiological positions. This positioning contextually informed and drove the development and progression of my qualitative research and analysis methodology.

As the literature review demonstrates, it is not well understood how UK military nurses experience or make decisions in deployed situations that have ethical implications. Therefore, there is a need to generate new knowledge to expand understanding of this phenomenon. As a qualitative researcher develops new theoretical ideas as their study progresses, known as an inductive approach, there are no existing scientific hypotheses which can be empirically tested (Holloway and Galvin, 2017). Qualitative study seeks to explore and explain by 'deep diving' into the meaning, underlying reasons, opinions, and motivations in the context of (for example) a particular phenomenon or observed behaviour, usually in the social sphere (Braun and Clarke, 2022).

As such it involves the collection and analysis of data in the form of words, in specific contexts, usually by talking to people, but can also involve analysing written accounts of human experience (Braun and Clarke, 2013). Qualitative inquiry was therefore selected as the most appropriate approach for this study, due to the depth of nuanced information and methods needed to answer the research question. Contextual influence makes lived experience highly subjective, as reality and circumstances are experienced differently by every person (Hicks and King, 2009). This makes a positivist research paradigm and the more objectivity-seeking position of the researcher within it problematic for many qualitative researchers (Burrell and Morgan, 1985).

Taking the above into account, throughout the course of this study I have applied the principles of the so-called 'Big Q' approach to qualitative enquiry. The 'Big Q' and 'small q' approaches were described by Kidder and Fine (1987) as a means of

distinguishing between research using qualitative tools and techniques within a qualitative paradigm (Big Q) and research using qualitative techniques within a positivist or post-positivist paradigm (small q). Finlay (2021) helpfully makes the distinction clearer between scientifically descriptive (small q, positivist) and artfully interpretive (Big Q, non-positivist, reflexive) thematic analysis. 'Big Q' can be thought of as a synonym for 'fully qualitative', rather than 'partially qualitative' research. Braun and Clarke (2013) refer to this overall alignment of research ethos or orientation underpinned by 'Big Q' qualitative principles as 'qualitative sensibility'. 'Small q' research on the other hand is occasionally and somewhat hedgingly referred to as 'qualitative positivism', which evokes images of a researcher who cannot commit to a clear ontological and epistemological position.

Ontological position

Interpretivist researchers accept the ontological position that the world is experienced differently by everyone (Parahoo, 2014), and as a result multiple perceptions of reality exist (Urcia, 2021). Interpretivist knowledge is therefore "*relative to the situations and persons from which it emerges*" (Hiller, 2016, p.103). As I aimed to gather the lived experience of a group of military nurses in relation to their experience of EDM, all of whom would have experienced their combat and humanitarian tours differently, I accordingly embraced a relativist ontological position. This is because in qualitative research using a relativist ontology, "*the emphasis is on the understanding of human phenomena through analysis and interpretation of meaning people ascribe to events or objects*" (Bradshaw et al., 2017), and this is what I wanted to achieve. Braun and Clarke (2013, p.27) state that in a relativist ontology, reality "*entirely depends on human interpretation and knowledge*", and that what is "*'real' and 'true'*

differs across time and context." (Ibid.) There are many ontological positions for a researcher to consider when designing their research but some, like realism or critical realism, are better suited to positivist research than interpretive research. Poucher et al. (2019, p.165) state that this is because a realist ontology "*implies a belief in an external reality that exists independently of the researcher's knowledge of it*".

Epistemological position

An epistemological position is related to a researcher's assumptions about the nature, origin, and limits of human knowledge (Stroll and Martinich, 2024). Expressed another way, it is the theory of knowledge, or how knowledge is created, conceived, or communicated (Ayton and Tsindos, 2023; Park et al., 2020). Given that I am examining military nurses' deployed experience of EDM in the combat and humanitarian contexts, which involves a subjective way of knowing, I embraced a subjectivist epistemological position. This fits well within the interpretative research paradigm, as it holds that "*truth and meaning are shared subjectively between people*" (Urcia, 2021, p.2; also see e.g., Creswell and Poth, 2024), including researchers and their participants. Due to the exploratory, qualitative nature of the research question in this study, I regard my adoption of an interpretivist research paradigm with relativist ontological and subjectivist epistemological positions as an appropriate choice to meet its aims and objectives. This is *inter alia* because "*relativity and subjectivity are considered natural and expedient aspects of such knowledge pursuits*" (Hiller, 2016, p.111).

As alluded to above there are a wide range of other philosophical assumptions and

research paradigms used in the social sciences which were considered and rejected at the early research design stage, such as positivism. Other paradigms considered at this time included pragmatist, critical, post-structuralist, and post-positivist approaches (See e.g., Ayton and Tsindos, 2023; Kaushik and Walsh, 2019). A pragmatist paradigm, for example, was considered because of its flexibility. However, this was also rejected as it is considered better for mixed-methods study as it values the views of both interpretivist and positivist paradigms (See e.g., Brierley, 2017; Kaushik and Walsh, 2019).

Axiological position

A researcher's axiological position refers to the understanding they have of their values and ethics and how these are reflected in the conduct of their study, as well as considering the role they play within the research (Alele and Malau-Aduli, 2023; Ayton and Tsindos, 2023). This is not always straightforward as the question of what constitutes research values is contested amongst qualitative researchers (Polak, 2023) and ethics differ between individuals. However, through stating their axiological approach, researchers demonstrate their intent to present a balanced and ethically sensitive account of their findings (Kivunja and Kuyini, 2017).

The literature suggests that subjectivity is to be treated as a valid qualitative research resource (Braun and Clarke, 2023) rather than something undesirable, as in the case of objective positivist research (Park et al., 2020). Indeed, Silverman (2022) says that subjectivity should be embraced as a strength in qualitative research rather than a weakness which threatens academic rigour. As a military nurse of five operational tours in Kosovo, Iraq, and Afghanistan, I found that critically reflecting on my

deployed experience from an *emic* (subjective, or insider) rather than an *etic* (objective, or outsider) perspective enriched my analysis of the data (Vijver, 2010). This is because I was able to effectively parse the nuances of deployed care challenges to EDM, as I had been immersed in the same care environments (albeit at a different time) as my participants, in a way which an *etic* researcher could not.

It might seem, at *prima facie* examination by a positivistically aligned reader, that my position as an *emic* researcher, incorporating my existing knowledge, experience, values, and perspective could lead to a suggestion of subjective bias in my study. However, my position in the research is consistent with Braun and Clarke's (2021, p.6) view that the influence of researcher subjectivity in qualitative thematic analysis is "*not just unproblematic, but an asset, especially if reflexively engaged with*". This is supported by their 2023 (p.4) statement that RTA is "*premised on the researcher always shaping their research; it will always be infused with their subjectivity, and they are never a neutral conduit, simply conveying a directly accessed truth of participants' experience*."

This makes the reflective practice and reflexively applied experience of the researcher a valued element of 'Big Q' research. I therefore do not regard them as a flaw in my paradigmatic approach, but rather a benefit, because the focus for an interpretivist researcher is not about obtaining objective information (Espedal, 2022). Indeed, Gudkova (2018, p.81) suggests that examining "*human experience, interpretations of facts, events and behaviours*" is of far more importance to the interpretivist researcher in their data collection and analysis than objective facts and figures.

As alluded to above, consistent use of reflection and reflexivity throughout the research process is a conventional method of limiting the impact of researcher subjectivity in interpretive, qualitative research (Braun and Clarke, 2023). These assist researchers in reducing the impact of their perceptions, values, beliefs, and assumptions on their study, particularly in their philosophical and methodological approach (Lathlean, 2010). Reflexivity and reflection are tied concepts with a shared etymology. The word 'reflexive' is derived from the Latin *reflexus*, which is a conjugation of the Latin verb *reflectere,* both meaning 'to bend, or bent back on', in other words to be 'self-reflective' (Nazaruk, 2011). Brown et al. (2015, p.713) state that self-reflection is "*fundamental to learning from and applying one's life experience".* This is why reflection in qualitative interpretive research, with the inclusion of reflexivity, is Braun and Clarke's idea of good qualitative research practice. Reflection is a skill inculcated in and practiced by nurses from the start of their professional education, evidence of which is required by the NMC as nurses must revalidate their registration every three years (Brockie, 2017).

Archer (2007, p.4) defines reflexivity as "*the regular exercise of the mental ability, shared by all normal people, to consider themselves in relation to their (social) contexts and vice versa.*" It is therefore a self-reflective process, which at its most basic can be referred to as "*internal conversation*" or "*internal dialogue*" (Ibid., p.2). Practiced appropriately, reflexivity therefore offers a researcher the opportunity to 'bend back' their thoughts upon themselves and engage in an internal dialogue to develop the self-awareness of their own values, assumptions, and beliefs necessary to conduct good quality interpretivist research (See e.g., Dowling, 2006; Furman, 2004; Carolan, 2003). Accordingly, I was careful to work reflexively throughout my

fieldwork and analysis. I made sure I was always aware of and reflecting on my own experience, values, assumptions, and beliefs in relation to the research question so that I could complement but not overshadow my participants' voices, which I aimed to prioritise throughout this thesis. Engaging with reflective and reflexive research practice has meant that I can present an axiologically balanced and accurate account of my findings and maintain a transparent philosophical, theoretical, and ethical position in my work.

Ultimately, and regardless of the paradigm and methodology used, research must be an academically and scientifically rigorous, transparent, and ethically conducted process (Harper, 2005). For my study, as well as following conventional civilian guidelines on undertaking human research, specific military regulations also applied in the form of Joint Services Publication 536 - 'Governance of research involving human participants' (MOD, 2024b). These both helped me ensure that my research was conducted in such a way that my participants were kept safe, and diminished the probability of the quality, reliability, validity, or defensibility of my study being called into question (See e.g., Barrow et al., 2022; Correia, 2023).

Design

The final element of a research paradigm is its methodological approach. This is an umbrella term which describes the practical methods a researcher employs to conduct their study, encompassing everything within the research design including participant selection, data collection, analysis, and final write-up (Kinjuva and Kuyini, 2017). Mayan (2009) states that it is important to ensure that qualitative research is both methodologically coherent and rigorous, meaning that researchers must be

mindful of their ontological and epistemological positions and their philosophical assumptions when designing their study (Poucher et al., 2019). Some methodological approaches, like the research paradigms above, were considered early in the design phase but rejected. These included e.g., Husserlian phenomenology and Ricouer's mimesis.

Edmund Husserl was an influential philosopher, and a key figure in the development of phenomenology theory, which called for the rigid application of a 'detached consciousness' in describing and analysing lived human experience (Thomas and Sohn, 2023). However, his views evolved over many years to eventually accept, as his pupils Heidegger (1962) and to some extent the existentialist Merleau-Ponty (1962) concluded, that the detached consciousness he once aspired to was unachievable (Thomas and Sohn, 2023). As a methodology however, and as Ashworth (1999, p.707) states, Husserlian phenomenology still called for researchers to "*set aside theories, research presuppositions, ready-made interpretations etc., in order to reveal engaged, lived experience*." This made descriptive phenomenology unsuitable for the aims of my study, which incorporates my influence as a subjective interpreter of human experience in the specific context of EDM in deployed care. This is because I wanted to draw out any commonalities of experience with my participants, which necessitated interpretation of the findings rather than being purely descriptive.

Another interesting but ultimately rejected methodology was Ricouer's 'mimesis', which has its origins in Aristotelian theory as detailed in his book 'Time and Narrative' (Ricoeur, 1984). Although it claims phenomenological, hermeneutic, and reflective

roots, as Josephsson et al. (2022, p.3) state, it is primarily concerned with interpretation of written narrative as this "*provides a paradigm for interpreting action*." This preference for the written word diminishes the opportunity for, and importance of, the face-to-face interaction. Through the latter, qualitative researchers can gain valuable non-verbal insights into their participants' accounts of their lived experience during fieldwork, e.g., facial expression, body language, and gestures inconsistent with their speech etc.

This is true even in the case of digital interviews (i.e., taking place via online video calls) due to ever-increasing video quality, as many of mine were due to Covid restrictions during fieldwork (Thunberg and Arnell, 2021). Indeed, I kept a fieldwork record of non-verbal cues from my participants, which got more detailed with each interview as I gathered experience. Interestingly, and consistent with Thunberg and Arnell's findings (Ibid.), I found that I gathered more non-verbal cues from digital interviews than from being face-to-face in the same room, because I could re-watch them at any time as they were digital files. I attributed this to participants feeling more comfortable with sharing their lived experiences from the comfort of their home environment than in a neutral room, potentially in the workplace.

Thematic analysis is often misconceived by novice researchers as a single method (Clarke and Braun, 2018), but is instead "*better thought of as a* ***family*** *of methods*" (Braun and Clarke, 2023, p.1, their emphasis). Amongst the typology of thematic analysis, I determined that RTA was appropriate to use in the context of the underlying theoretical and paradigmatic assumptions of my study, and best suited to helping me answer my research question. Braun and Clarke try to make its use easy

for researchers, variously offering a six-step (2006, p.87) or seven-step (2013, p.202-203) process to conduct thematic analysis. They also offered a 15-point 'checklist' (2006, 2013) to determine the quality of thematic analysis, which has evolved over the years to now reflect RTA (2022). However, they are always at pains to stress that these processes are intended as a loose guide for novice researchers and are not prescriptive, encouraging more experienced researchers instead to 'do their own thing', if they can explain and justify the divergence and why they did it. As it will add to the academic rigour of this study (Ibid.), a reflective RTA quality check is included in the concluding chapter of this thesis to assess and document the conduct and quality of my analysis.

Although they do not declare adherence to any specific theoretical or philosophical underpinnings in RTA, Braun and Clarke (2023, p.4) acknowledge that thematic analysis "*cannot be conducted in a theoretical vacuum*." As a family of methods, TA was designed to be deliberately 'theory-agnostic', making it flexible enough to work well with a variety of philosophical and theoretical approaches. Braun and Clarke (2019, p. 594) say that RTA is about "*the researcher's reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process*". They therefore assert that analysis of data in TA is conducted interpretively at the intersection of: (i) the dataset, (ii) the theoretical assumptions of the analysis, and (iii) the analytical skills and resources of the researcher (Ibid.; Byrne, 2022).

As RTA is 'theory-agnostic', it allowed me to collect data reflectively and analyse it in a reflexive manner, keeping underpinning theoretical elements of neo-Aristotelian

virtue ethics, phenomenology, and hermeneutics in mind. This is important, as I was examining and interpreting the contextual lived human experience of deployed military nurses in relation to EDM in dangerous circumstances beyond their routine peacetime NHS practice. As an active researcher in my *emic* insider position, I was able to reflexively respect and give priority to my participants' voices while acknowledging and embracing, but still effectively limiting, the influence of my experience on my interpretation of their lived experience as RTA demands.

This is also important because as far as I am aware, my study represents the only in-depth empirical exploration of UK military nurses' lived experience of EDM and I want to give as clear a picture of that as I can in this thesis. As discussed above, I have a common deployed background with my participants and as such have a great deal of insight into the EDM they have experienced on the macro (strategic) and meso (organisational) levels. However, I needed them to relate to me their experience of deployed EDM on the micro (personal) level. This is so I could obtain the depth of information needed to allow me to answer my research question and analyse it to determine if there were any commonalities with my own micro level experience from which to draw wider conclusions. I regarded phenomenological and hermeneutical analysis as the best way to achieve this, within an interpretive paradigm.

Sampling strategy

Purposive sampling is common in qualitative social, nursing, and medical research (Stratton, 2024). This is because the end goal of qualitative research is to generate insight and deep understanding of a specific topic or social group (Patton, 2002). In contrast, quantitative data sampling strategy is typically derived from a power

calculation designed to achieve the end goal of generalisability of results, which means that they can be applied reliably across a wider population (Althubaiti, 2023). The qualitative researcher will normally deliberately select their participants on the basis that they will be able to provide the thick, rich data needed to interpretively analyse the topic or group of interest. This can mean setting careful inclusion and exclusion criteria for a study. Purposive sampling can therefore be considered as 'bespoke targeting' of potential participants based on the researcher's knowledge of the population group which contains their proposed sample and the research question. In this way, it is both a cost-effective and time-efficient method for recruiting (Palinkas et al., 2015; Campbell et al., 2020).

Accordingly, I employed a criterion sampling method, a form of purposive sampling, for my study (Cresswell, 2009). This is because the nature of the research question demanded specific indicators for inclusion and exclusion. The inclusion criteria were that participants must be:

- Serving or retired UK military nurses.
- Professionally qualified and practicing nurses (i.e., registered with the UKCC or NMC) at the time of their service.
- Operationally experienced, defined as having deployed during their military career in a clinical nursing role on at least one combat or humanitarian mission.

Recruitment began just before the first wave of Covid in the UK. Exclusion criteria from the prospective participant cohort included lack of relevant operational experience and initial limitations based on geographical location. Only those serving

or still living in mainland UK were going to be considered for recruitment due to funding limitations for travel. However, because of the imposed lockdown restrictions on travel and the advent of remote working necessitated by the Covid pandemic, I was able to include, through video calls, some retired participants who no longer lived in the UK.

A short presentation relating to my proposed study was first delivered to operationally experienced nurses at an Academic Department of Military Nursing research forum in 2020 to raise awareness, but there was no effort made to directly recruit from that event. A recruitment email (see Appendix 2) was later sent on my behalf to all serving military nurses and many retired military nurses, through their respective Service Associations, by gatekeepers (neutral third-party administrators within the MOD). This was in accordance with a stipulation from the MOD Research Ethics Committee (MODREC) that I was not to be involved in directly emailing potential participants until they responded to me after receiving the initial invitation from the gatekeepers. Emails were sent deliberately without reference to my rank or position in Defence Nursing. This was to both meet the conditions to gain favourable ethical opinion from MODREC and to reduce any perception of rank coercion to participate by virtue of my seniority.

The recruitment email included a participant information sheet (see Appendix 4) to inform potential participants, demonstrate transparency, and assist with preparations to obtain informed consent. Interested potential participants were asked in the initial email sent by the gatekeepers to contact me to register their interest in participation, provide their details for follow-up communication, and make a confirmatory statement

that they met all the stipulated study inclusion criteria. They were also provided in the initial recruitment email with an explanatory document detailing the arrangements for the claim and payment of no-fault compensation to participants in studies reviewed by MODREC (see Appendix 5). This is a mandatory requirement for all MODREC-approved studies involving military personnel.

An initial thought to widen and potentially increase recruitment was to utilise an adjunctive snowball sampling method, where early participants are asked to recommend to the researcher other potential participants who meet the inclusion criteria (Parker et al., 2019). However, this did not occur because a) it is regarded as being of low validity with a high degree of selection bias (Stratton, 2024), and b) because it was unnecessary, as organic recruitment was successful in meeting the MODREC recruiting stipulation of >25 participants. There were 39 applicants in total, and most of those who expressed interest in participating in my study met the inclusion criteria. A final sample group of 30 nurses was selected. They had a range of specialities and skill levels, and some had more operational experience than others. A table of participants' relevant demographic details, which serves as an interesting point of reference and preserves their anonymity, can be found on page xi of the preamble to this thesis.

A further seven nurses expressed interest and met the inclusion criteria but then either did not respond to further communication, or could not agree an interview date because of other commitments. Two applicants failed to meet the inclusion criteria and were therefore excluded from the study. One was a nurse who had never deployed, and the other was a Combat Medical Technician, not a nurse. Fortuitously,

some ANPs were amongst the selected sample group. They represent the candidates most likely to be exposed to ethical dilemmas as the decision-maker in the remote deployed MTFs of the future. I hoped that this might add another dimension to the perspectives on military nurses' experience of, and attitudes towards, EDM.

Participant consent

Ethical consent of study participants was obtained according to the principles of the WMA's (2013) Declaration of Helsinki pertaining to medical research involving human participants. All participants were sent a consent form to be reviewed and signed before they could participate in the research (see Appendix 3). All questions were answered before the consent form was signed and dated. As the researcher, I countersigned all consent forms either electronically or in hard copy. Only after a consent form had been signed by both parties and a copy given to the participant did any research activity such as interviews take place.

Participants were informed that they were free to leave the study at any point and were not required to give a reason for doing so, with a caveat. Participants agreed that even if they wished to withdraw from the study, interviews which had already been anonymised, transcribed, and analysed may continue to be used in the thesis or in future publications. However, none of the participants expressed a wish to be withdrawn from the study. One participant completed a consent form in person as it was the only face-to-face interview I was able to undertake. All others sent them to me electronically from the personal email accounts they used to register their interest in participating. This was due to the Covid pandemic and associated travel

restrictions limiting face-to-face encounters, and the necessary move to video calls to complete data collection. All participants who had recorded video interviews were again asked to confirm their consent to proceed before data collection commenced, which is reflected at the start of each transcript. Their electronically completed consent forms have been retained on a secure, password protected computer.

Data collection

In accordance with established principles of 'Big Q' research and RTA, qualitative data collection took place via semi-structured interviews. This is one of the most common methods of data collection in qualitative professional healthcare research (Bearman, 2019). These allow participants the latitude to narrate their contextual practice stories while allowing the researcher the opportunity to explore any promising leads. Narratives were collected from this cohort of 30 serving and retired military nurses from all three Services (Queen Alexandra's Royal Naval Nursing Service, Queen Alexandra's Royal Army Nursing Corps, and Princess Mary's Royal Air Force Nursing Service (PMRAFNS)) within the DMS.

Following receipt of written informed consent as described above, most of these interviews were conducted remotely from home via video call, due to government restrictions on travel during the Covid pandemic lockdown period. For this reason, I was only able to conduct one of my participant interviews face-to-face, which took place in a comfortable, quiet, neutral, and private environment to limit distraction or interruption. All interviews were conducted in civilian clothing to further limit the potential for introducing a rank bias effect into data collection, which is a concern for researchers in any military study (Bernthal, 2015). Interviews were audio or video

recorded and the data stored on a secure, double password protected computer.

Positivist data collection is usually concerned with the researcher asking a standardised set of questions prepared in advance, without deviation, which are asked in the same order for all participants (Silverman, 2022). They are more focused on the answers given than the relationship between the researcher and the participant (Espedal, 2022). Qualitative semi-structured interviews are not as prescriptive as structured, positivist data collection methods. As qualitative research interviews are more open and permissive, I prepared a topic guide (see Appendix 6) prior to commencement of data collection. The recommended design of a qualitative topic guide favours open-ended questions to guide the conversation (Patton, 2002). The aim of a topic guide is to assist the qualitative researcher in generating the rich, thick description which will contribute towards answering the research question (Bearman, 2019). It provides a loose framework of questions for the researcher to refer to during the interview should the conversation wane or wander off topic. However, it also allows the researcher the freedom to follow up on participants' answers or ask further related questions for clarification or deeper detail which are not on the topic guide. This is why the term 'semi-structured' is applied to this method of qualitative interviewing, as it allows deviation from the topic guide based on the flow of the conversation.

Analysis

All interviews were fully transcribed for analysis. Transcription from face-to-face, audio, and video records of participant interviews was completed partly by me and partly with the assistance of the web-based transcription software which is included

in my Quirkos (a Computer-Assisted Qualitative Data Analysis tool) subscription. The task of manual transcription is recognised by researchers as laborious and mundane, even if it offers increased familiarity and immersion in the data (Bird, 2005). This is why many researchers now outsource the transcription process to a professional service or import their audio files of interviews into dedicated artificial intelligence-supported transcription software (Point and Baruch, 2023). I transcribed several interviews personally before utilising Quirkos' built-in transcription service to accelerate the process. All the remaining interviews produced by the software were reviewed carefully and edited line-by-line, then repeatedly checked alongside their audio or video recording to ensure accuracy. This enabled the familiarisation with, and deep exploration of the data required for interpretivist analysis and understanding. All transcripts were saved on a secure and password protected computer.

All transcripts were flexibly, reflexively, and sensitively coded line-by-line for semantic (explicit) and latent (implicit) meaning (Braun and Clarke, 2024b). This was a process which Braun and Clarke (2024a, p.3; their emphasis) say is "*characterized by organic and open procedures for coding and theme* ***development*** *that centre the researcher's interpretive engagement with the data*." The authors are careful to highlight the word 'development' in this sentence because of their strong assertion that themes in qualitative thematic analysis are not identified, found, or otherwise discovered (Ibid.). Themes do not emerge fully formed from the data (Braun and Clarke, 2022), but are instead an outcome of the analytic process and cannot be presupposed without this work (Braun and Clarke, 2024a). Indeed, in their RTA Reporting Guidelines (RTARG), Braun and Clarke (2024b) state a preference for the

term ‘dataset generation’ over data collection for the reasons above.

In addition, they say using the term ‘dataset generation’ highlights the researcher’s active role in generating data through research practices rather than ‘finding it hidden’ in participant narratives (Ibid.). However, I prefer to use the traditional term ‘data collection’ as I have been explicit throughout this thesis about my emic position as a subjective and ‘knowing researcher’ (Braun and Clarke, 2023), collecting rather than having to ‘generate’ data. Indeed, I have adopted Braun and Clarke’s (2022) position on keeping the researcher ‘visible’ in the analytic process, which involves a preference for writing in the first person, or ‘active-voice’ style, rather than the third person, ‘passive-voice’ of conventional scholarly writing.

Findings

Analysed data are presented logically in thematic sequence in the findings chapter, faithful to the two themes and one sub-theme I developed and refined from reflexive analysis of the coding. A findings or results chapter is necessary, dedicated as it is in academic work to presenting the main findings of a study as objectively as possible in a descriptive format (Alfaro-Tanco et al., 2023). The findings are then critically explored in the discussion chapter and situated within the broader literature, sympathetically taking account of my central and subjective position as the researcher. Conclusions are then presented with implications for practice and potential future research. Study strengths and limitations will be acknowledged and presented alongside a 15-point Reflexive Thematic Analysis ‘quality check’ to ensure that the process, conduct, and quality of my RTA is in within the guidelines offered by Braun and Clarke (2022).

Ethical approval

This study received favourable opinion and permission to proceed from the Ministry of Defence Research Ethics Committee (1009/MODREC/19, dated 16 Mar 2020; see Appendix 1). The University of Birmingham's institutional Research Ethics Committee accepted MODREC's judgment (ERN_17-1414-BROCKIE, dated 23 Mar 2020; also see Appendix 1) and granted ethical approval on this basis. This was in lieu of conducting their own ethical review of the study, as they acknowledged MODREC as a more rigorous process of obtaining ethical approval.

Participant confidentiality and protection

A confidentiality statement was written into the study's consent form, explaining that all data transcripts would be anonymised, and participants assigned unique and sequential numbers to protect their identities. However, this included a caveat (a research fieldwork convention) that I could breach this confidentiality if their safety or that of any patients or others was threatened, or a potential crime detected. Electronic data, e.g., anonymised transcripts, were stored in accordance with the terms of the Data Protection Act 2018 on a secure, encrypted and double password protected server for the duration of the study. This data will also be stored on the University of Birmingham's research data storage servers for the required period of ten years after the study has concluded. Written data (e.g., field notes) have been stored securely in a locked cabinet in my home, and in accordance with my data management plan, the need to continue to store the data will be reviewed. If there is no longer a need to keep the written data after successfully defending my thesis, it will be destroyed as confidential waste according to University and MOD regulations.

Chapter 4

FINDINGS

A meticulous line-by-line analysis of the data was conducted according to the principles of Braun and Clarke's (2022) RTA. Data were coded and themes were developed reflexively in an organic, fluid process over a long period. This allowed plenty of time to continuously reflect on, and revise, both codes and themes to ensure they were in the right place and appropriately constructed. I developed two themes, each organised around a central concept, with one sub-theme which sits comfortably within the broader central concept of the first theme. The first theme is named 'Doing the right thing', because I found that this is the concept which encompasses and underpins everything that EDM means to my participants. It focuses on how my participants conceptualise, view their place in, and make ethical decisions within the context of military nursing. It has a sub-theme which reflects their thoughts on the utility of professional codes and guidelines as an ethical handrail to doing the right thing. The second theme is named 'The deployed context influences the EDM of military nurses', because everything my participants discussed around the nature of EDM in the deployed space seems to be context dependent. It therefore focuses on the core role of context and the contextual ethical constraints which influenced my participants' navigation and experience of EDM on deployed operations.

Theme 1: Doing the right thing

Participants in my study had a wide range of views on, and the meaning they attached to, EDM in nursing. Most participants described EDM as a carefully

considered process and agreed that it should always hold patients firmly at the centre of nurses' thoughts. In a military hierarchy, decision-making responsibility generally increases with rank, and incorporates more strategic ethical issues than tactical bedside issues. However, my senior participants never lost sight of the patients at the end of each decision, no matter how high level. Many used the phrase 'doing the right thing for the patient', or a variation thereof, for example: *"Making the right decision in relation to doing what's best for the patient."* (P023)

Doing the right thing for the patient is more than just that, and others qualify this. For example, P030 says "*What it means to me personally would be making a decision that is in the best interests of the patient. […] It's doing the right thing, at the right time, for the right reason."* (P030) She is clear that she feels this is a contextual and subjective endeavour, being influenced by "*time, person, and place*" and "*because my moral compass may be entirely different to yours*." P020 however also implies this could be objective, in that *"[In] ethical decision-making...you've got to ensure that you are doing the right thing.*"

Other nurses also perceived EDM to be patient focused and maintained self-reflection about the process:

> *"Everything that we do for our patients, a question should be asked. Why are we doing it? Are we doing the right thing?" (P029)*

> *"It's doing the right thing for you and doing the right thing for others. It's doing what's best for that individual at that time. Erm, and you should make it based on what, what value is it going to add to them? You know, what is the quality of life going to be like?" (P023)*

For a few participants, however, it is not enough to simply do the right thing for a

patient. As P003 says, *“As well as doing the right thing, you need to explain that you've done the right thing.”* This, she believes, leads to better EDM, especially in the context of helping staff to rationalise and process particularly difficult decisions. Placing much importance on this aspect of ensuring that (in her case, emergency department) teams are a component part of the EDM process, P025 agrees with P003 when she says:

> *“In the military we're placed in positions where decisions have to be made not only for the best of the patient, but also the situation that we're in. And also on a larger scale. As a nurse, quite often you feel forgotten about, especially […] you know, that input to a decision of whether it's the right or wrong decision at the time. Erm...in the military, working with such small teams, it's even more key to sort of understand why decisions are made, and for what reasons.” (P025)*

She believes that even though nurses may not be directly involved in the process, by explaining how they have arrived at an ethical decision, the decision-makers can still give nurses a chance to contribute to the wider ethical debate and disagree, comment or ask questions. This approach adds to the nursing voice in EDM by allowing clinicians with decision-making responsibility to gather bedside feedback in real time.

As well as being patient focused and doing things for the right reasons, the idea that EDM should be impartial was raised by several participants. For example, one participant says, “*Ethical decision-making to me is, if you're in an operational scenario, that you treat the most injured first regardless of side.*” (P015). This is supported by P011, who states:

> *“Ethical decision-making was having no specific judgment, you know. At the end of the day, if you're treating patients you're treating the patient on whose*

> *care is needed, the most priority regardless of who they are, you know. Whether they are on the ARGUS [The UK's Primary Casualty Receiving Facility at sea] for example, whether they're one of our boys or girls, or a prisoner of war." (P011)*

P027 says that although she might be internally thinking ill of an enemy combatant, she would endeavour to ensure that it did not show in her treatment of him: "*Even though you wouldn't tell it in my body language, my brain is thinking, you know, 'You bastard!' to the [enemy combatant]. But ethically…you treat everyone the same."*

P008's opinion is in line with the wider intent of always doing the right thing and working impartially in the patient's best interests, but he also hints at the complexity of EDM and the confounding factors of context and constraint making it a more difficult process: *"[EDM is about] doing the best for the individual based on their own needs and within the context of who they are, where they are, and, you know, everything else. So, it's not always cut and dry*." This takes on relevance in the deployed context with some of the unique operational constraints which military nurses face.

For many participants, context is principal amongst their thoughts when preparing to make an ethical decision. When we discussed the importance of circumstances when making ethical decisions on deployed operations, one retired Army nurse who transferred to nursing quite late after a career in a frontline combat regiment said:

> *"It's [about] ensuring that when you're making your ethical decision, you look at what you're doing. And you try to take a blank page. Every situation is going to be different, you can't, you know, you can never replicate anything. Because there are so many moving parts in every ethical decision that you've got to make, that it would...you can never, you can't write a script and say this is what we're going to do, ABC. It's not airway, breathing, circulation, you know…we'd have to look at everything and take everybody and everything in*

context." (P020)

The World Medical Association (WMA, 2012) issued a regulation which stipulated that medical ethics in times of armed conflict is **identical** to medical ethics in times of peace (my emphasis), despite the juxtaposition of contexts. However, one participant succinctly sums up the doubt of many other participants about the feasibility of this when involved in EDM during combat and humanitarian deployments:

> *"I think that's probably erm…a slightly naive statement [by the WMA]. Because actually, yeah, I'd say by and large you should be trying to kind of work within the same sort of channels, whether you're in wartime or peacetime, but the landscape potentially can change quite a lot once you're into a sort of wartime scenario."* (P008)

Mathes (2004) declares that EDM is an important and integral part of nursing. In perhaps the clearest expression of the importance of EDM in the nursing profession in my study, one participant agrees emphatically, stating that "*ethical decision-making, to me, is an important component part of nursing, I think it always has been.*" (P024).

As Mathes (Ibid., p.431) writes, historically, nurses were expected to obey doctors or senior nurses and had "*little opportunity for the exercise of professional autonomy*". This implies that they consequently had little or no voice in the EDM process, and instead focused on embodying the "*traditional view of the 'good' nurse as one who obediently follows the orders of those in authority*" (Ibid., p.431). This is borne out by P016, my oldest participant (at 88 years old), who started her nursing career in this era. During the discussion around her interpretation of how she experienced EDM during her nursing career, she stated that "*It's something I never even considered until I had the email from you. […] A good [ethical] decision? It never occurred to*

me." Consequently, EDM meant something different to P016 and was firmly rooted in doing her job as an operating theatre nurse to the very best of her abilities: "*I was being ethical in a sense, because I was making ethical decisions about giving the surgeons the right instruments so that they would be able to easily continue to operate*."

The idea of nurses' role and employment, whereby nurses should follow clinical guidelines and policies, raised issues as to the distinction if any between clinical decision-making (CDM) and EDM. This was seen by participants as a dichotomous issue - EDM is either integral to or distinct from CDM. There was also debate around the role of clinical guidelines and the role of ethical guidelines. I therefore revised my topic guide to explore what, if anything, participants thought distinguished a clinical decision from an ethical decision.

Some participants clearly expressed the view that EDM is separate to CDM, requiring a different thought process. Further, a few participants also linked this divisibility of EDM and CDM to the clarity of the decision to be made. The general opinion was that clinical decisions are more obvious and unambiguous than ethical decisions, which are complex, messy, and less well-defined. One participant, for example, believes that CDM is a much simpler endeavour than EDM because of the often protocol-driven and objective nature (certainly in her area of emergency nursing) of clinical nursing care*:*

> *"I think clinical decisions are often underpinned by policies, protocols, guidelines. Ethical decisions, there's very few er...ethical decisions that are set out by NICE [The National Institute for Health and Care Excellence]. They don't give you a nice number to follow, or they don't give you a perfect set of circumstances. So, I think the ethical decisions are more...there's sometimes*

> *not as clear a cut an answer as to what the right or wrong answer is. And people's ethics are different depending on […] their relationship with the person or their direct or indirect experiences. So, I think the clinical decisions are a bit more clear cut often. Er, because there's...there's maybe more that underpins them."* (P014)

Agreeing that the use of clinical guidelines makes CDM inherently easier, P027, a primary healthcare nurse, also sees a clear division between the clinical and ethical elements of a healthcare decision:

> *"[A] clinical decision to me is so obvious, it's just what's best for that patient and using your experience, going into the DPHC guidelines as to what to do with, for example, ingrown toenails and that sort of thing. Ethical decisions? A lot more complicated. They need thought. They need pros and cons written up. And you have to look at the bigger picture. So, I would be going back into their notes, back into their history to see whether there's anything that might hint, you know, might give me insight into the ethical decision I'm going to make."* (P027)

Interestingly, this extract states that P027 believes that EDM requires 'thought', and by implication, CDM does not, in part because CDM can be supported by clinical guidelines.

In contrast, and consistent with much of the relevant literature, some participants stated that they believed CDM to be an inherent and indivisible feature of EDM. They explicitly expressed the view that they are both a constituent part of the same thought process, and that the two are inextricable for a variety of reasons. Beginning with a prevaricating Emergency Department (ED) nurse, P008 presents a somewhat self-contradictory view, at first stating that he thinks "*All clinical decisions should have a degree of ethical input, I would hope*." However, he immediately followed that statement up by saying that "*a clinical decision sometimes can be taken without bearing in mind the ethical issues*". He appears to be mixing the 'can we?' argument

(i.e., do we have the equipment, the means, the personnel etc. to fix this person's injury?) with the 'ought we?' argument (i.e., is it ethically wise to commence this treatment, or will it cause further harm now or later?). He also draws in the ethical points of discussion which place the decision to be made in context to expand understanding and deliberation (such as age, location, socio-economic background etc.). And so, for P008, despite his apparent confusion, much of EDM is contextually rooted.

Several participants believe that CDM and EDM complement each other, or else are indivisible regardless of the size, gravity, or scale of the decision to be made:

> *"[Ethics are] part of the clinical decision. So, you've got your clinical pathway, your clinical decision, and you know what you would do in the ideal world...circumstances, if you had all the staff, all the resources, all the equipment, all the drugs, all everything. But also, you have to then think about quality of life, but also what the patient wants as well, what the family want. […] But it all needs to be taken into account. […] I think ethical decision-making goes part and parcel with your clinical decision-making."* (P010)

P009 says of CDM and EDM that "*it's not always possible to separate them. It's obviously sort of doing the best for the most."* Her mention of a utilitarian ethical concern implies that she would make her ethical decisions with the practicalities of scarce resource management firmly in mind to maximise the benefit for as many as possible. Implicitly, she routinely considers ethical elements in making a clinical decision in a deployed care setting. However, there would still be other constraints like the Medical Rules of Eligibility (MRoE) and two-tiered care (2TC) to consider in a deployed environment, which P009 later acknowledges when she says, "*you can't always make the clinical decision you want to because of then needing to apply that to a broader group of people."*

One participant, from a mental health nurse perspective, would also find it hard to separate EDM from CDM because of the dual loyalty conflict involved in his role: "*That's really difficult, because you've got your clinical picture and your occupational picture. Those should drive your ethical decision.*" (P006) This means that in the armed forces, a particular clinical diagnosis and decision on treatment (medication or certain therapies) may have a direct occupational effect such as being restricted from deploying, carrying firearms, or driving etc. The clinical and occupational pictures are therefore intertwined, which necessitates an ethical decision. This EDM is necessary to give the best possible balance between limiting the impact of occupational restrictions and protecting the patient and others from coming to harm, given the combat roles military personnel occupy and the weapon systems they have access to.

Even if they had not experienced it personally, a few participants expressed the idea that despite the obvious clinical need, it would sometimes be ethically kinder to local national patients to deliberately avoid treating them to the full capability of their MTF, or even to not start treatment at all. This is because deployed MTFs are designed to operate as close to UK standards as possible (Greaves, 2019), but local civilian healthcare facilities in the places the military deploy typically have much lower capabilities and standards. As a result, patients would deteriorate quickly or even die soon after discharge from the MTF to local hospitals (Kondro, 2007). This introduces the concept of two-tiered care, which will be examined further in theme 2. It is also indicative of the inter-related nature of the ethical issues important to my participants. As P023 puts it, paraphrasing Shakespeare's Hamlet, "*To treat or not to treat? That is the moral question*."

This is a situation in which it would be hard to make a clinical decision in isolation without considering the ethical elements of onward care, suggesting that EDM is also regarded by these participants as integral to CDM in operational healthcare. One participant discusses this, strongly linking CDM with EDM regarding delivery of care to seriously wounded enemy combatants in an MTF. She uses the Taliban and her time in Afghanistan as her example:

> *"You would get members of the Taliban in, you know, and again they just despised you. And I always remember one doctor saying...and it was, it really was quite poignant when he said, 'You know, we do everything for these', you know, and they would have lost arms and legs and big gunshot wounds in the chest and abdomen and things. And he said 'we're doing all this for them [life-saving surgery etc.], but we're not actually saving them. We're just changing the date of their death'. Because he said, 'As soon as they are removed from our care and go to the local hospital, they'll either be killed because of who they are, or they'll succumb to infection, or lack of care, or no drugs, or...', you know. And so actually, you'd be running down the corridor backwards and forwards to the lab to get blood for somebody that you think is actually…he's going to die in a few days, because he'll be transferred to Kabul or wherever to the civvy hospital. And you know, and I thought that's so true. Are we saving him? Or are we changing the date of his death?"* (P030)

One senior military nurse, P021, started his career as a Corporal (a Junior NCO). He remembers EDM being strictly the domain of the doctor, but remarks that it was often heavily weighted towards and presented as CDM:

> *"I think from [when I was] a junior nurse, when it came to ethical decision-making, it was the doctors. And you acted upon what they said. I think as we moved through, even to not that many years ago really, it was seen as a clinical decision-making body. […] I think from my perspective, of course, you're a patient advocate. This is not a pure clinical model. […] During my tenure [as Commanding Officer of a field hospital], I ensured that nurses were involved within the [clinical and ethical] decision-making process." (P021)*

In a final comment on EDM vs CDM, one of my participants suggests that different professional groups may have different views on the integrated nature of CDM and

EDM. Or, they may have different priorities in the decision-making process, veering more towards either the clinical or the ethical considerations. As an example, he describes a situation he was involved in with a paediatric patient, where the discussion at least appears to be collegial in nature, but with the doctors and nurses focusing on different aspects of the decision-making:

> *"I looked after a young girl in Kurdistan, who sadly died. She was brought in with raised intracranial pressure after a road traffic accident, and she sadly coned in the early hours of the morning. And her family wanted to take her home, and that was a big decision. And we talked as a team about how to facilitate that. So that she could go home to her parents, and die in a culturally appropriate...and be mourned in a culturally appropriate environment. There were things that we felt as a team, and particularly the doctors, that they needed to do from a medical point of view, a doctor's point of view. And the nurses' was, it's about getting her back to her parents so that they could mourn her death."* (P024)

This hints at the concept of moral sensitivity, which is regarded as an individual's awareness of their role and responsibilities in morally sensitive situations and the EDM process (Kovanci and Atli Özbaş, 2024; Ohnishi et al., 2018). The effect of moral sensitivity in EDM and how it may differ across professional groups will be examined in greater detail in the discussion.

Sub-theme of theme 1: Codes and guidelines as an ethical handrail

Many participants agreed that written codes and guidelines of various forms have their place in nursing, but sometimes with caveats. In most cases, however, they largely agreed that codes and guidelines are useful because they give nurses a framework which helps them to practice within the ethical boundaries of their scope of professional practice. Some are unequivocal in this belief, like P005 who states that in relation to ethical practice in nursing *"you need a code of conduct, definite,*

100%", and P013 who says, *"I think they're really important, I think all of them are really important."* P010 takes this one step further, voicing her opinion on what would happen if nurses did not have some sort of guiding framework like a code of conduct:

> *"I think you have to have some sort of framework, or a handrail for people to give guidance, because otherwise...it's about being...it's about having a conscience, about having that thinking about the efficacy of doing what you're doing. And actually, should I be doing it? Because if you've got no boundaries, and you've got no framework, and you've got whatever...chaos will ensue. And patients die."* (P010)

Some participants felt that the main purpose of the codes and guidelines which are presented to nurses as a handrail to ethical practice are no more than tools to 'pin blame' on them in the event of a complaint. For example, P017 is an experienced ANP who reported feeling unsupported by the NMC while enduring a professional investigation process:

> *"I feel in my practice that the NMC and some of the other policies are...I feel like they're going to be used to blame us. I don't feel I'm very supported, if I had to make decisions that were probably a little bit on the edge of those policies or pushing those boundaries. I feel like the NMC would be the organisation that would end my career and blame me for it."* (P017)

P012 is a senior officer who has more of a strategic leadership focus than many other participants. He thinks that with more seniority in the military nursing organisation comes the ethical responsibility to empower nurses to operate ethically within the NMC Code of Conduct and other written guidelines, such as Standard Operating Procedures and the Defence Operational Nursing Competencies (DONC) etc., and according to operational tempo. It involves creating a culture and environment of ethical practice and setting the conditions for success. This is not normally a concern for junior nurses, who are largely focused on their own practice -

it is an additional function of command responsibility. However, he also thinks the adjunctive written codes and guidelines mentioned above, which are applicable to all nurses in the military context, complicate matters:

> *"I think the Code of Conduct...the revised Code of Conduct is actually quite a good thing. And it...it is interesting. […] But I think for us, awareness of the Code, I think there's something about…how do you marry the Code with those other things [that make] nursing complicated...you know, military nursing competencies, SOPs? And there's also something about military law as well that plays into it. So, it's how do you not play them off against each other...how do you understand the interplay between those things, I think is important. And for most people, though, it's pretty straightforward, isn't it? I think, you know, it is...I'm here to do this job. It's when you get to perhaps more senior roles you're sort of thinking 'I have a responsibility to enable my nurses to operate within the Code'. And if there are issues around that, we need to explore what the issues are, and work out the solution. Again, because there are consequences of not being able to operate within the Code, aren't there?"* (P012)

One of the consequences of not being able to operate within the Code may manifest as nurses exhibiting defensive, or risk-averse, practice. One retired military nurse thinks defensive practice has been influencing EDM in nursing for some time. For him, this is based at least in part on fear of the perceived NMC attitude to investigating nurses (described by P017 above) and the potential consequences of working outside the Code. He also perceives that it is different for doctors, because nurses have more of a 'blame culture' than doctors, who are generally reluctant to assign blame within their professional group and instinctually protect each other when things go wrong, or they exceed their ethical boundaries:

> *"Doctors will never criticise a colleague, even though they might be the worst doctor on the planet. Nurses - pfft, slightest problem they're scuttling to the corners. 'Well, I wasn't on duty, thank God'. But you just get the feeling that if something did go wrong, it's the NMC, they've got your head on the block. Then they'll investigate it, where the GMC [General Medical Council] work the opposite way round. I mean just take Harold Shipman, he'd been in front of the GMC numerous times, and they still let him off. But nurses, you know,*

> *they're almost guilty before they're proven innocent. And I think that's the difference. And I think that's why people are worried. And nurses are worried about making mistakes, doing the wrong thing [including ethically]. So therefore, they [employ] defensive practice. I think that's what it is."* (P007)

One participant, something of an outlier in her opinion, explains why she thinks the NMC Code of Conduct is useful:

> *"I certainly found it useful myself when dealing with other people and saying 'This is the line in the Code. Can you honestly say to me that you have not breached that line?' And normally, people can't fight it. So, I do find it a really useful [ethical] handrail. Not necessarily just for me, but for my dealing with others. [Rather] than a handrail for myself, because I think I just...instinctively know what's right and wrong. Do I sit and read it like a Bible? No. Have I read it? Yes, of course. Do I go back to it frequently? Yes, I do. But I'd like to think I'm not checking my own practice. And I might just be going back to check it for the sake of others' practice, measure their practice against."* (P019)

The importance of doing the right thing for the patient, a core finding synthesised from military nurses' perceptions of how ethical decisions are made, is also at the forefront of P027's approach to the care of her patients:

> *"[Codes and guidelines] are actually…I do find them useful. [But] not every square peg fits in a square hole. […] So, if I feel that it's not quite right for that patient, I tend to go and discuss it with the SMO [Senior Medical Officer]. And I will say, you know, 'Yeah...I see this. This is the protocol. However, in these circumstances, I think it would be better if we did this'. And providing you've got top cover, then...you know, that's fine. […] Because, you know, not everything fits everyone. That...that's the critical point. You can have these as a guideline, but they're not always right for every patient. […]."* (P027)

This need to deviate from the boundaries or recommendations of professional guidance can be exacerbated by the deployed setting. Consider another extract from this senior nurse, who is responsible for setting an example for her subordinates:

> *"The Code of Conduct is always there. When you're on deployment, the Code of Conduct, you will be able to apply it…not always on all occasions, and you'll have to go outside the boundaries, but you need to come back in as quickly as*

> *practicable. […] And the thing is, even in a battlefield environment, you still have to remember you're a registrant but actually, sometimes you do have to step out. And for the most, people will have had some sort of experience, or training in, or been involved in doing whatever it happens to be that they're just stepping outside of, but as long as they come back in and they can justify 'Well, if I didn't do it, the patient was going to die.'"* (P010)

Along similar lines, P020 describes an ethical dilemma his surgical team faced in Afghanistan:

> *"When the Unit did HERRICK [tour number redacted], we had an orthopaedic surgeon and an upper GI surgeon, and they were in there...local national's brought in with a crushed chest, flail ribs. And they said 'What are we going to do? What are we going to do?'. And they stood there and looked at each other for a nano second, which took about a month. And it was 'We've got...if we don't crack this guy's chest, he's going to die'. And they looked at each other. And they said, 'Have you ever done it before?' and they said 'No...'. 'OK, right. Can somebody get the Marsden out, please [Royal Marsden Manual on emergency surgical procedures], let's have a look and see what we do here...'. And they didn't know, so...and they saved the guy. When you're looking at GMC guidelines, NMC guidelines...you know, that should have been something that should not have been carried out."* (P020)

However, one nurse was resolute in his belief that even in the dynamic and stressful environment of an operational tour, nurses should always abide by the Code. This, he says, is because it is always incumbent on them as registered nurses to do their duty and follow the rules set by their governing body, the NMC:

> *"I think the overriding [document] has to be our Code of Conduct as nurses. I think that's without a doubt. […] But ultimately, I think this is difficult because a nurse has got to be responsible for their own conduct. Because that's about being a professional, isn't it? You know, you operate on a body of evidence that you understand […] and you conduct yourself ethically, within the framework that's set within the Code of Conduct. I don't think really, for nurses, there's any excuse to go outside of that Code of Conduct."* (P006)

Among those who rate written codes and guidelines as a handrail for nurses to make ethical decisions at the lower end of the continuum of utility is P001. She is a career

Army reservist who gives the impression that she does not pay written ethical codes and guidelines much mind in her personal practice, judging by the dismissive look she has on her face and the scornful tone of voice she uses as she speaks in the video recording of her interview. She states quite forcefully and almost resentfully:

> *"So, for instance, the NMC Code of Conduct…I feel that I'm a very moral, upstanding person myself. And that, really and truly, I feel a lot of these things… [Sighs, 5 sec. pause for thought] that I shouldn't have to be told how to behave. Now, there are certain things in there, so for instance medications. This is what you must sign and date and print and whatever, and it tells you exactly what you should be doing. But the values and standards and your Trust and whatever that tells you you should be nice to people and…[tuts] all of these things I actually think are a little bit […] obvious, and they're telling…they're saying things that everybody should be anyway. But I suppose not everybody is moral and upstanding and looks after their patients and doesn't want to be horrible and doesn't want to bully people."* (P001)

In a similar vein another participant is dismissive of the NMC Code's utility:

> *"Aw...it's a load of bollocks, it really is. […] Maybe it's just me and being slightly detached from the regulatory bodies and the governance of it, but the values of the NMC…why do they need…I know why they need to be written down. But if being a good nurse is at your core, then you read the NMC stuff and it's like stating the bleedin' obvious. […] Because maybe for someone like me, I'll read it and I think 'My God, this is just...this is the absolute basics of what someone should be."* (P014)

A document often mentioned in this section, which is relevant to military nurses but not their civilian counterparts, is the Defence Operational Nursing Competencies - or as it is colloquially known, 'DONC' (Defence Medical Services, 2021). This is a mandated framework, the objectives of which need to be achieved to certify a military nurse as competent and ready to deploy on operations. The strength of feeling and emotional response of participants around the DONC clearly identified it to me as worthy addition to the written codes and guidelines sub-theme. The DONC's reputation appears to be so poor that it was almost universally derided by my

participants, who cheerfully expressed at its first mention the low regard in which they held it through not only their words, but also through a range of visual and physical reactions including dissolving into laughter, face-palming, eye-rolling, pretending to gag and the like. Common criticisms of DONC included the feeling that it was a tick-box exercise and too far out of date to be useful for guiding or assuring any nurse's EDM:

> *"So, I don't really think [the DONC's] worth the paper it's written on, it feels like a paperwork exercise. Erm...I know that there's some substantial work being done to sort it out, but there's nothing that stops me signing off my mates and my mate signing me off. It's a tick box for when you deploy."* (P017)

> *"The DONC you can throw away tomorrow, because it's unbelievably bad, you know? It's not even a competency, it's a knowledge framework. […] So, it should be DONC with a K, not a C, but that doesn't prove anything. You know? And it gives a false sense of security."* (P003)

P025, while initially checking that I had nothing to do with writing the DONC, was particularly critical in her opinion of its utility. Her main issue, related to DONC being perpetually out of date, is that it represents a huge risk to our deploying nursing personnel in modern operations after the large, protracted operations in Iraq and Afghanistan. This is because she believes it fails to adequately assess or contribute to military nurses' ethical preparedness against the changing character of conflict:

> *"It is the biggest load of rubbish I've ever come across. […] The DONC is one of those things that is put in place for us. Now, it's got good grounding, it's got some good points behind it. But it's not kept updated. It's got nothing behind it...it's not substantial enough for it to be classed as a competency. […] It hasn't been updated since prior to my last deployment, which was 2014 [correct at the time of interview]. So, unless you're going to keep it up to date, unless you're going to constantly review it, it's not worth it. […] I think when it comes to the DONC, it served its purpose for getting guys out the door for a specific conflict. It doesn't necessarily meet [ethical] expectations for the conflicts we are looking at these days."* (P025)

Some participants, while not necessarily appreciating the DONC themselves and suggesting a change is needed, could still see the utility of it in an operational setting:

> *"Much as I hate to say the word, we have the deployed operational nursing competency document. Now though many of us hated the DONC, I think what it did allow us to do was look at and understand why decisions were maybe made, erm, that we hadn't necessarily understood at an earlier point from a deployment point of view."* (P002)

Very few thought that the DONC was a document which was fully fit for purpose, and these participants very much represented the minority opinion. For example, P022 believes that if it generates a curious and questioning nursing workforce, this can only serve to improve deployed nursing care:

> *"I think it provides a platform. The [Defence] Operational Nursing Competencies are...yeah. They've evolved over the years, definitely, from when we started doing them. […] I signed off some yesterday, actually. And, you know, they seem to be usable. I think if it's a usable tool, and people get something from it, and it's not just another paperwork exercise, then yes, I think it can help shape, you know, a person and help stimulate thoughts. Which is always a good thing - ask questions."* (P022)

The perspective of reserve nurses, while united with their regular colleagues in their general disdain for the DONC, have a slightly different view of why that is. One participant described the issues reserve force nurses encounter in completing assessed DONC every three years to achieve readiness for deployment:

> *"With the DONC, I know that a lot of staff...I know that my [reserve unit] hierarchy is very keen on DONC. I know a lot of 'Commissioneds' [those of Commissioned Officer rank] are sick to death of it, because they see it as more work trying to prove what they do. And [though] they're doing it in the NHS, day in day out, they've [still] got to prove what they do for a living. […] Again, with DONC, getting your competencies signed if you're a really busy A&E nurse, erm...it's really hard to get your supervisor or manager to sign your DONC. And also, the NHS staff don't always recognise some of the military stuff. So that's an issue for a lot of our guys as well."* (P005)

Another participant explains how this practice can cause problems for reserve nurses completing the DONC, because they can find it difficult to complete all the generic competencies covering the many areas which are not normally required for their civilian role:

> *"Oh, DONC is quite controversial! [...] So there's an expectation really, that from a reserve, really, aspect is you're expected to be a jack of all trades. The hospitals now, in doctrine, are getting smaller and smaller. […] So basically, I think it's hard as a [reserve] nurse to be a jack of all trades."* (P026)

Theme 2: The deployed context influences the EDM of military nurses

The importance of context in ethical decision-making

As stated in theme 1, the World Medical Association (WMA, 2012) told its international members to practice, no matter the context, on the inviolable principle that medical ethics in times of armed conflict is **identical** to medical ethics in times of peace (my emphasis). It also goes on to state that care should be delivered with neutrality and impartiality, without discrimination. However, neutrality and impartiality is not always possible for deployed MTFs to claim or exercise, because of the contextual situation and external and internal constraints which will be discussed in greater detail below. For example, a deployed MTF, unless it forms part of an invading army, has already *de facto* taken sides because it has been invited in by the government of a country as part of a security, peacekeeping, or stabilisation force (e.g., ISAF in Afghanistan, KFOR in Kosovo etc.). Therefore, they cannot claim neutrality.

Most of my participants alluded to the importance of context, and how it has affected EDM during their careers. Sometimes this was in a generic sense, as illustrated in

theme 1, but it was the military deployed context which provided the clearest picture of the contextual issues which affected their experience of EDM. Evoking a harrowing image of the stark contextual difference between peacetime nursing practice (which is typically experienced in the NHS environment for most military nurses) and wartime nursing practice, one participant very clearly believes that context impacts heavily on EDM in her pre-hospital care delivery. She says:

> *"When you're at war, things are very, very different. And you can't do what you would do in a normal environment, in a normal peaceful environment. You know, you're being shot at, you can't hear a lot of things, your decision-making…you don't always have enough people to do what you want to do. […] You haven't got the equipment, you haven't got the peace, you haven't got that calmer environment. And you have to make big decisions. And what you would make in peacetime as in... you know, chopping off someone's leg or something like that, we chop off someone's leg to save their life. Peacetime, they'd try and save it. We [in deployed practice] would pronounce someone dead if we had lots of other people to deal with. […] Or we'll just have to...one incident that happened to me, my first shout in Afghanistan. An IED [Improvised Explosive Device]. The Marines were in the MOG units. An IED blew up. And one of the guys got caught under the armoured vehicle. All his mates couldn't lift the armoured vehicle off him, and [it] caught fire. They pumped him full of their morphine jets because he was screaming…because it was getting hotter, because they couldn't get him out of the fire. They all got their Marine daggers out and they all tried cutting off his leg. And they couldn't do it. That was horrendous."* (P027)

Seeing her describe these raw experiences to me [in a video call] in a detached, unemotional, matter-of-fact way left me feeling emotionally affected, recalling and reflecting on my own similar experience in the combat environment for a few days afterwards. During analysis I read and re-read this transcript reflexively, watching and listening to the video to carefully ensure I was capturing her voice accurately and not enmeshing it with my own assumptions, beliefs and judgments due to my homogenous experience (Jamieson et al., 2023).

Another participant gave her thoughts on the WMA 'regulation' about medical ethics being identical in times of war and in peace and relates it to professional colleagues, describing the national struggle against the Covid pandemic (during which much of the data collection of this study was undertaken) as a 'war', or a 'battle' being fought within the UK to highlight her point:

> *"[It's] rubbish. Rubbish.* ***[AB: Do you want to explain why you think that?]*** *Well...OK. So…I get it in some contexts, OK. But let me tell you about a recent situation I've had. In the current Covid lockdown moment, a lot of my colleagues, who have no military background, are making similarities [between] Covid and war zones. And that it's a war that we're fighting, and it's a battle. And I can't quite get my head around that. Erm, and I feel a bit frustrated that this is being...paralleled, if you like, because actually, no-one was prepared for Covid. No one knew this was coming. There was no preparation, there is no 'team' that's together in this. Most people are isolated in their own homes. They are so far...separately different, it's unbelievable. And I can't get my head around why this is a war zone for people in the UK...and this is coming from the mouths of people that have never been to a war zone. And I had to interject, and I felt a bit awkward because some of them were professors. I was like...oops! But they need to realise that it's so different. Oh gosh, you know now I'm thinking more deeply about it, and I'm thinking well, [the EDM] should be identical. It should be, but if it were identical, then I wouldn't have a history of these examples that I've given you. Do you see what I mean? It would be the same. Yes, and that's what we all strive for, that's what we want. [But] my history demonstrates it hasn't been."* (P028)

P028 does agree, in the end, with the WMA statement that the principles of healthcare ethics *should* remain identical; but manages to use her experience of EDM in both contexts to show that this is often problematic to apply in practice.

Another participant, P018, described how ITU nurses' contextual emotional responses directly influenced and compromised their EDM and their impartial delivery of care, which are likely to be tied to the specific circumstances of the case:

> *"I think [EDM] should be [identical]. But…it's not always.* ***[AB: OK. Explain that?]*** *So that's what I was saying earlier with my Iraqi woman. She was a*

combatant. I didn't know it when she came into ED. She came into ED; she came straight into theatres. They amputated an arm and a leg; she went on to ITU. Few days later, she ended up back in theatres to have the pressure area care de-sloughed because the staff on ITU have refused to turn her, because by that stage they've figured out she was a combatant and didn't want anything to do with her. And they'd left her in one place. And I was just like 'This is so wrong!', and that's when we all came in…different departments came together and we had, you know, from the hierarchy down saying 'Look, whatever your personal opinion is, at the end of the day, this is a patient. And you've got to do it'. Two days after that her mother, the patient's mother, turned up at the gate with the baby that she'd been breastfeeding. Handed it to us. And we're like, 'Well, we can't take the baby, we've not got the facilities. And your daughter isn't in a position to breastfeed.' The ITU staff then had a complete flip round of the way they cared for that person. And I was like 'Why? What difference does it make?' I said you know, 'If you'd have known on day one that she had a child, would you have treated her any different? You shouldn't have been treating any different. She's a patient'." (P018)

Following up on a question about the WMA statement and his thoughts on the context of delivering care on deployment, I asked one participant if he thought (like P018) that context could affect nurses' EDM around the quality of patient care delivered to certain patient groups, such as 'Captured Persons' (CPERS):

> *"[Exhales and laughs, like it's going to be difficult to answer] Situation dependent, I would say. […] Unfortunately, I think it has to be. Because you could have three people laid in three separate bedspaces with exactly the same injuries. But how they got those injuries could be totally different. And are we going to treat them all the same? Probably not, if the person in bedspace 1 was shooting at me earlier on that day, but bedspaces 2 & 3 had just been caught up in the crossfire… and that's the context on which we're basing that. […] If somebody was shooting at me, and then they got shot, and then I had to treat them in the ITU after, I'd find that very, very difficult. […] But if you've physically seen somebody shooting at you, or shooting at your mate or anything like that, I think everybody...if they were to treat that person, their mindset would change.* (P029)

Other participants, while they believe (like P028) that in an ideal world the principles of peacetime healthcare ethics *should* be wholly transferable to the deployed care environment, acknowledge that external contextual difficulties (i.e., those things over which military nurses would not necessarily have reasonable control) are more likely

to prevent these peacetime ethical principles from being applied in practice:

> *"We're not the arbiters of what the enemy does. And sometimes the enemy will deny you the opportunity to do the right thing, because they are the enemy. But I think, as far as possible, the ability to bring peacetime ethical constructs and rules, which is what we aspire to anyway, is a perfectly reasonable thing to expect. But it's sometimes difficult."* (P012)

One participant, something of an outlier in her opinion on whether context affects EDM, was adamant that she would not compromise the ethical principles which she adheres to no matter where she works. However, she does not mention what influence or impact contextual deployed constraints would have when they inevitably caused an inability to apply her ethical principles as she would like:

> *"Why should it change? You know, your ethical decision-making is ethical decision-making, regardless of what's going on around you. […] At the end of the day, if you're treating patients you're treating the patient on…whose care is needed, the most priority, regardless of who they are, you know."* (P011)

Recognising the influence the military deployed context might have on EDM in military nurses, P015 talked about what he thought nurses might need to be better equipped to understand and make difficult ethical decisions in the field. He also says that the scale of the differences between the NHS and deployed military contexts can cause an 'ethical paralysis' of thought due to lack of a frame of reference:

> *"[You need] some life experience, some professional experience and experience in the right context…erm...to understand the implications of your decision. You know, you can be very altruistic until you're actually put into a position where maybe you are in fear of your life, or you're feeling overwhelmed. Because if you've never felt overwhelmed in peacetime it can be very, very difficult to then still have that clarity of thought or still understand about making reasonable decisions, given the set of circumstances that you find yourself in. But it's also almost knowing that you've got some cover or someone sensible above you, who's going to back your decisions. Or then being morally courageous enough to live with your decision despite what might*

happen." (P015)

Dual loyalty conflict and the Medical Rules of Eligibility

Nurses who deploy on combat or humanitarian missions typically face an interesting set of ethical challenges when navigating their daily practice. One of these is dual loyalty conflict (DLC), and another which is closely related is the Medical Rules of Eligibility (MRoE).

Dual loyalty conflict

Military nurses simultaneously belong to two professions, that of nursing and that of the military, and must try to practice within the competing demands of both (Chamberlin, 2013). In addition to being urged to adhere to professional nursing guidelines, the swearing of an oath is also commonplace internationally in both healthcare professions and military service. Nurses in some countries, for example, might swear something similar to the Hippocratic oath normally taken by doctors. In the UK armed forces, everyone swears an oath pledging their allegiance to the serving monarch and the State to obey orders, creating a complexity for military nurses and other MHCPs. Dual loyalty conflicts can occur in the civilian nursing context as well as the military, and this will be examined in the discussion below. However, the dangerous volatility of an operational warzone contrasts markedly with the relatively peaceful NHS clinical environment, which seems to make decisions on which loyalty to prioritise far more challenging than in the civilian context (Brockie, 2022).

DLC is not a new concept in military nursing, and it is interesting to note the attitude of my oldest participant who served as an RAF Nursing Officer in the 1950s, which

clearly prioritises the primacy of nursing in her professional identity. The fact that she was serving as an Officer in the RAF appears to be largely incidental to her:

> *"I had never, until I got your email, considered that I was a military nurse. I was a nurse who cared for Servicemen. […] Those two words, the conflict's wrong. How can you be a military nurse? I still can't get around that term...military nurse, because to me, there is no such thing. It makes absolutely no sense at all. I nurse. I nurse airmen."* (P016)

The personal dichotomy of whether the 'nurse' or 'military' identity takes precedence in a military nurse's EDM is interesting. There is some relevant discussion of this in the literature, though it is more commonly related to physicians. This will be examined in greater detail in the discussion. However, the dichotomy remains the same regardless of which professional background an MHCP has. Following up, I asked P016 what she believed she would have done if she had received a military order as an RAF Officer which conflicted with her professional responsibilities. Having told me she likes to keep abreast of developments in nursing, her response is indicative of her perception of the shift in attitude and effect of DLC on EDM that has taken place in nursing, and military nursing, between the 1950s and today: *"If it was today, I would argue it. If it was in the 50s, I would do as I was told.*"

More recently, one participant described the literal manifestation of a dual loyalty conflict she experienced in Afghanistan:

> *"So, what was really challenging was, and as Camp Bastion was growing, like, [at a] ridiculous rate…nurses were asked to go off of the ward and to be on sentry duty, so to man the sangers [Sanger = a dug-in, fortified, defensive machine-gun guard post on the perimeter of the base]. And there was this decision that, you know, you'd be a nurse on shift, and you wear your Red Cross. But then when you come off shift, you've got to go and do your guard duty, and you take your Red Cross off and, you know, you are kind of, erm, you're on sanger duty. […] But really interestingly, while I was on sanger duty,*

while I was Guard Commander, somebody came, and they were doing donuts in a little Pinzgauer vehicle in the sand down at the bottom of our sanger hut. And they flipped it. And of course, everybody was just like, 'You're a nurse, you need to go and do first aid now!' and I'm like, 'I'm supposed to be manning a sanger. I am the Guard Commander for this sanger!' … Erm...you know, so I literally had to like bomb-burst down the ladder, get somebody else to make sure that they were covering the arcs, and make sure that this numpty doing the donuts was OK! Erm, you know, we radioed, and they got an ambulance and C-spined him and everything. I think he was fine. Erm...but yeah, that was...so from a moral and an ethical perspective…yeah... [Pause] […] it was interesting. But you know, I suppose I think now […], the ethical question first is, are you a soldier first or a nurse first? And I was just like... 'I'm a soldier-nurse. [Laughs] Don't ask me to separate the two'. [Laughs]" (P004)

Another participant described a more contextual view of DLC and does not consistently prioritise either her military or nursing identity when making ethical decisions. When the subject of duality of role came up in her interview, I asked her if there was a role she felt more loyalty to and affinity with throughout her career as a military nurse - was she a nurse-soldier, or a soldier-nurse? After a 5-second pause to consider her answer, she was quite hesitant and halting in her speech, but became more forceful and animated towards the end when confirming her role as patient advocate in the firm base (where she practices in the UK in peacetime, usually within the NHS or in a military medical centre):

[Pauses for 5 seconds to consider her answer] "A nurse-soldier. But I could always do the job of a soldier, I think quite happily, if I had to. As in…yeah, I... you know, I could be the soldier if the situation required it. […] I think I could be if I had to be...so, yeah, I'm not...like, a complete pacifist or anything. [Laughs] ***[AB: Which role takes primacy in your mind, then? The role of the soldier or the role of the nurse?]*** *Yes...so it is a tough one. And if I was deployed and I was told to do something, and it was a legal order, even if I didn't particularly agree, I would go with the order. So, in that respect, soldier. But in the UK, when it comes to clinical stuff, I will quite happily shout very loudly if I don't agree with a decision, and the rank or whatever doesn't make any difference. Because I think when I'm at home, my role is to be the patient's advocate. And I don't care how...it's not that I'm afraid to do that, I think it's situational."* (P009)

This comment alludes to P009 feeling as though she cannot remain a patient

advocate on deployment in the same way as she does in the firm base. This is largely because of the effect of military hierarchy and, like all Service personnel, her 'sworn oath' to obey orders. The effect of the military hierarchy was reflected upon by most of my participants, making it one of the two most frequently coded phenomena (*n*=126). As an example, P019 has experienced first-hand the effect of that form of DLC. She talked of her frustration with a non-medical senior Officer overriding her professional and ethical decisions when trying to obtain support for a seriously wounded local Afghan boy in her MTF:

> *"I think it's where you're in a situation where...there's a gut instinct that it's not right. And I think the chain of command gets in the way. And it's that fine balance in military nursing of doing the right thing by the patient, but also compromising militarily. I think that's where I felt it was difficult.* ***[AB: OK, interesting. Compromising militarily. You'll have to explain that one a little bit further.]*** *I think the hierarchy gets in the way. Erm...there is...pressure from that hierarchy culture that you shouldn't challenge it. And I think that gets in the way for people, and it gives you that...awful situation of how do I best challenge this? Because I know I need to challenge it. But it would be easier to...I don't know. Would it be easier in an NHS situation? I think it would.* ***[AB: OK. Do you think the hierarchy getting in the way...is that from a medical hierarchy or a non-medical hierarchy?]*** *I think both actually. But certainly, on Ops I've had it...in fact […] there was definitely pressure from a [non-MHCP] Commander, Royal Marines commander, a Major, in one situation I was in that was just ludicrous. It was a difficult situation, yeah. To do the wrong thing, by the way […], to do the wrong thing for the patient. I felt it was the wrong thing. And then when I challenged it, then I'm challenged that I'm being insubordinate [rather than having my professional clinical opinion respected]."* (P019)

Some participants mentioned that they felt military rank and experience gave them more confidence to take on the role of ethical decision-maker for their patients. P017 framed her views around the complexity of divorcing professional nursing qualifications and experience from military rank, particularly in the Army, giving another perspective on DLC and how it affects EDM in military nurses:

> *“Yeah, I think it depends which Service you're working for. I think my experience with the Army is that actually, the primary touch point with the Army, in most respects, is Captain and above. And I find that when you are not using your rank, followed by your surname, erm...it doesn't always stand you up in good stead for what's going to come after. So yeah…I do think rank, in the organisation we work in, is important. We work in a military hierarchy. But then it also is complex, because we work in a medical hierarchy as well. So, you know, working with a doctor, for example. I think it's a very complex thing. So, you could be a Sergeant, for example, an advanced [nurse] practitioner, and you might work with maybe a Major / Squadron Leader nurse [a much higher military rank than Sergeant], but actually you’re advanced clinically, and you probably know a bit more, perhaps, than your Officer in Command. I mean, how does that work? That's quite messy.”* (P017)

The EDM of highly specialist nurses who deploy in very small numbers, typically in teams of one to three, is apparently as equally affected by DLC as that of their general nurse peers, but perhaps with slightly different concerns:

> *“I think I'd say there is, within mental health, there's never any clear, prescriptive decision because there's so many factors a military mental health nurse has to take into consideration. And the ethical aspect of it is on a scale both occupational...because if you make the clinical decision, it might mean they're losing their job, their livelihood, their employment and their family home. But if you don't make that decision, it could be their life or somebody else's life. So, they're in this real juxtaposition constantly in the mental health field. […] Safety critical, I think they used to call it. Safety critical decision-making.” (P006)*

Medical rules of eligibility (MRoE)

Compounding the ethically constraining effect of DLC is the set of limiting criteria, usually drafted at a government or strategic military level, which dictates who can and who cannot be admitted for treatment in a deployed MTF. These criteria change from mission to mission, and ‘authorised patient’ status depends on the political will and strategic direction of the campaign at the time they are issued. These are commonly referred to as the Medical Rules of Eligibility (MRoE).

To illustrate the emotive nature of EDM based around a set of MRoE, one participant

described the reaction in his MTF after the Deployed Medical Director (DMD), who holds final EDM responsibility and accountability for ethical decisions, decided under the extant MRoE not to admit for treatment an unentitled civilian casualty brought by their family to the gates of the MTF:

> *"The only time we got raised voices in 2007 was over the eligibility criteria, and the person I felt who had the hardest job was the DMD at the time. […] And he got a hell of a lot of stick. Because it's very easy to criticise the poor bastard that has to make those decisions, and you sit back as a nurse and go [uses high-pitched pseudo-female mocking voice] 'that's terrible...', you know, and there was a fair old bit of that, and then other people would react and probably myself, say 'listen, you try making those friggin' decisions, you try walking down to that gate and turning a family away'. You know, because I felt like he needed a lot more support than he got…erm, from his own colleagues. You know, and I couldn't agree with everything, every decision he made, but I wasn't bloody making them! You know, so that…that was quite a learning point for me. […] I could've had a conversation with somebody and said 'listen, do you remember the organisation you joined?' You know, this is not [the] NHS out in Afghan, we're here to get the fighting force back to the frontline. If you can't handle that, you're in the wrong bloody job, you know, go back and join 'Médecins Sans Frontières' or something. Don't join the army. So, uh, yeah, that's where we...there was quite a lot of discussion and tension, if you like. People knew it [that the MRoE were necessary logically]. But knowing it and living it, I think, were two different things."* (P003)

Most participants accepted the logic underpinning a policy like the MRoE for a resource-constrained deployed MTF, aimed at preventing the 'floodgate effect' (creating a precedent of treating non-entitled people) and protecting the limited resources in the MTF. However, many expressed the view that it is ethically difficult to turn potential patients away based on a set of criteria designed by non-clinical people remote to the situation, such as politicians or funding committees, who would not have to experience first-hand the ethical tension they caused in a front line MTF.

P014, for example, feels that she would always try to seek a contextual work-around based on the circumstances of each situation, also hinting at the requirement for

moral courage to circumvent policy in this way:

> *"You start looking from that side of things when you start seeing...certainly from an operational point of view, of who you can and can't treat. And if someone makes that ruling based on politics, or funding, or finance or whatever it is, and then lo and behold you have a parent turn up with a child that doesn't meet the criteria, that goes against everything that your nursing or your medical experience tells you to do…But a policy like that is there to protect the integrity of the service and to stop the service from being overwhelmed. Er, so there's a logical part that you can process, so I appreciate why that's the case. In the thick of it, if something was to happen at your doorstep, would you deny people who were injured or hurt access to life saving treatment? I don't...I'm not sure I would. […] And it's, you know, is that the right…but actually, can you do something? If people aren't allowed in, can you go and provide some sort of mobile medical...can you go out, and what can you do? What can you do in that situation? Er, rather than what can't you do? How can you bend the rules slightly?"* (P014)

A few participants, mostly more senior Officers, presented their view of the circumstances and personal consequences of breaching the MRoE because of dual loyalty decisions favouring professional healthcare identities. One alluded particularly to the moral courage required to overcome the fear of those consequences in favour of making the ethical decision to save life as the priority regardless of eligibility or status, factoring consideration of two-tiered care into his decision:

> *"In Afghanistan, I can recall a consultant who had made a decision in an aircraft…on the MERT…who had made a decision to bring a patient, he'd gone out to pick up a soldier. And when he got there, there was at least one civilian badly injured, who he was going to drop off at the BOST hospital [Afghan local armed forces hospital] on the way back. And it became very clear to him that…that wasn't an option for this patient. Because if he did, that patient was surely going to die. And he made the decision, which was contrary to the eligibility matrix, to bring this patient to us. And I can remember being in the ED department and he was in tears, this…you know, this very experienced consultant. And he was in tears. And I didn't know him well, but we had always…we had got on. So, I kind of took him aside and…you know, and he thought he was going to get court-martialled [for breaching the MRoE]. […] I mean, that eligibility matrix...I think it's fine as a guide, but whoever's designing that is not sitting...is not on the ground with these people who have to make these dynamic decisions."* (P012)

This comment implies that pre-hospital clinicians in a deployed environment (which includes nurses) should favour professional over military obligations in certain contexts and be more trusted to make decisions to admit casualties who may fall outside the MRoE. In contrast, and painting a negative picture of the organisational consequences of admitting patients who fall outside the MRoE, this participant talks about the hubris of a departing clinician influencing the EDM which allowed a paediatric patient to be inappropriately admitted to her MTF, which had long-term consequences:

> *"I can remember one delightful clinician [said very sarcastically, with a disparaging look on her face] allowed...somehow got through the front gate, allowed [a] child to come in, erm...didn't meet the criteria to actually be there, because this was like...this was old, old, old. But they had horrendous pressure sores...and he left the next day, but then we were left with a child. And what do we do with it? 'Cause they're now in the system. And we ended up with this child for about three months before we could get them back out again, and to be able to get everything in place within the local setting. But it was that ethical thing that actually the individual didn't actually meet the criteria in the first place. The child, it was a chronic issue, which was already being looked at within their health facility. But it's…sometimes our ethical decisions are made on the arrogance of being a developed country and being a UK practitioner, and not thinking about the fact that they're already in the national health system of where they are, but we think we can do better."* (P010)

Offering another perspective, and given the high level of public scrutiny of recent military campaigns through the increasing use of war correspondents and near-instant social media reporting etc., excluding people from admission into an MTF under a set of MRoE in some circumstances could carry a significant reputational risk for the MOD:

> *"I also wanted to see when [my team] were going to come to me saying 'We think this may seep outside of the four walls based upon a decision', and I wanted to ensure that as the Commanding Officer, I'm not going to be in every single place every time that they got where something could be perceived*

[badly]. And whether it was an MRoE type issue, whether they may have disagreed with something where they felt that they were enforcing the MRoE when actually what they were missing was the multitude of wider contextual factors in relation to the wider mission. Well, as a Commanding Officer, I was someone that would have a view on that, as to whether I believed what a binary decision [someone] within the hospital may make is not necessarily something which would be viewed accordingly beyond the four walls, and therefore it required command oversight." (P021)

Some participants talked about admitting children for treatment in their deployed MTF, which is doctrinally excluded from planning preparations and is a broadly applied prohibition under most operational MRoE, but which still happens with regularity:

"So, this should be in black and white, but there's a lot of grey areas sometimes. So, if someone pulled up in a car and dropped off a child, and didn't fall into that rules of eligibility, what are you going to do? […] I think you'd have to be in that situation to make that call. And you'd have to have some balls, and you'd have to have some rank to make that decision really, to be fair. […] And sometimes it may be wrong, and sometimes it may be right." (P026).

Indeed, there seems to be a perception amongst my participants that once a casualty is tacitly accepted by someone 'official' such as the guard at the front gates (who is not a healthcare professional) by simply asking if they are OK, physically taking charge of them, or contacting the MTF to send out an ambulance or nurse etc., MTF staff are duty-bound to treat them. A casualty presenting at the front gates seems to be, for many participants, the critical point at which the EDM process begins for that individual and the MTF staff. Therefore, some called for knowledge of the MRoE to be communicated to such personnel to prevent accidental or unauthorised admissions:

"[We need to] understand the eligibility matrix, [which] I think is really important. But you know, extend it to people other than just ourselves within the medical facilities. So erm, for the individual on the gate, often perhaps a young Squaddie,

> *that's really hard to turn round and say to somebody, 'you can't come in', you know, 'you're not eligible', or 'we don't have the resources'. So, I think, you know, having that ability to communicate more effectively from outside of the medical facility to allow decision-making to take place before it gets to the point where multiple people are exposed to that decision-making is also important as well."* (P002)

Two-tiered care

From the data, I identified another frequently encountered ethical issue, two-tiered care (2TC). Military nurses are not only aware of this issue, but through their voices they have confirmed that it exerts conscious or unconscious influence on how they experience and make ethical decisions in their deployed practice. As local healthcare facilities in e.g., Iraq and Afghanistan were not able to treat their patients to the same standard as the UK and coalition MTFs, many of my participants found themselves involved in making ethical decisions to treat those patients to a lower standard than they are able to provide. One participant alluded to how the deployed environment, and the reality of 2TC for civilian patients in Iraq, directly influenced EDM in her MTF. In this case, she identified that treatment pathways were often altered for these patients, e.g., reduced in scale and complexity from the 'gold standard' norm they strive to deliver. This was due to the knowledge of what was available to them in their own national healthcare infrastructure and based on matching that standard, combined with managing patient expectations:

> *"I'd picked up on the sort of…the treatment matrix and the...what's sensible to do for somebody that's going back to somewhere with no health care from the time in Iraq, and you know, still then it was just...erm, you didn't necessarily do what would be your normal practices in the NHS, because it just wasn't gonna work out there."* (P009)

A highly operationally experienced participant discussed her opinion of 2TC. She

believes that some nurses feel compelled to treat local national casualties to the highest possible standard, with everything they have available to them, based on a false sense of beneficence possibly borne of professional hubris. However, she says that this does not consider the reality awaiting them in their own healthcare system:

> *"I think that sometimes, this is just my own opinion, I just think that sometimes people want to just go hell for leather and do everything and do whatever. And they don't think about the long-term effects of what they might be…thinking they're doing good at that time. But they're not thinking about...I'm not saying don't do anything, I'm not saying that at all. But I'm saying that you have to think seriously about how far you're going to go with somebody because you've got to think about, what are you? Where are you? What sort of life are you going to leave them to?... That was another one that caused real angst. If [the casualty she was talking about] had been in the UK or America, there's loads of things they could have done for him."* (P013)

Neatly encapsulating the influence on nurses' EDM in cases of 2TC in the operational context, this participant also used an example from her time in Afghanistan to summarise the intentional limitation of treatment boundaries based on nationality, which would not ordinarily occur in her NHS practice:

> *"[Six members of the same family] were brought to the field hospital. And I think when I mentioned before about...to what level you treat these people, knowing what our skill set, and our scope of practice and resource availability was. Erm...that was really challenging because we did end up making a decision that we would do [only] the very, very fundamentals of burn care for this family, but there was no point doing revisions, there was no point doing skin grafts, because we couldn't maintain the aftercare."* (P004)

Her feelings about the suffering caused to local national civilian patients by a lack of continuing or follow-on care in their local healthcare system are echoed by P008. He questions the moral rectitude of an egalitarian treatment approach in the ethically challenging context of a deployed MTF:

> *"What's ethically right or wrong, you know? Some would challenge what we were*

doing for erm...Afghan nationals in HERRICK, where we were doing lots of complex surgery and then sending them off, potentially, to fester and die where they weren't getting the support, or there wasn't the kind of [expertise] to deal with their kind of ongoing complex needs." (P008)

Several participants discussed the adverse effect of the ethical implications of 2TC on military nurses. Some even implied a high potential for moral injury or moral distress, precipitated by the knowledge that they would eventually have to discharge their local national civilian patients to the lower tier of their local healthcare system:

"We had casualties in Afghan, and you knew that they needed a bit more treatment, but we couldn't give it, and then [we had to] arrange for them to go to their local hospital. And then to hear that they'd died within hours of getting there because they weren't being looked after...that's frustrating, more than anything. And again, there's nothing you can do about it. But then you are left wondering, 'Could we have done a little bit better while we had them in our care?' sort of thing." (P018)

We...we put all this effort in […] but then there he was, just shipped off and no feedback given as to how he would be or anything like that. I don't imagine he would have survived for any length of time afterwards post, sort of like, discharge from us, but that was quite hard to take, actually. And I don't know where you put that on the ethical / moral decision-making process, because there's lots of factors to take in there. […] It's different standards of care […], different types of care. Because if it was a UK soldier, they'd have been flown back to the UK, they'd have had the best rehab that we can give them, and onward care and things like that." (P029)

One participant talked about the reality of discharging a ventilated, critically ill paediatric patient from her ICU in Afghanistan to the local healthcare system:

"She would have only been with us for a week or so because we would have needed the bed, no doubt. So, she would have been taken to another healthcare facility, which is in inverted commas really, because they're only Monday to Friday these healthcare facilities. If they survived the weekend, they were still there waiting for you on the Monday, then you look after them again for the rest of the week. Which is again, you're thinking 'Oh, my God!' […] But I know of colleagues who left their ventilated patient with somebody [on transfer], and were like 'Oh my God, they're not even going to survive the night'. You know, and you send somebody across on a ventilator and nobody's checking their obs

> *and checking they're on a ventilator every hour throughout the night. Just put it on...if there's a power cut, then that's it! You wake up and there aren't any patients left on the Monday."* (P022)

As discussed above, despite military nurses being doctrinally told that they should not expect to treat children on operational service, this seemed to happen a lot - often outside the MRoE and at the DMD's discretion:

> *"What we did in the end, we renamed the department 'Great Helmand Street', because we had so many children in… And it's really difficult when you get these kids in, because where do you send them? And if they're ventilated, do you know that if you send a ventilated child to somewhere, are they gonna stay ventilated, or are they gonna just take the tube out and then just hope for the best?"* (P013)

> *'What can we do?', you know, and it's the issue of then will it survive the flight back? What are we going to do with the baby when it's back in the UK, because it's not a, you know, like a Colles fracture, we're not going to sort it and then 10 days later send them back home. They're going to need to grow up [in the UK] because they need ongoing care. So, I was involved in that. And I found that quite a difficult one, because in the end it was it was decided by the UK that no, you would just keep the child there and make the child comfortable. And the child passed away about 10 hours later. And then the issue that I found quite heartbreaking was then obviously the same we did with everybody, every local civilian, every child, we took them down to the main gate, we gave them some money. The baby was then put in clingfilm wrapped in a boot box and they were sent home, to go in the back of a taxi to go home. And I found that...that was quite distressing."* (P020)

UK forces provided nurses, doctors, and AHPs as clinical mentors to the Afghan military medical services from each unit rotation during the setting up of the indigenous Camp Shorabak hospital in the latter stages of OP HERRICK. This was a facility to be run by Afghan military medical personnel, treating only Afghan forces. It was an attempt to increase their medical resilience and 'wean them off' reliance on the British Role 3 hospital at Camp Bastion prior to the withdrawal of UK forces from the country. One senior commander recognised the difficulties his mentors faced in having to radically adjust their mindsets and practice due to the two tiers of care they

were working across. They initially worked part time in the Role 3 hospital and spent the rest of the time in the Camp Shorabak facility, and interestingly:

> *"They were constantly having to adjust their mental model between first world and emerging nation. Equipment, different equipment types, level of interventions, level of anaesthesia etc, etc. And we felt that it was almost that it could be a dangerously schizophrenic existence, jumping between one treatment model and the next. Which is why we got agreement during our deployment to separate out the mentor team from [Role 3] hospital activity...to stop that mental model, nursing model schizophrenia."* (P021)

This is an unusual working situation, even for military nurses, which seems unsustainable given the description of having to work across two tiers of care with completely different treatment protocols as a 'dangerously schizophrenic existence'.

Scarce resource allocation

Scarce resource allocation (SRA) is an ethical constraint faced by deployed military nurses, often at the tactical level. It means deciding on the most efficient and ethically optimal way to use finite resources to maximise their utility to the wider force. NHS nurses, by contrast, face more strategic issues of prioritisation of care as resources (at least at the tactical level) are not usually a concern.

Most of my participants identified SRA as an ethical issue which impacted significantly on their experience of deployed EDM. One captured the root of this issue succinctly during our discussion:

> *"What I'm saying is…from a UK perspective, we do not deploy with unlimited resources…or from any perspective. We do not deploy with unlimited resources. And that always has to be in the back of your mind as well [when making ethical decisions]."* (P025)

P009 singled out the unreliable resupply chain as a key factor when I asked her if

she thought that EDM on deployment should be identical to EDM at work in the UK:

> *"In an ideal world, yes. I think that it may not always be the case, because you just don't always have the kit and equipment to be able to make the same decisions. So erm...[pause] the ethics may be the same, but the final decision may not be.* ***[AB: Right, OK. Because of…]*** *Logistics, movements. Those things that become a nightmare during war may not allow you to do what you want to do."* (P009)

Another participant talked about how the personnel in her MTF developed the ability to make the hard ethical decisions in resuscitations from trauma injuries which were *prima facie* regarded as 'unsurvivable', to conserve vital resources:

> *"We, particularly in the early days, we were throwing all our resources at unsurvivable patients or casualties, no matter what nationality they were. And then so...for some people, we were then...trying to resus when actually we should have called it some considerable time ago. And actually, the resus, you know, we were using, oh, if I think back, 35 to 40 units of blood products, plus all the Factor VII [Blood clotting medication] and everything else that was going on. But actually, in the reality, if you took a step back, the patient had been down for 15-20 minutes before they came in. So that's where they started to make that decision, ethical decision. And they started to learn from what had gone before.* [...] *If somebody was down, no output when they came in, they got an echo straight off. Any electrical activity, then we just cracked on. No electrical activity, actually, it was called. I think before, people were...they struggled to make that decision, to say 'Actually, I'm going to call it.' Particularly on a UK soldier."* (P010)

Another group of patients who inspire mixed feelings about EDM in my participants are enemy detainees or prisoners, as mentioned above, commonly collectively referred to as CPERS. For example, in discussing how SRA would impact upon her EDM in relation to care of CPERS, P018 felt that although she has a strong opinion on the matter it would not really affect her:

> *"If you've got limited resources like we did have in Iraq, then you would obviously prioritise your guys over combatants. Erm...whether that's right or wrong. At the end of the day, that wouldn't be my decision. It would be somebody higher than me."* (P018)

The environment in which military nurses deliver care is also a factor in scarce resource decision-making for P029, because deployed MTFs tend to set up in austere conditions, located in remote places around the world which are experiencing disasters or humanitarian crises, or to improve security and defensibility in hostile conditions:

> *"The practicality of it is one of those things. If you take South Sudan for argument's sake, when we were there, we only had enough supplies…and because of the remoteness of the location, if we'd have had a number of casualties come in, we could only sedate people for 48 hours and the cold chain would allow us another 24 hours. But then after that...and that was only for two patients. You know, if we've got three patients in, the decision on 'Who are we going to treat? Who are we going to keep alive for that 72-hour period?' I wouldn't have wanted to have been the person that makes that decision to be honest, because it's literally like picking your favourite kid! Is it the one that's in the room or the one that's out of the room? So yeah. But it's that type of decision. Supplies [limited resources] plays a big part [in EDM] when you're in remote locations. So that taught me to respect that as well, looking at the decisions within intensive care."* (P029)

When we were discussing his thoughts on whether the deployed context makes EDM any more or less important in military nursing, one participant specifically mentioned SRA as a reason that it was more important. He also suggested applying an ethical template to ensure that the decision-making process is conducted fairly in a resource-constrained environment:

> *"I think it's vital. I think it's probably more important, because you are dealing with a more finite resource. […] I think those ethical decisions are more important when you're deployed a) because you're in that foreign situation, [and] b) you've got to live with yourself afterwards. But you've got to do the best with what you've got. And the only way you can do that is if you have an ethical template. […] That's why I think ethics is important. It's to give you, along with your ABCDE [Military casualty assessment pnemonic], at some stage there has to be kind of an ethical template that you apply to situations. Um, again, so that you know that in that situation, you did the best with what you had and made the decision based on an ethical process."* (P015)

The MOD currently recommends the use of such an ‘ethical template’, or EDM tool, to enable a full discussion of the ethically relevant information in any healthcare decision which requires it - the Four Quadrant Approach (4QA). This EDM tool was adapted for military use from a civilian model for end-of-life EDM in response to the increasing intensity of the Iraq and Afghanistan campaigns. This is because they were the UK’s largest campaigns since World War 2 and saw high casualty rates, which presented a corollary increase in ethical challenge. P015 left the regular service long before the 4QA was adopted and enshrined in the MOD’s Clinical Guidelines for Operations (2018), so would have been unaware of it. The utility of the 4QA will be examined in more detail in the discussion.

Some participants mentioned experiencing scarce resources as a direct factor in life and death situations which resulted in serious adverse outcomes for their patients. One told me about this incident in which scarcity of resources in her MTF led to a second order effect which later killed her patient, one which would be relatively easily corrected in a well-equipped hospital:

> *“I was on my own in another room with a MASCAL [Mass Casualty incident] doing my thing. Doing the absolute best I could in the situation with...aware of all the kit you've got! You know. We'd got a guy who had…erm...came in with fractured femur, he'd been laid God knows where all night with a fractured femur, hadn't been warmed up. Came to us completely unconscious. I was like 'What the hell's wrong with him?' and it was hypothermia. And he died! With a cardiac arrest...when he arrived at Bastion. He was 30 years old. That's bad, isn't it? But we couldn't warm him up, we'd nothing to warm him up with… The family came back to say, 'Right, we've been told he's here'. And you're just like 'Yeah, he was here...but he's dead.’ ‘[And the family said, but] he broke his leg!”* (P019)

This participant described an ethical decision taken in her small, remote MTF in Iraq which was driven by conserving a vital and scarce resource ‘just in case’ it was

needed by a coalition soldier. This was a decision of which she was fully supportive:

> *"There was one case […], we had a patient who'd been bitten by a venomous snake, and we knew that we'd only got one…erm, vial of anti-venom. And the decision was made that because it was a local, it wasn't either you know, British forces or allied forces, the decision was made that actually we couldn't treat that individual because we were there for British forces. Erm, and so if we were to give that anti-venom to the local, and then, er, you know, either an allied or a British forces personnel needed that we wouldn't have anything for them. So that was what we were there for. […] I can fully understand why that decision was made. So erm, had no concerns with this decision-making that was then made."* (P002)

In addition to the focus of my participants on their experience of EDM in the operational context, several nurses commented on ethical issues they experienced in the NHS context. Synthesising their comments, these were generally related to their practice during the Covid pandemic, from which parallels to the deployed context can be drawn, principally in SRA. For example, this former Army ICU nurse discussed the influence that SRA has on EDM in her NHS job, nursing in a small hospital:

> *"At the moment with Covid, there's a huge amount of ethical decision-making having to go on. Masses. About you know, who gets ventilated, or at least in the very beginning stages of the outbreak, who gets ventilated, who doesn't get ventilated? […]… Any patients who need ventilated have to go off-island. So, you really have to think...we have, we have finite resources, none of the island boards have a critical care unit, all patients have to be retrieved to the mainland. And you have to think, well, I've only got this amount of staff, I only have this amount of resource. If I've got more than two people who need to go on a vent at any one time we start...we're starting to push the boundaries of what we actually can do."* (P010)

The ethically challenging nature of these situations is also acknowledged by this participant who is experienced in making resource-based decisions. She feels that it is an ethically just solution to apply a utilitarian lens to EDM when deployed MTFs are overwhelmed and resources are dwindling, despite the harrowing nature of the situation, seeing little difference from her NHS practice in this regard during the early

waves of the Covid pandemic:

> *"It's also what you're taught with military procedure as well, isn't it? You know, what you're bound by, like for example if you're in a small facility, you've only got three days' worth of kit. And you can only hold so many patients for that length of time. And then it comes down to the fact that we can't accept any more patients if we take x, y and z. Erm, and that's always a difficult decision to make. But at the same time, you've got to look to your facility, being able to...it comes back to doing the best for the most. […] I suppose you know, like God forbid, another...something else happens here. And the hospitals are looking to get overwhelmed, the same decisions have to be made in relation to who gets treatment and who doesn't. And the exact same thing's happened with Covid just now, hasn't it? The admission criteria to ITU was really focused on…and that was some really horrific decisions to be made there, wasn't it? In relation to 'OK, you're such and such an age, you've got so many comorbidities, what's the likelihood of you getting better? I'm sorry, you're not being admitted to ITU'. And that's a horrific decision for anyone to make. It is playing...essentially playing God a little bit, isn't it?"* (P023)

This reservist nurse (P001) also relates her experience of EDM in a resource-constrained environment to her NHS practice during Covid. Broad parallels can be drawn with the military context from her statement about EDM in situations where allocation of scarce resources is a significant factor. In addition, her allusion to collegial decision-making in ethically challenging situations is equally applicable to the deployed environment. Speaking about this SRA situation obviously affected her, as she exhibited hesitant, halting speech and looked uncomfortable throughout this section as she recalled the difficult ethical discussions which took place in her hospital:

> *"Back in the first wave of Covid, they were talking very much when Italy went pear shaped and they had ICU patients in every corner of every ward in the hospital… when we were preparing for it, were having some conversations and things were coming out, like, you know, if you're over 60, you won't get a ventilator. And… we're going to have to make some really difficult decisions because um... oh, we don't have the resources. […] And that…that can't be done on a whim. That has to be done ethically. People have to sit down and take in everybody's viewpoint and come up with what is the right way to limit*

> *resources, and who's going to get them and who's not going to get them. […] [For example,] because they're eighty years of age, their co-morbidities are such that the chances of them getting off this ventilator are so slim, that we could have them on a ventilator for six weeks and five other people could die because they couldn't get this one ventilator. So, for the greater good... these decisions have to be made, so that everybody understands them, and everybody buys into them, and everybody follows them."* (P001)

Impartiality and cultural issues

It has been explained in previous sections that military nurses and doctors, like their civilian counterparts, have professional and moral obligations to treat the sick and wounded that come under their care without prejudice, irrespective of their specific job role. This is predicated on a foundation of non-discriminatory triage and prioritisation of those most urgently in need (Vaidya and Bobdey, 2021), also known as the humanitarian principle of impartiality.

Participants described a range of experience of challenges to impartiality in making ethical decisions in their deployed nursing practice. A few spoke about the struggle of personal bias when considering deployed issues of impartial care. One participant remembers the struggle she had to maintain her sense of impartiality when she was forced to treat a terrorist patient on her ward during a night shift, and her distress at what others might think of her based on her decision:

> *"I can remember feeling really sick when I had to do the handover in the morning, after I'd accepted the IRA [Irish Republican Army] bloke on the ward. Because I kept thinking everyone's going to think I'm a bit of a traitor. Whereas I was just like 'Oh...you know, in the side room we've got…and he's da, da, da.' And everyone was like 'OK, yeah. Fine'. You know, and I kept thinking 'Wow, they're much more professional than me!' Because all they were saying is […] 'What fluids is he on? What's his urine output like?' […] But I honestly thought they were all going to think 'Oh, that's awful. You've accepted this man on the ward', and that it was really my fault. Whereas it was just like 'Yeah, he's another patient'. […] I didn't like the man. I didn't like what he represented. I don't think it clouded my judgment on how I looked after him, I*

> *looked after him to the best of my ability. But I found it difficult. So yeah, there are times when it's made me feel...all...you know, that sort of horrible sort of lead weight feeling in the middle of your chest."* (P030)

Another participant was also concerned with others' perception of the virtuous nature of her character, but in this case the focus of her concern was the enemy combatant she was treating rather than her colleagues:

> *"I suppose with the Taliban guy [I was treating], I was like, 'I know I wear the same uniform [as the soldiers who wounded and captured him].' I want him to understand that I'm a different person to...I want him to realise that we are, we are good people. And we will do the right thing by him despite the fact that he probably wants to murder me on the spot. I need him to go away understanding that I'm a better person than he thinks I am because I wear a uniform."* (P019)

It became clear quite early in data collection that the status of patients had a large part to play in how military nurses experienced issues in the EDM around impartial care on their operational tours. Some participants experienced or observed in others a challenge in maintaining impartiality in the face of treating enemy forces, and the reasons underpinning that principle. Some staff groups found this more difficult than others. For example, this participant discusses the need to treat Taliban patients the same as any other patient because the intent is to exploit their intelligence value once recovered. He commented on the struggle his American colleagues had in this regard:

> *"One of the hardest things I found was when you look after a Taliban. So as a nurse, you treat everybody as equal. You treat them exactly the same, because the end game that people want is to actually...to question these people as to why they were doing what they were doing. The Americans found that really, really hard, and you could see their treatment wasn't necessarily the same as it would have been for a civilian, or for one of our military guys. Yeah, but once again, they're entitled to exactly the same medical care as I was or as you were, if you were over there. So that can be a little bit difficult to fathom at times. But as nurses, we do treat everybody as equal, and we*

should do." (P029)

When talking about cultural issues in the places the UK has deployed in recent decades, some participants recalled the animosity of misogynistic local national patients, regardless of their combatant or non-combatant status, towards female nurses, with one commenting:

> *"If we're talking about Iraqis, Afghanis, then obviously with the female side of things…a lot of spitting, not wanting the females looking after them. Erm...that was quite difficult, especially...I mean, I was a Chief at the time, but seeing the youngsters deal with that, um, could be a bit tricky...for them."* (P011)

Adhering to an impartial treatment model is important to P020 as part of the wider 'hearts and minds' ethical justification for doing so. In his opinion though, to achieve that objective it is necessary also to protect or enhance the reputation of such occupying forces, in a way which best supports the mission. However, his aspiration to treat impartially was clearly not shared by some of the nurses under his command:

> *"You look after everybody. It's the same whether it's in Afghanistan, Iraq, whether you're out in Kenya. […] Ethically, I believe that in order to promote the best picture that we have of the military, not just ours, but of any military, we should be there to care for everyone. […] We were discussing the Geneva Conventions and the rights of care. And some of them said 'Well, I can't...I'm not going to look after the assets [CPERS].' And I said 'Whoa, whoa, easy tiger - what do you mean you're not going to look after the assets?' 'Well, I can't look after them as well as I'd look after our troops.' 'OK...well, you will look after them exactly the same, whether you feel [animosity] for them and you can [still] give that extra mile is going to be the difference that you make'."* (P020)

Another ethical concern was the apparent variation in the standard of care delivered to trauma patients by clinicians of different countries, and apparently based solely on patient nationality. For example, this participant describes his irritation at this kind of issue, implying that a US clinician thinks it is acceptable practice to take less care

with his civilian patient, even though the decision to treat them has clearly been taken:

> *"In ED, when you're busy and you're having to make decisions, and you've got to…you're using your value judgment a lot. I found myself questioning, 'So why are you letting him go? Is it because he's an Afghan?' Well, you know, why that situation? Why that? And I just…I can remember an anaesthetist intubating [a local national civilian patient] horribly, and quite brutally, and I'm sure if that had been a US guy he bloody well wouldn't have done that. He'd have took more care. So that's the sort of thing that by the end really started to grate on me."* (P003)

This participant was shocked by the intensity of her dislike of one such captured Taliban insurgent:

> *"I get that everyone's a human being and they deserve the right to be comfortable and to be looked after. But at times, after seeing what they've done to my colleagues and my mates, it made it hard. It made it hard in the fact that...it's not that you didn't want to help them, you just knew that...I just knew that they were evil people. But there was one time when I actually wanted to inflict pain on someone, not bad pain, like a Chinese burn pain. Like a big pinch. And that was...they had caught five guys setting up an IED, and they'd caught four of them and one of them got away. […] And we found him under a bush in an old riverbed. […] And he just sat across looking at us, and we just looked at him. But I just wanted to pinch him. I just wanted...because he'd blown up, what, eight of our guys? And I just wanted ...nothing that would cause stitches or a fracture. I just wanted to pinch him. And I've never felt like that about anyone. And it shocked me that I, as a nurse, wanted to actually inflict a little bit of pain on someone, because I was just so cross that he had just killed eight of my mates. But that's the only time I've ever wanted to inflict pain on someone."* (P027)

Taking different approaches to care to an extreme level, several participants observed a shift from international nurses' passive but noticeable ethical attitudes to taking a more active and obvious position:

> *"I was in ITU once, in the Role 3 in Bastion, writing some notes. And I watched this American nurse lean over a ventilated patient, an Afghan patient, who was possibly um...suspected of being an IED bomber or something like that. And I overheard her say 'Well, that's what you get when you make bombs. This is*

> *what you deserve.' type thing. And I was really horrified and got up and told her - 'It's totally unacceptable. A patient is a patient, and it's not for us to judge what they've done prior. Treat the patient as a patient.' […] And I...to be honest, I did tell the ITU manager at the time, or the OC at the time. I mean...because that sort of behaviour is, you know...next thing it's followed by leaning on the ventilator tube, isn't it? [Both laugh] Come on!"* (P017)

> *"I think the one that really stands out for me, and it very much sort of reflects the differences in how we will often work with our…allied colleagues, was an incident that I was involved in in HERRICK [Afghanistan]. […] The Americans captured and brought in a Taliban fighter that was thought to be responsible for [killing a lost UK soldier]. […] So, the trauma team call went out, and all of the Americans who were on shift with our team just said, 'That's it, we're not going to nurse him, we're not going to treat him'. And they just walked out. […] And [the duty British consultant] just went, 'OK, just call in all the Brits'. So, the team we were on, sleeping off nights, were on standby. They got called in. So, we had an all-British trauma team, and this guy came in and, you know, lots of erm, American forces around him who are very, very much like, 'what are you doing? Why are you doing that?'... you know, er, very aggressive in their stance to us which made it much harder."* (P002)

In the only overwhelmingly positive experience amongst my participants of working with partner nations, this nurse said:

> *"I loved it, absolutely loved it completely. As I said, you know, with Shorabak, working with the Americans, working with the Danes as well...I love it because it gives you the opportunity to go out and soak up other people's knowledge, other people's morals and ethics and values and the way that other people look after their own wounded soldiers and civilians as well. I found that a very colourful experience."* (P020)

The deployed context and impartial treatment of local national civilians also offered some interesting cultural issues. Many of these are related to the country and environment in which the MTF has been deployed, and the cultural mores of the local population. Deploying military nurses are prepared to some extent to encounter the moral values and standards of the population they might be treating through the pre-deployment training (PDT) process, but until the most recent campaigns this typically included little or no ethical education. Consequently, cultural complications to the

EDM process, often around the care of women and children, came as a surprise to deployed nurses as they did not feel adequately prepared:

> *"And the fact that we had men on board meant...because they saw their legs and they saw part of their flesh, that meant [these Afghan women] would never marry. And things like that you find quite hard to understand and sort of, you just think 'How sad. We've just looked after your kids, and you've looked after them. But now you're unable to lead a normal life. […] They're outcasts from their village...and that I found quite hard. Because you know, normally...we'd manage to save all the kids through surgery, but the women were left out in the cold."* (P027)

Some participants described their feelings when encountering other ethically and morally challenging issues around cultural mores which they would be unlikely to experience in the UK. One is a military nurse who was unprepared to release a young girl from her ward into the custody of a man who was not related to her, without any parental involvement at all. It is clear to see that this represents a moral injury for her, which endures many years later:

> *"The worst one was a young girl that I'd looked after for a couple of weeks. She only had a broken arm, and obviously, some soft tissue damage and bits and pieces like that. But we couldn't get her home until we knew that, until the cast was able to come off, because otherwise we couldn't trust that it would get taken off and get taken off properly. […] And when it came to time for her to go home, it was the fact that I had to send her home with a village elder. And he...he just didn't look a very nice man. I didn't feel like it was somebody that I could trust. And obviously, I was completely aware that in any other situation, I would never let a child leave hospital with a non-relative without the parent's permission, without having any control of where that child was going to, if that child was even going to get home…if, you know, just not being able to trust or have any follow-up for the care that that child was gaining. She was a pretty little girl. And I just...yeah. She…like…her face, and then walking away, will stay with me [sighs]. […] No sign of parents, at all, for the entire process. Didn't come to visit. Not in the hospital."* (P009)

Another described the clash of cultures he experienced in his hospital ward when dealing with attitudes found in some male-dominated societies:

> *“We'd got [to Afghanistan], we'd been there for about a fortnight or something. And then a young girl come in. And she was a... just above ankle amputee. Little 18-month-old. Wandered out, trod on mine. Probably a Russian legacy mine. Erm...she came in, she was my little darling. And we got in touch with the locals. The family, the father and the brother were both Taliban, so they couldn't come in. So, they sent a young lad from the village in, who came in who didn't understand what his job was, and even when we you know, we told him 'It's your job to look after her', he turned around to [a locally employed interpreter], […] he said 'No, no, no...that’s a woman's job to do'. So [the interpreter], the young man and I went out the back of the hospital and we had a quick chat. And it was explained...nicely...that I understand it's his culture, and we're in his country...but he's in our hospital, and therefore he needs to be doing these things if he wants to be eating and drinking and settling down with us. In a nice way...not like you would do with some squaddie down the back.”* (P020)

This chapter presented the findings from the reflexive thematic analysis of the data. They were presented in a thematic narrative sequence, starting with my participants’ thoughts on the abstract nature of EDM and how they conceptualised the process of making an ethical decision against their personal values. It then explored their thoughts on the importance of context in EDM, and the effect wrought on their experience of EDM by the context of working within a deployed MTF. The next chapter discusses the findings in greater detail, situating them within the broader literature, and presents the discussion, again, in a thematic narrative sequence.

Chapter 5

DISCUSSION

Introduction

The stated aim of this research was to explore the lived experience of EDM of military nurses who have deployed to MTFs in challenging conditions on combat or humanitarian missions. This was to gain a deeper insight into how military nurses understood, navigated, and processed the EDM to which they were exposed or involved. My motivation for conducting this study was linked to my own feelings of inadequate preparation for the ethical challenges of working as a military nurse on a combat deployment, which I was largely unaware of until I had arrived in-country. I was interested to find out how well prepared other military nurses felt to manage or cope with EDM in the operational context, and whether there was a need for enhancement of existing PDT to include greater exposure to ethical education in the future. This study provides a novel contribution to the literature as the first empirical qualitative exploration of UK military nurses' experience of EDM from such a broad range of chronological, geographical, and operational perspectives.

This chapter presents a discussion of the research findings, situating them within the broader literature. Like the findings, the discussion is presented below in thematic sequence for continuity of format and ease of reference. Of the two themes I developed, the first, 'Doing the right thing', calls attention to how my participants conceptualised, viewed their place in, and made ethical decisions within the context of military nursing. Key findings included illumination of the multi-perspectival approach of my participants to deployed EDM and what it meant to them, which

synthesised mostly into an enduring drive to do the right thing for their patients. In a novel contribution to the existing literature, I identified a perception among some of my participants, both explicit and implicit, that a moral sensitivity 'gap' exists between military nurses and doctors in the deployed practice context. They appear to believe that military nurses have a higher degree of moral sensitivity than the doctors they deploy with when it comes to EDM. The implication from this finding is that nurses' ability to separate ethical issues and decisions from other issues and decisions, e.g., clinical, is the greater of the two groups.

The second theme, 'The deployed context influences the EDM of military nurses', sheds further light on the beliefs and ethical motivations of my participants. It also illuminates some of the specific constraints and ethical challenges they encountered during their operational tours, which impacted on their ability to do the right thing for their patients. In a novel conclusion, I found that these constraints are either substantially different, less impactful, or are just not a consideration in their routine NHS working lives, making deployed EDM far more complex and messier than in their firm base nursing practice. Moreover, nurses' attempts to manage the prioritisation of their sometimes-conflicting identities of healthcare professional and military professional compound this complexity, leading to further ethical tension.

'Firm base' is the military term used to refer to where MHCPs routinely practice at home in the UK. This may be as part of a Joint Hospital Group secondary care military unit embedded in an NHS Trust, in a medical field unit like a Multirole Medical Regiment or a Field Ambulance, or in a military primary care medical centre. There are reasons why clinical care on deployment may be fundamentally different from

NHS practice in the firm base and why it may prompt different reactions and ethical outlooks from MHCPs. There is limited expression of this in the literature in relation to UK military nurses (See e.g., Finnegan et al., 2016a; Draper and Jenkins, 2017), possibly because of what Conlon et al. (2019, p.268) state: "*the experiences of military NOs [Nursing Officers] working in trauma teams is a phenomenon that is largely hidden, as these experiences are rarely voiced outside the military.*" Serendipitously, this study aims to give voice to UK military nurses outside the confines of the military and analyse their contextual deployed experience of EDM in the hope of enriching knowledge in the field.

'Doing the right thing' (Theme 1)

A clearly expressed core philosophical belief of most of my participants about EDM and what it means to them as military nurses was that it should in all cases be driven by the desire to 'do the right thing' for their patients. Indeed, when healthcare professionals "*feel unable to do what they perceive to be the right thing, or when faced with ethical uncertainty*", moral distress could ensue (Harvey and Gardiner, 2019, p.68). This is echoed by Burston and Tuckett (2013, p.321), who identified multiple intrinsic and extrinsic contributing or ethically limiting factors to nurses developing moral distress, arguing that all of these are "*generally deleterious either to the individual (self), others and/or the system.*" It seemed to be taken for granted that military nurses would do the right thing technically speaking, that is they had proficient technical knowledge and that by doing the right thing for their patients had a moral import.

Literature suggests that for healthcare professionals, the technical and the moral

cannot be separated, because almost anything technical done to, for, or with a patient is also moral (Benner, 2003). Haahr et al. (2020) advocate a holistic and context-based approach to nursing practice based on elements of virtue ethics and 'ethics of care' which relies on nurses combining their clinical wisdom and moral competence to do the right thing for their patients. Healthcare professionals act for the good of the patient (Pellegrino and Thomasma, 1988; Pellegrino, 2001), with Haahr et al. (2020, p. 259), supported by Goethals et al. (2013), commenting that "*nurses are driven by the ideal of care and the aim of 'doing good'."* My findings show that overall, participants held that doing the right thing for their patients was doing the morally or ethically right thing. However, there were also a few who voiced concerns that the confounding factors of contextual complexity and constraint in the operational space made the ability to live by this moral conviction less certain.

There was some discussion by participants about the differences and similarities between clinical decision-making (CDM) and EDM, ranging on a continuum from being distinct to being essentially entangled. Preisz (2019) is of the opinion that two 'systems' of thinking govern CDM and EDM, which are distinct but often work in synergy. She says that 'system 1' is the default, always on, which is the instinctual, emotionally driven 'primitive thinking' (Kahneman and Egan, 2011) which allows clinicians to make quick, complex decisions under pressure, but which can lead to errors and flawed conclusions based on 'intuition' (Preisz, 2019). 'System 2' is the slower, only on when needed, rational and deliberative thinking which is required for complex decisions involving ethical reasoning (Zavala et al., 2018). Although 'system 2' is harder to engage in time-pressured situations, it should be able to executively overrule the cognitive processes of 'system 1' (Preisz, 2019) to allow a clinician to 'do

the right thing' ethically. Conversely, for Benner et al. (2008a; 2008b), CDM and EDM are indivisible because safe nursing practice involves combining both technical nursing knowledge and expertise, and ethical and clinical reasoning.

One claim from participants was that nurses are perhaps more focused on EDM than doctors, who are perhaps more focused on CDM with regards to doing the right thing. An example of this is the issue of moral sensitivity. Lim and Kim (2021, p.2) define EDM in nursing as "*a sequential process consisting of professional accountability and moral components, such as moral sensitivity, judgment, motivation, and behaviour.*" While professional accountability in EDM could be considered a *res ipsa loquitur* matter (i.e., 'the thing speaks for itself'), moral sensitivity is more abstract and is what enables someone to recognise moral conflicts, empathise with the vulnerable, and be aware of the moral implications of making decisions about others (Escolar-Chua, 2018; Ohnishi et al., 2018). For example, Lützén et al. (1995, p.132) define moral sensitivity as:

> *"[The nurse's] ability to recognize a moral conflict, a contextual and intuitive understanding of a persons' vulnerable situation and insight into the ethical consequences of decisions made on behalf of another person.*"

Kristjánsson (2024, p.789) also likens moral sensitivity to what he calls the 'constitutive function' of Aristotelian *phronesis*, an intellectual virtue which speaks of discernment and contextual deliberation in navigating the engagement of moral virtues in decision-making. He says, similarly to the authors above, that this is because *phronesis* "*involves the cognitive ability to perceive the ethically salient aspects of a situation and to appreciate these as calling for specific kinds of responses*", enabling the moral agent to identify the central or most important ethical

issue which needs to be addressed. Moral sensitivity can therefore be said to be central to step one of the MOD's preferred EDM tool, the Four Quadrant Approach (4QA), identifying the ethical issue which requires a decision, or at least deciding which ethical issue is the most urgent. This will be discussed further below.

Moral sensitivity is a term which is also referred to as 'ethical sensitivity' in some studies (Dalla Nora et al., 2017), but Milliken (2018) argues that the two are different concepts. While Grace (2018) largely concurs she concedes that, at least in the contexts of professional judgement and ethical action, the two terms are synonymous. However, I have chosen to use the term moral sensitivity in this thesis as it aligns more with my, and my participants', contextual understanding of EDM and ethical action.

The experience of one participant was reported in the findings chapter, where it was implied that the nursing team in his MTF in Iraq displayed greater moral sensitivity that the medical team (i.e., doctors) in the care of a fatally wounded young Iraqi girl. The doctors' judgment, motivation, and behaviours in this case were perhaps focused on the clinical aspects of the care decision, specifically about whether to remove the girl's endotracheal tube before discharging her. P024 reported that the doctors appeared to have accepted that she would die quickly on discharge, and did not seem to be concerned with where or who she was being discharged to. This was despite their MTF being the only high standard healthcare facility for hundreds of kilometres around. Conversely P024's focus, and that of his fellow nurses, was on the ethical aspects of the decision and empathetically preserving privacy and dignity for the girl and her family.

A study by Dalla Nora et al. (2016) found that such ethical issues were among those most frequently experienced by their participants, and they emphasise the importance of nurses defending their patients' interests in such circumstances. This is a specific phenomenon which is also reported in the literature, with Pakkanen et al. (2022, p.731) stating in their systematic review findings that "*ethical conflicts arose when physicians made treatment decisions from a curing point of view, while nurses made decisions from a caring point of view and considered patients holistically*." This is supported by Haahr et al. (2020, p.259), who state that "*the hallmark of nursing is a holistic approach whose central values constitute an ethical obligation to maintaining and respecting the individual's dignity and integrity*", which applies in circumstances of both routine and emergency care.

In the case described above, with the clinical outcome beyond doubt, the holistic, caring view of the nurses translated to a desire to provide privacy and dignity in her death, honouring the request of her Kurdish family. With the knowledge that cultural factors often play an important part in end-of-life care decisions (Glyn-Blanco et al., 2023), this manifestation of moral sensitivity resulted in the nurses understanding and supporting the parents' wishes to return their daughter home to die in a familiar environment and limit further medical interventions. A review and synthesis of other participants' comments, and much personal reflection, imply that this is a phenomenon which is more prevalent amongst military nurses than the single explicit instance reported in this study.

Despite its single explicit (but multiple implicit) mentions, it is an important finding consistent with some international studies. Some of these were written by nurses,

and others by doctors, which have suggested that nurses have a moderate to high degree of moral sensitivity in clinical practice (See e.g., Lützén et al., 2000; Comrie, 2012; Saritas et al., 2020). By way of comparison, there are other international studies, again some of which were written by doctors, which show that doctors are suggested to have a low to moderate degree of moral sensitivity (See e.g., Alyousefi et al., 2021; Menekli et al., 2021; Wong, 2020). However, the relative level of moral sensitivity in nurses and doctors remains a contested issue in the literature. This may be because much of the work in this field is positivist in nature, claiming to measure or calculate moral sensitivity using one of many established scientific instruments or methods.

For example, Reynolds and Miller (2015) reported several studies which have attempted to do just that, via functional Magnetic Resonance Imaging scans of the brain while study participants consider vignettes involving moral challenge. Alyousefi et al. (2021) claim in their study a series of positive correlations between age, experience, and other demographic factors and the level of moral sensitivity in physicians using Lützén et al.'s (1995) 'Moral Sensitivity Questionnaire'. However, Zhou et al. (2024) conducted a SR of 29 studies using 12 different instruments to measure the moral sensitivity of nurses. They found that "*only one of the included studies could be given at least adequate ratings for the methodological quality and sufficient results of content validity*" (Ibid., p.25). There are of course other scientific papers which make claims that one professional group has greater moral sensitivity that the other, but many of these are not peer-reviewed sources and are therefore untrustworthy to cite as evidence in academic work.

Conversely, Dalla Nora et al. (2016, p.5) argue that moral sensitivity is a "*personal component, acquired through each [nurse's] experience*", making it subjective and difficult to measure objectively. From this, it can also be inferred that moral sensitivity could be linked to the virtue ethics theory of character development through experience and habituation of good moral behaviour. It might even make more sense to situate discussions of moral sensitivity in the qualitative domain, with Reynolds and Miller (2015) urging researchers to shift the existing focus in the moral sensitivity literature from examining explicit (conscious) moral recognition to implicit (non-conscious) moral recognition.

Simplifying the term, moral sensitivity is what allows nurses and other HCPs to distinguish ethical issues and decisions from other issues and decisions, e.g., clinical (Dalla Nora et al., 2017). The literature suggests that in some cases it may be that nurses display higher levels of moral sensitivity than doctors. Empirically building on this, suggested by the data analysis, and based on the perceptions of the participants in my study, a tentative conclusion is that military nurses' ability to separate the ethical aspects from the clinical aspects of decision-making is perhaps the greater of the two professional groups. However, while that appears to be the case in this situation, the conclusion remains tentative because there may some factors which undermine its validity. For example, it could be reasonably argued that the military nurses who chose to participate in this study may have done so because of their existing interest in ethics. Therefore, this sample group of participants may be more morally sensitive than is typical.

The doctors in this case may well have had the moral sensitivity to recognise,

understand, and consider the ethical issues. However, they decided on a different course of action instead - focusing on its clinical aspects. This may be because, as Storch and Kenny (2007, p.481) say, when doctors feel under pressure they tend to "*focus on what they do best, their technical skills and judgments based on good scientific evidence. Attention to the moral and ethical nature of practice, particularly from the patients' perspective, is often lost."* If deployed military nurses, as tentatively implied in this specific case, demonstrate greater moral sensitivity than their military doctor colleagues, then it could be argued that this should afford military nurses a valuable role in the EDM process for their patients. Although not measured using positivist methods, this finding represents a novel contribution to the qualitative field simply because its discussion here adds depth to the contested issue of moral sensitivity in unique contextual dimensions, i.e., UK MHCPs working in a demanding environment in a deployed capacity, evidence of which I cannot find in the existing literature.

Participants presented a multifaceted account of how they view the differences between CDM and EDM in doing the right thing, many of which relate to the notion of the challenges of impartiality in deployed nursing care to be discussed below. Some believe that the way nurses make ethical decisions about what is right to do to prioritise treatment of injuries and illnesses is clear-cut. They cite the conventional triage systems used to assess patients for treatment based on the severity of the medical issue, which prioritises those most acutely in need of care first. Others classify an ethical care decision, by comparison, as a decision where one brings personal feelings into the situation, and often relating it to a treatment scenario as well. One participant, for example, offered a unique consideration of how the military

deployed context might alter nurses' decision-making regarding doing the right thing in terms of delivering impartial care. He talked about a CPERS, a Taliban patient, and described the enemy combatant's life as less important than the life of 'one of his own'. In that scenario, he seriously considered treating all the coalition and allied soldiers in his ED first, regardless of comparative severity of injury, before treating the CPERS.

This conscious bias, were he to have acted upon it, would have contravened the deontological obligation to treat the patient in front of him, who had been accepted for care in his MTF, as well as the other ethical and professional principles which prioritise treating the patient who is most in need first. This includes a derogation of his duty to abide by the rules, which would have placed the CPERS at a disadvantage. In military terms, he would also have been in contravention of the Geneva Conventions Act 1957 and extant CPERS doctrine (MOD, 2020), by which all MHCPs must abide. This could lead to objectively unethical decision-making (British Medical Association, 2012). His thought process appears to be on a scarce resources allocation basis (SRA principles are discussed further below). This would also presumably apply to the 'ethically just' treatment of allied personnel as opposed to enemy combatants.

I interpret his (internally held but not acted upon) view above as seeing treatment of the Taliban as a 'waste of resources' which could more profitably be spent 'on the good guys and the innocents'. Indeed, Jones (2018) reports that deployed MHCPs in Afghanistan faced moral distress through CDM and EDM issues associated with 2TC and impartial care. This is because they were forced to discharge seriously ill

children to much lower tiered healthcare facilities, while treating Taliban in the MTF (often for a considerable period) until they could be safely released. Regarding the principles of beneficence and non-maleficence, many nurses worried that they were unable to act beneficently towards paediatric patients, even *de facto* exposing them to further harm on discharge. At the same time, acting beneficently and restoring a CPERS to full health might result in causing harm to troops in future, when the CPERS is recovered and eventually takes up arms against them again (Ibid.), causing feelings which amount to moral injury.

One participant's view is unique within the study, in that he believes CDM is 'easy' compared to EDM because it is largely an algorithm or protocol-driven process, particularly in ED where he worked. This is an approach which Kaldjian et al. (2005) sought to transpose to EDM. They offer what they call a 'novel systematic strategy' (see Fig. 1) in the format of a CDM process flow map, situating clinical ethical reasoning within the paradigm of clinical reasoning. Indeed, they claim this "*addresses the heterogeneity of clinical problems that at first appear ethical*" (Ibid., p.306). It is designed as an EDM tool which aims to incorporate CDM into the EDM process and moves the discussions away from a purely 'hard science' clinical model to a blended model, allowing for wider input and subjective ethical considerations to be assessed as part of the decision. EDM tools or decision-making frameworks were discussed by many of my participants, including the MOD's favoured EDM tool, the 4QA as described by Sokol (2008).

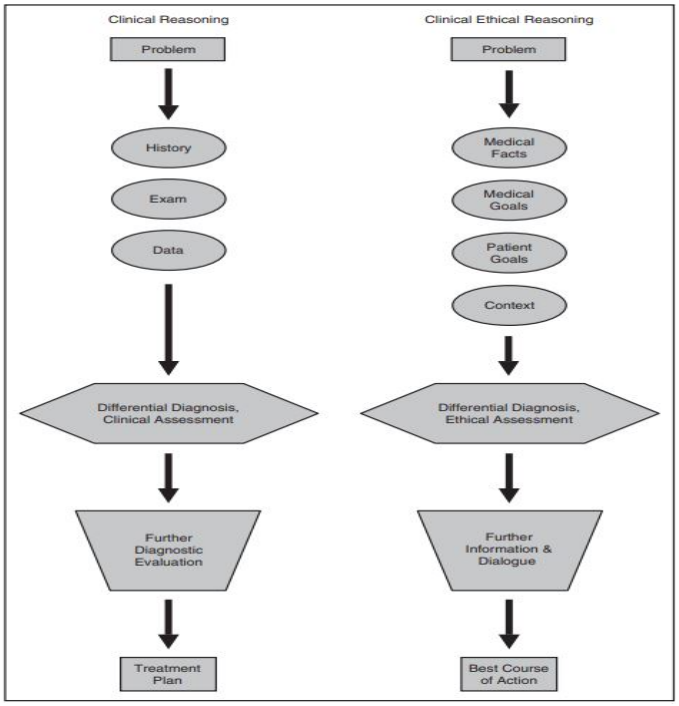

Fig.1: Comparison between clinical reasoning and clinical ethical reasoning. (Kaldjian et al., 2005, p.308).

Importantly, according to my findings, it is not enough to simply do the right thing for a patient - as one participant neatly summarises, *"As well as doing the right thing, you need to explain that you've done the right thing."* (P003) The consensus in the findings is that explaining decisions leads to better EDM, especially in the context of helping staff to rationalise and process particularly difficult decisions. This is especially true when those decisions are made by others which, according to over half of my participants, in the military context are usually doctors. They often perceived military doctors as not always acting in the patients' best interests, or otherwise failing to 'do the right thing'. However, there was a mixed view of the role of explanation by participants, dependent on whether such explanation was given after the EDM was completed or during the EDM process itself.

One consistent argument that EDM can be improved through such explanation-giving was raised by participants, in that it at least gives nurses a voice in the EDM process.

This was meant in the sense that even though nurses may not be directly involved in the EDM process, by explaining how they have arrived at an ethical decision, the decision-makers can still give nurses a chance to contribute to the wider ethical debate *post hoc*. It gives them an opportunity to disagree, challenge, comment or ask questions, even if it does not change the final decision. For example, Browning and Cruz (2018) found in their study that discussion and encouraging interpretation of ethical reasoning during *post hoc* critical debriefings helped ITU nurses to overcome moral distress. This was particularly beneficial if nurses felt that the decision had been inconsistent with their own ethical values (Ibid.).

Supporting this, a scoping literature review by Evans et al. (2023) concluded that explanatory *post hoc* debriefings of this nature not only give HCPs a voice to help them improve their resilience in ethically challenging situations at work, but also improve patient outcomes. This is important, because as Mealer and Moss (2016) state, nurses typically experience higher levels of moral distress when facing ethical challenges than many other HCPs. The authors go on to explain that this is because of their perceived lack of voice and power, despite their central role in patient care.

The emphasis above on explaining, and perhaps justifying an ethical decision, could influence nurses to change their minds about the right thing to do, or, of course, it could not. If the latter, then it is possible that moral distress could still be a potential resultant risk despite such explanation and justification. For example, Moverley et al. (2023) conducted a narrative review of quantitative and qualitative studies assessing interventions designed to reduce moral distress in nurses, suffered through experience of repeated ethical conflicts. They established that some interventions,

such as debriefing and explaining ethical decisions, did not demonstrate a significant change in levels of moral distress between pre- and post- intervention assessment.

Of course, if explaining EDM to the care team takes place before a final decision is reached, this can change the narrative. Discussing pertinent ethical issues in a multidisciplinary environment can amplify the nursing voice in influencing EDM and allow clinicians with decision-making responsibility to gather bedside feedback in real time. Indeed, in their meta-synthesis of peer-reviewed papers, Pakkanen et al. (2022, p.731) determined that "*open discussions by different professions would strengthen ethical patient care and provide what was best for the patient.*" Simultaneously, such ethical debate could contribute to a reduction in the prevalence of moral distress amongst nurses in ethically challenging situations where they feel as though their ethical values are under threat (Epstein and Delgado, 2010). This approach was valued by the decision-makers (critical care doctors) in a study by Flannery et al. (2020, p.315), who stated that there was "*a strong respect for and reliance on the information provided by nurses in the EOL [ethical] decision-making process*". However, the results of my study showed that such gathering of EDM feedback and opinion from military nurses did not always occur on combat and humanitarian deployments. Theme two picks up this thread on the contextual issues.

As reported in the literature review, making moral decisions, like determining the right thing to do for a patient, is often reported as the central goal of effective EDM in nursing literature. It is often strongly tied with the virtue of moral courage in enacting it (In addition to the literature review, see also e.g., Pajakoski et al., 2021; Raso, 2021; Dennis, 2022). This was especially true when nurses felt the need to challenge

doctors' ethical decisions. Service personnel can exercise a reasonable, respectful challenge, or even practice 'intelligent disobedience' under the terms of the Armed Forces Act (2021) and Army Leadership Doctrine (MOD, 2021b). This ranges from questioning views and pointing out mistakes to lawfully refusing to follow orders which conflict with prevailing law, or which would require soldiers to breach legal or ethical rules to achieve. This is an important part of military codes of conduct and international humanitarian law and is intended to ensure that soldiers act in accordance with the principles of humanity and justice, even in the context of armed conflict. Indeed, the British Army's Leadership Doctrine (Ibid., Para. 3-06) states that the practice of "*respectful challenge [and intelligent disobedience] requires moral courage, careful thought, and the application of skill, knowledge, and experience*", as well as a strong moral compass.

In my participants' experience, however, this is difficult to achieve in the military healthcare context. As will be discussed below, the military context could also make 'respectful challenge' somewhat hazardous to one's career. Generally, in my participants' experience, challenging EDM in this way is difficult to achieve in the military context because of the complex and rigid dual hierarchy (professional healthcare and professional military) within the DMS. This is consistent with the evidence presented in the literature review which highlights the 'oaths' of allegiance sworn by military personnel, including nurses and doctors, to obey the orders of their monarch and superior Officers (Jensen, 2013).

Indeed, Robinson et al. (2022, p.751) state what this really means when they comment that all military personnel, including nurses, are subject to "*the mandatory*

and legally enforceable subordinate compliance of military practice." It is this hierarchical ethical dilemma of which 'oath' of loyalty takes primacy in EDM that causes a dual loyalty conflict with their professional 'oaths' and responsibilities as a healthcare professional. Thus, there seems to be difficulties faced by military nurses in doing what they believe to be the right thing for their patients. This may have similarities in the context of their peacetime work in the NHS, but the difference in degree of problems faced as a military nurse may be a significant one.

Harvey and Gardiner (2019, p.68) explain that doing the right thing in the civilian nursing context is difficult and requires moral courage because "*historically, medical decisions made by doctors went unchallenged.*" This is because EDM has been seen for a long time as the sole preserve of the doctor. This is the phenomenon of medical paternalism, traditionally regarded as an ethical norm in that a physician's central duty was to make decisions to "*promote [their] patient's welfare, even at the expense of [their, and I suggest also nurses'] autonomy*" (Kilbride and Joffe, 2020, p.1973, my parentheses). According to Murgic et al. (2015, p.2), this "*implies that the physician makes decisions based on what [they] discern to be in the patient's best interests, even for those patients who could make the decisions for themselves*" and without due regard for nurses' opinion.

Similarly, paternalism in nursing has been increasingly reported and studied in recent years (See e.g., Bladon, 2019; Mortensen et al., 2019). One suggested reason for this is burgeoning recognition of the growing power differential and subsequent potential for 'soft' or 'hard' paternalism-driven EDM which now exists between nurses and their patients, in much the same way as it did previously for physicians and their

patients (See e.g., Ly, 2023; McCullough et al., 2021; Zugai, 2023). It has been suggested not only by some of my participants (e.g., P004, P012, P021, P025) but also in the literature (See e.g., Wiles et al., 2016; Dennis, 2022; Botes, 2000) that team, or collegial, EDM may be an effective way to avoid this paternalism in healthcare. Collegial EDM, they argue, keeps the patient central to the process and focuses decisions to be made on doing the right thing for patients.

This is further supported in the literature. Johnson and Cerminara (2020) for example advocate taking an 'all things considered' approach to EDM, particularly if a patient is unable to represent their own autonomous interests. They infer that it is then important to deliberate the various issues and perspectives surrounding a decision as widely as possible, with a wide range of stakeholders, thereby increasing the volume, breadth, and depth of relevant information to enhance the quality of decision-making. This collegial or shared approach widens decision-making responsibility beyond MHCPs, who have the actual knowledge of healthcare required, understood factually as much as it can be so understood, to make clinical decisions. It moves it into the ethical realm, because other stakeholders in the decision (the patient, the family, the wider military chain of command etc.), though unlikely to have the detailed factual healthcare knowledge required to make clinical decisions (e.g., anatomy and physiology etc.), can instead feed wider information and ethical concerns into deliberations. This could help, or equally, complicate matters. For example, what the patient wants or demands may be at odds with the clinician's diagnosis or what their family wants.

In relation to doing the morally or ethically right thing, it seems that some think

different ethical standards might apply to military nurses than to non-military nurses. Kelly (2015) for example believes that deployed nurses, and other clinicians, cannot be held to the same ethical standards as their civilian peers. This is because there is a disparity in autonomy between the two, constraining EDM to the point that makes adherence to civilian professional codes and ethical guidelines challenging, or even at times inapplicable (Ibid.). Whilst in the literature, notions of how autonomous human beings can really be is contested at the everyday level of ethical practice, the demandingness of morality is recognised. For some, its over-demandingness is a fault with consequentialist ethics, thus making it psychologically impossible, and for others it is an expected part of morality to be perfect. In the military nursing context, doing the right thing is at least made more difficult because of the inherent contextual, structural, and legal constraints involved in delivering care in the deployed space. Additional pressures, such as high operational tempo, limited time, or imminent attack in combat deployments, may also increase the difficulty for nurses in doing the right thing. These factors preclude lengthy discussions, and urgent 'snap decisions' may become necessary to protect the strategic or tactical military position.

There are EDM tools which claim to help HCPs make critical 'snap' ethical decisions, like the RAPID EDM in resource-scarce environments model described by Iserson (2011). However, its first step is 'buying time' to deliberate and make simplistic, but subjective, assumptions about e.g., quality of life, functional status, and patient wishes, and relies on applying its three 'tests' of impartiality, universalizability, and interpersonal justifiability (Ibid.). This all takes time, making it seem less efficient for rapid EDM than it claims. It also seems designed for an individual HCP to make the ethical decision, rather than allowing for a collegial decision to be made with the

wider care team. In such circumstances, another EDM tool such as the MOD's 4QA seems more appropriate in guiding holistic ethical deliberations, allowing for multidisciplinary input, which will be discussed further below.

Many participants reported believing that in order to make the right decision and do the right thing for their patients, relevant experience is important in EDM, and that it can come from a variety of sources. These can include life experience, professional experience, and other contextual experience. This is supported to some extent in the literature, with development of 'moral sense' being highly contested. For some, like many of my participants, it is socially constructed through life-long interpretation of lived experience (Limone and Toto, 2022). While this seems a very neo-Aristotelian emphasis, at least with some qualification about good experience in being well brought up and habituation, the emphasis is that not just any experience matters for moral development and thus for EDM (Schinkel and de Ruyter, 2017). However, there is an opposing view that moral sense is a natural, innate human function present from birth, although this too seems predicated on praxis of social interactions as a child ages, making a credible argument for social construction (Laible et al., 2019).

But for military nurses, a question arises about the fact they may be exposed to stressors they have never encountered before during their careers, and thus perhaps until one is in the situation, no amount of preparation can really prepare one for the actual specific context. This has echoes of the particularism / generalism debate regarding the role of moral principles in understanding morality, and that both awareness of the situation one is in as well as a working knowledge of some general

rules or principles or virtues are probably both required. The findings suggested that the quality of EDM will suffer if that specific context is warfighting, particularly if it is a nurses' first deployment. Taking an example from my own career, a major stressor affecting my ability to function properly and make wise ethical decisions in my work was being near-constantly and indiscriminately bombarded by enemy rockets and mortars while trying to assist in performing life-saving surgery. Exposure to such stressful situations has been demonstrated to affect the EDM process.

For example, in a series of studies, Mazza et al. (2020) found that front line HCPs during the Covid pandemic were more inclined towards utilitarian care decisions, and found ethical decisions denying care less unpalatable when they considered their own lives at risk than when they did not. Additionally, in a strong correlation with the military context, Gustavsson et al. (2022, p.2) wrote about the moral challenges and associated consequences experienced by HCPs in disaster healthcare response, explaining that:

> "*Deployed disaster healthcare responders are faced with significant challenges. They carry out their work under extreme pressure and need to make prompt decisions in often dangerous and challenging contexts. […] The choices involved in deciding who and what to prioritize expose responders to moral challenges well beyond those encountered during normal healthcare provision*."

Other stressors of practicing in a deployed capacity as an MHCP have been reported in the literature. For example, the isolation of MHCPs and the complexity of far forward EDM (i.e., in the kinetic zone, close to the forward edge of the battle area) (Sessums et al., 2009), and nurses struggling to maintain compassionate care when faced with wounded enemy combatants (Agazio and Goodman, 2017). The latter

refers to the phenomenon described in the findings chapter of nurses impartially *delivering* clinical care but not '*caring'* for these patients. Without relevant contextual experience, the literature confirms that these stressful conditions are in concordance with my study's finding that they may lead to an alteration in nurses' normal EDM process. This may be due to fearing for their own life, or through being emotionally or psychologically overwhelmed and 'shutting down' the brain's capacity for rational thought or ability to reason through tricky ethical dilemmas (Gustavsson et al., 2022). This may lead to potentially unreasonable ethical decisions. Paraphrasing the old military planning axiom, quality decision-making, like planning, generally does not survive first contact with the enemy - meaning that it can deteriorate rapidly due to dangerous or overly stressful circumstances.

Consequently, I found that many participants expressed the thought that debating the particulars of ethically challenging events encountered previously, and decisions made by nurses in similar circumstances, in a safe and non-stressful environment (such as a classroom) would be beneficial and facilitate easier EDM for them in the future. This benefit of this finding is supported in the literature, with MacIntyre (2009) identifying both the lack of and the need for moral debating resources in professional education, echoed by Conroy et al. (2021). One way to effectively achieve this in the DMS might be through case-based learning (CBL). CBL is a teaching method which has been shown to link theory to practice and induce deeper learning in adults, the impact of which "*can reach from simple knowledge gains to changing patient care outcomes*" (McLean, 2016, para. 40). Indeed, CBL has been shown to be useful in assisting MHCPs to synthesise, rationalise, and fully understand the implications of such ethical decisions before they are exposed to them on deployment (Beardmore

et al., 2024), potentially reducing the reaction lag and deliberation-to-action time. Similar findings were reported in studies examining the benefits of CBL involving UK medical students (Al-Bedaery et al., 2024) and international doctors (Suliman et al., 2019), both in person and online (Lim and Veasuvalingam, 2025).

As mentioned in the findings, doing the right thing was given Aristotelian overtones by some participants, e.g., *"It's doing the right thing, at the right time, for the right reason",* being contextually influenced by "*time, person, and place*" (P030). This brings out an important yet problematic concern within EDM, that of how particular is the context and how much use can principles and rules be for guiding one to do the right thing? For example, Aristotle seems to hold that principles are of no use in such matters, preferring EDM rooted in *phronesis,* or *'*practical wisdom'*.* Indeed, Junker-Kenny (2013, p.11) states that *"virtue ethics […] seeks to enable the individual to make context-sensitive, prudential decisions".* Consequently, EDM for neo-Aristotelians is contextually based, and for them, "*wise moral decisions based on the specifics of a context cannot be formulated via the kind of algorithmic principle-based decision-making typically favoured by Enlightenment and post-Enlightenment thought*" (Vaccarezza et al., 2023, p.3), such as deontology or consequentialism. Conversely, others such as Beauchamp and Childress (2019), the authors of principlist ethics theory, believe that principles are of great use as their theory revolves around the ethical principles of beneficence, non-maleficence, autonomy, and justice.

Conroy et al. (2021) report more practical concerns for HCPs, also advocating for *phronesis*-based EDM education for healthcare professionals. They express their

doubts about the utility of the ever-growing and unmanageable number of deontological guidelines clinicians are expected to follow (over 7000 at the time) and the abstract nature of principles-based approaches to EDM. They regard rules, guidelines, and principles as often ethically problematic, difficult to apply, and of little practical use to practitioners. This, they say, is because they tend to oversimplify a complex clinical situation, and do not account for humans as multifaceted entities who require a holistic approach to EDM, focusing on one principle or moral rule out of context (Ibid.).

Codes and guidelines as an ethical handrail to EDM (Sub-theme to theme 1)

In the first few study interviews, I began to hear participants' views on the influence of written laws and regulations, rules, professional guidelines, codes of ethics, and policy etc. in military nurses' EDM. This offered another interesting dimension to my study, so I adapted my topic schedule to include an open question around this. A few participants, for example, felt that such written material was useful and helped them navigate ethical decisions in practice. However, having knowledge of ethical codes, guidelines, and policies etc. is no guarantee that they have been understood or will be used appropriately (See e.g., Sayers and de Vries, 2008; Ohnishi et al., 2010). This is a finding consistent with a European study by Tadd et al. (2006) which posits that this is because nurses often have a poor understanding of their professional codes of practice. They thought the reason for this was that nurses believed that codes were of little value, because of the seemingly insurmountable internal and external barriers to being able to use them as intended in practice, and were therefore not driven to familiarise themselves with their content (Ibid.).

Although Williams et al. (2015, p.29) concur that "*a code must be interpreted because it usually contains broad statements",* meaning that it is subjectively understood and therefore potentially different for every nurse, they also hold that a code "*does serve as a general guideline for professional ethical issues*" (Ibid.). Indeed, the literature further reflects that some are very supportive of codes of standards and ethics for nurses as a handrail for EDM (See e.g., Yakov et al., 2024; Gurney et al., 2017).

Some participants felt that such written material was either unhelpful, restrictive, or to be used as a resource in specific situations only, usually tied to matters of discipline and professional accountability. Several participants even stated a preference for trusting their own practical wisdom, judgment, or personal codes of ethics built up throughout their career over written guidance. Furthermore, written policies have been described in several studies as unnecessarily restrictive and stressful for nurses because they create a conflict between the needs of patients, as identified by nurses, and those of the wider organisation, such as cost savings etc. (Haahr et al., 2020). This constrains nurses' EDM around doing the right thing and prevents them, as a matter of policy, from delivering the level of care they want for their patients (van der Dam et al., 2012).

Doing one's duty or following rules, emphasising the consequences of one's actions, and acting virtuously are not mutually exclusive in the 'big three' normative ethical theories of deontology, consequentialism, and virtue ethics typically found in ethical codes and professional guidelines (Hursthouse and Pettigrove, 2023). Indeed, any credible normative theory will at some level account for rules, consequences, and

virtues (Ibid.). For example, while both deontologists and consequentialists have developed rules to guide EDM, attempting to address criticism of a lack of codifiability (Reid, 2019), some virtue ethicists have developed moral rules mapped to moral virtues and vices to guide EDM. Hursthouse (1999) calls these ‘v-rules’. They take the form of exhortations such as ‘do what is honest, and do not do what is dishonest’ (Ibid.). But although virtue ethics still has a general directive to ‘be virtuous’, and utilises Hursthouse’s ethical v-rules, they are not algorithmic and therefore remain subject to individual interpretation.

Two contrasting examples synthesised from the findings highlight the range of views amongst my participants about the utility of professional codes at work. The first is nurses objecting to being directed by the NMC (2018) Code in how to act in one’s job or life and to maintain a virtuous character or a virtuous nursing practice, either explicitly or implicitly. This seems to offer support for the earlier notion of ‘innate moral sense’, but in the professional context. This is because some participants said that nurses should be capable of demonstrating virtue in their practice through being e.g., open, honest, and reliable, and they should not be a nurse if they cannot. There was no mention of career stages and associated accrued experience. This implies that those participants believe moral sense and virtue are innate character attributes in nurses which enable the unconscious embodiment of virtuous practice. The second is pondering what unregulated and unethical practice would look like without the safeguard of a guiding professional code. One specific example was seeing an unqualified and unregulated Sierra Leonean army environmental health technician performing abortion surgery in a makeshift clinic at weekends, through a purchased ‘certificate of practice’, but with no accountability. Imagining the potentially serious

consequences of such widespread unregulated and unethical healthcare practices, if they occurred in the UK, would be unpleasant indeed, and morally unconscionable to UK nurses.

A common idea was that written codes and guidelines etc. are generally important, and that some of those are even useful as a handrail to guide nurses through the EDM process in their day-to-day practice. However, one military nurse neatly summarised the wider feeling amongst many of my participants that "*no framework is going to totally make up for experience and gut feeling*" (P013). She went on to refer to this phenomenon as 'intuition', while some other participants were not as specific about it. 'Gut feeling' is a term also used by Gorick et al. (2024) to describe nursing intuition, a visceral feeling that 'something is not right' with a patient. Indeed, in a systematic review of the concept of intuition in nursing practice Hassani et al. (2016) translate the 'gut feeling' of intuition to mean 'knowing without reason'.

Rather than relying on written codes and guidelines, policies, or standard operating procedures etc., those participants believe it is more likely that nurses will unconsciously synthesise their pre-exposure to a variety of circumstances and experiences in clinical practice, gathered over time, to come to a decision in an ethically challenging situation. The literature supports this to some extent, with Anton et al. (2021) commenting that the major influencing factor in nurses' decision-making in the clinical context (which includes both CDM and EDM) is pre-exposure to similar cases experienced in similar circumstances.

In the nursing literature, Patrica Benner's work (2001; 2021), drawing on that of Dreyfus' on skills acquisition, is particularly notable for the use of intuition by the

expert nurse. Given the inherent ties between nursing work and morality, it is likely that such intuition includes that of EDM. Much has been published about nursing intuition, at least in the civilian context, with some supporting and others denying its place in EDM. A mixed-methods study by Rosciano et al. (2016), for example, found that intuition plays an important part in nurses' ethical and clinical decision-making. They state that this is characterised by physical sensations such as nausea, a 'lump in the throat', and hair 'standing up' on their arms or necks (which links neatly with P013's description of a 'gut feeling'), as well as emotional and spiritual awareness. A similar study by Melin-Johansson et al. (2017, p. 3936) found that intuition "*is more than simply a 'gut feeling,' and it is a process based on knowledge and care experience and has a place beside research-based evidence*." They continue to say that by analysing and synthesising 'intuition' alongside objective data, nurses can improve patient outcomes through optimised decision-making (Ibid.), which I interpret to mean for both ethical and clinical decisions.

This perhaps explains why many hospitals, including internationally, now include a free text section on their Early Warning Score (EWS) documentation, of which there are many variations. Ansell et al. (2015) suggest that this section allows nurses to apply their subjective clinical reasoning, judgement, deliberative rationality and critical thinking (including ethical deliberation) to a deteriorating patient's clinical condition (See also e.g., Haegdorens et al., 2023; Le Lagadec et al., 2024). This is assessed in tandem with objective data such as temperature, pulse, and blood pressure etc. and is recorded on the EWS chart. This section can record, for example, whether a nurse is subjectively 'worried / not worried' (Douw et al., 2017), or offer the option for a nurse to adjust an aggregated EWS based on physiological

measurements using their judgment to create an Individual EWS (Nielsen et al., 2022). Indeed, Coulter Smith et al. (2014) state that objectively derived EWS in isolation cannot be a replacement for clinical (and by implication, ethical) judgment at the bedside, which may explain why the authors above refer to the importance of 'intuition' in nursing assessment. This addition to the EWS allows nurses to routinely enact their judgment and make prudent ethical decisions to escalate care where the objective data alone does not support it. Military nurses do not have this option with the current FMed 828 (military Field Nursing Card), as they do not contain an EWS system. Adopting this nursing assessment model into 'business as usual' may also go some way to overcoming the barriers to nurses exercising moral courage that some of my participants described, of hierarchy and associated power differential, when deciding whether to escalate a concern.

As alluded to above, many of my participants felt that relying on their own experience and 'intuition' to make ethical and clinical decisions on deployment was preferable to following written guidelines and policy. Interestingly, this attitude did not differ much from their civilian practice, although they felt there was better decision-making support in the NHS environment. Further research is warranted to examine nurses' attitudes towards perpetuation of the concept and role of intuition or 'sixth sense' in the EDM of clinical care. This is important because there is a narrative tradition in nursing of sharing intuitive, experiential knowledge through a 'storytelling' culture (Gould, 2017), with Carper's (1978) taxonomy of knowledge referring to intuition as the basis of the art of nursing. This would be enlightening to explore among military nurses, given the unique context in which they deliver nursing care, and could provide a useful further contribution in understanding EDM among military nurses.

The International Council of Nurses (2013), in their most recent revised statement on the scope of nursing practice, says that nurses worldwide should be aware of and prepared to work within their scope of practice. Certainly, in the UK, it is part of the 'preserving safety' section of the Code of Conduct for nurses (NMC, 2018), of which section 13 is "*recognise and work within the limits of your competence*". This directs nurses to work within the boundaries of their competence (or scope of practice). Para. 13.3 says a nurse must "*ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence*" and para. 13.5 says a nurse must also "*complete the necessary training before carrying out a new role*". The context of serving in a field hospital in a remote location, and in a combat zone, raised ethical issues for participants around working within their scope of practice, particularly ANPs. For example, many expressed their alarm at having to care for paediatric patients, for which they were neither trained nor experienced, making them uncomfortable with the idea of exceeding their limits of competence and compromising their ability to do the right thing.

Regardless of this, military nurses will sometimes feel compelled to exceed their peacetime boundaries by the circumstances or context of their situation. Finnegan et al (2016a, p.457) explain this by suggesting that while civilian nurses can utilise a 'personal continuum' to choose the specialities in which they are comfortable working, "*military nurses are not offered this luxury and have to face whatever comes their way*." My participants cited several reasons for feeling compelled to work beyond their normal scope of practice, considering factors (which I have synthesised in the interests of accuracy, brevity, and clarity) such as:

- Acknowledgement that ‘There's no one else to do it’, i.e., scarce resource of personnel, especially amongst ANPs deployed far forward.

- The ethical principles of beneficence and non-maleficence, wanting to actively do good for and prevent further harm to their patients regardless of circumstance (i.e., doing the *right* thing, not the *easy* thing).

- A feeling of fatalism or inevitability, e.g., ‘This was bound to happen, but it's got to be done regardless of circumstance, or the patient might die’.

- Self-justification to assuage their ethical conscience, e.g., ‘Surely an adult trained nurse looking after this child is better than no nurse at all?’

- Acting out of empathy or compassion for children and their family.

- Following their own closely held and developed internal codes of ethics or religious motivations.

There was a suggestion in the findings that some Medical Services Officers (MSO; non-medical administrators usually in a command role) perpetuated the notion that professional governing body rules and domestic law did not apply to nurses on combat deployments. This is of concern, because from my own experience, the nurses subordinate in the chain of command may take those words as a directive which erodes or obscures the boundaries of their regulated scope of practice. This would have left them open to the risk of at best, professional sanctions, or at worst criminal prosecution based on orders from a military commander with no idea of professional regulation. Yet in the military context, in addition to being a protective mechanism, creating the conditions for the ethical success of military nurses (Agazio and Padden, 2024), and indeed all soldiers, is a basic command and leadership responsibility (MOD, 2021b).

This is also important in the civilian context, with the literature highlighting the

requirement for nurse leaders to set the organisational ethical climate to best support their nurses in ethical practice (See e.g., Stucky and Wymer, 2024; Miller et al., 2024; Birkholz et al., 2022). This has been shown to be a duty embraced by the more senior Nursing Officers taking part in this study. As reported by my more junior participants, failure to protect or support nurses in ethical practice engenders mistrust of commanders, or even feelings of being 'betrayed' by the senior leadership. This is reflected in civilian practice, particularly during the Covid pandemic, with one study reporting that around a third of their healthcare respondents felt betrayed by their leadership (Park et al., 2024). This was directly related to a rate of almost 50% and 38% of mental distress and post-traumatic stress disorder symptoms respectively amongst this 'betrayed' group (Ibid.). Feelings of betrayal based on a perception of being forced into unethical, dangerous, or morally unsafe practice could exacerbate the prevalence of moral injury or moral distress in nurses (Greenberg et al., 2020). This could lead to burnout (French et al., 2021) or perpetuate feelings of disgust, shame, or guilt in nurses (Williamson et al., 2020) leading to diminished ethical efficacy and increased moral uncertainty in the nursing team (Brewer, 2021).

One military-specific document which caused a great deal of angst amongst deployed nurses was the Deployed Operational Nursing Competencies (DONC). The DONC, introduced in the findings chapter, is another example of the different values and standards to which military nurses are held. It is a form of written guidance that all deployable military nurses must adhere to (Beaumont and Allan, 2014), even in their practice within the NHS in the firm base, that their civilian counterparts do not. My findings demonstrate that the DONC is widely ridiculed as just another 'hoop to jump through' to satisfy PDT requirements. Many participants used unambiguous

words to convey the depth of their disdain for the DONC, such as ‘hate’, ‘rubbish’, and ‘unbelievably bad’. This is in concordance with findings from a recent empirical study conducted by Hughes (2024), which examined non-technical competencies required for operationally deploying UK military nurses.

My findings showed that a key driver for nurses to complete the DONC is financial, because it attracts a pay enhancement. This corroborates findings in a study conducted by Finnegan et al. (2015), who state that this meant the work to achieve accreditation was often hurried, with poor levels of scrutiny and integrity in the assurance process. Regardless, it seems that the perceived utility and relevance of the DONC is poor, perhaps more so than that of other professional codes and guidelines. The document itself has had many iterations as the changing character of conflict has led successive Defence Nursing Advisors (the DMS equivalent of a Chief Nursing Officer) to try updating and contextualising it to make it more relevant. This remains an ongoing process.

The DONC contains many specialist sections built around a foundation of generic ‘core competencies’ which try to address specific operational concerns and key operational nursing skills. In terms of ethical and legal competencies, previous iterations of the DONC focused on issues which do not really amount to an understanding of the likely ethical challenges which may be encountered in operational clinical nursing practice. These competencies included e.g., how to treat war graves and human remains on deployment, and protection of the chain of forensic evidence. There were no explicit ethical learning objectives or competencies, so it was difficult to assure the chain of command that deploying nurses were

ethically aware, competent, and confident. As my participants stated, nurses often forgot these competencies were a part of the DONC document in the first place. This implies that in the past, Defence Nursing either did not place much importance on preparing military nurses for ethical deployed practice, or the authors of the DONC were unsure of what ethical competencies nurses required.

There is still not much content within the current iteration of DONC which pertains to EDM. However, a new section in the latest version released in November 2021 contains implicit competencies around applying the MRoE and the difficulties and consequences of non-adherence. These are situated under the broad umbrella of core knowledge required to 'Adapt the role of a RN(A) as appropriate within a Medical Treatment Facility' (MOD, 2021a). This appears to be the only concession to nurses' ethical awareness on operational deployment. DONC still fails to address EDM in routine nursing practice as well as other practical concerns over its content, so is viewed as unfit for purpose and of little practical help to nurses 'on the ground' in this regard (Hughes, 2024). While much of the regular (i.e., full time military personnel) participants' thoughts about the DONC were in this negative space, there were specific concerns raised by participants around its use in the reserve forces.

As stated in the findings chapter, reservist nurses are not full-time military personnel. They are employed on a part time basis, often working full time in the NHS or private practice. However, they held a particular aversion to completing the DONC due to the complexities of achieving 'sign-off' in all elements while working full time in the NHS. There were two specific concerns raised by my participants around reserve nurses and the difficulty of DONC completion - over-qualification, and the lack of

understanding of the military operational role by their civilian nurse managers who need to ‘sign them off’ as competent. For example, even though (in a typical situation) a reserve nurse may be more highly qualified in a particular skill or area than the DONC requires, it still requires adherence to its ‘tick-box’ format. This forces the individual to undertake specific online or practical teaching and assessment on a topic he or she could or does teach, often at a much higher level, in the NHS. This is in the name of justifying their ‘operational competency’, as it does not ask for or recognise ‘higher-than-DONC’ level qualifications in lieu of completing the military training. Perversely, using this rationale, ‘operationally competent’ often means to be less qualified and skilled than ‘NHS competent’ in the same role.

Reservist participants working in the NHS also expressed frustration at trying to get all elements of their DONC, an operationally focused military document, signed off by civilian nurses. This is because civilians simply do not, and cannot understand the operational military context unless they have experienced it. Unfortunately, this is often the only option for a professionally qualified reservist to get the practical element of their DONC signed off - by asking a civilian senior nurse to do it. This can cause issues because civilian nurses will not always understand the clinical or EDM frameworks of military nursing. They also may not recognise military terminology or abbreviations, or know the equipment they need to be assessed on, potentially leaving assessment to be completed in simulated and stressful conditions at HOSPEX (a large-scale hospital exercise) or similar immediately prior to deploying (Finnegan et al., 2015).

The problem is compounded for reservist nurses working in a non-clinical

environment (Ibid.). This could lead to a delay in DONC completion, and could cause associated problems with pay or deployment readiness for reservists. These issues can then present an ethical dilemma for units. If their nurses cannot get all their DONC completed prior to deployment, the chain of command may choose instead to deploy them ‘at risk’ to ensure that all deployed roles are filled, despite knowing they are not strictly fully prepared to do their job on arrival (Hughes, 2024). This defeats the purpose of the DONC, which is to prepare nurses to deploy operationally. As mentioned above, and perhaps in preference over the DONC, this study demonstrates that CBL is a recommended way to prepare military nurses for EDM on deployment. This will be discussed in greater detail below.

One central aspect of at least consequentialist thinking, and the Kantian notion of respect, is impartiality and its importance for morality. However, this idea is much more contested in neo-Aristotelian virtue ethics and communitarian criticisms of impartiality. As well as being patient focused and doing things for the right reasons, the idea that EDM should be impartial was raised by many participants. However, the detailed and contextually limiting factors to EDM forming the second theme below show how difficult military nurses found this to uphold in deployed practice.

The deployed context influences the EDM of military nurses (Theme 2)

Providing healthcare to military forces and civilians during conflicts and humanitarian and disaster relief operations presents multiple challenges, far removed from routine NHS practice for military nurses. This was apparent right from the start of my fieldwork. My first participant, from her perspective as an operating theatre nurse for example, referred to the work schedule and relentless pressure experienced on an

operational tour and how it affects staff. The norm was living in austere conditions and working 12 to 16 hours a day, operating on patients with complex ballistic trauma injuries and experiencing frequent mass casualty incidents. This was the routine every day until handing over and returning to the UK three to six months later, depending on tour length. She uses the phrase *"we literally were slaughtered that first time [on tour]*" (P001).

This correlates with my experience in the field hospitals of Iraq and Afghanistan. There is no resilience for MTF personnel on tour, they have only the teams and supplies they deploy with. In combination with living with the constant sense of personal danger (Kelley et al., 2017), this would make it easier for military nurses to be susceptible to or experience emotional, caring, or compassion fatigue and burnout (See e.g., Kraemer, 2008; Gibbons et al., 2012; Ormsby et al., 2017). The importance of context in EDM is also easily illustrated based on the military platform in which care is being delivered. For instance, whether it is in a pressurised aircraft at 30,000 feet, a tent in the desert, or on board a warship, the SOP for patient evacuation (e.g., in the event of a fire) will necessarily be different. This may prompt different EDM processes between platforms, based on what is achievable and what is not.

In a tent in the desert the canvas walls can be cut through quickly (emergency knives are even provided in each tent space) and immediate evacuation can easily be achieved for patients and staff, as the patients could be on stretchers or wheeled beds. In a pressurised aircraft in flight, the options are clearly much more limited and urgent. The same is true of warships, which sailors refer to as 'floating bombs' because they are packed full of explosive, flammable, and other hazardous materials

in close quarters. This is particularly true of the UK's Role 3 Primary Casualty Receiving Facility on board the RFA Argus, which in addition to a fully stocked hospital complete with piped medical gases etc. holds a lot of ammunition, aviation fuel and aircraft, as well as marine diesel due to its dual role as an aviation training ship. The context is what drives the EDM in these situations of emergency in the deployed environment, involving decisions on whether to try and rescue patients as well as healthcare staff.

During its existence since the end of World War II, the World Medical Association (WMA) has produced several high-profile Declarations, Resolutions and Statements on wide-ranging medical topics. This includes an international code of medical ethics and some 'regulations' for doctors to follow in times of armed conflict and war (WMA, 2012). By extension, this includes nurses as medical treatment is typically ordered by doctors in such situations, and nurses administer it. As stated in the findings chapter, the 'regulation' of interest read, "*Medical ethics in times of armed conflict is* ***identical*** *to medical ethics in times of peace*." (Ibid., p.1, my emphasis.) The WMA (2023, para. 10) has since softened its stance, reissuing the 'regulation' document as a 'statement' and amending the phrase above to now read more circumspectly: "*During times of armed conflict and other situations of violence, the ethical standards of the medical profession apply as in times of peace*." However, as this statement was released after data collection and initial analysis had occurred, my participants' responses are limited to the 2012 WMA 'regulations'.

The strength of rebuttal received when I asked participants what they thought of this 'regulation' demonstrates that context in EDM is a critical issue for military nurses. It

is neatly encapsulated in the sentiment expressed by P012, who said in relation to deployed EDM, "*We have to think of the context within which we operate*". Synthesising this with many other responses, I have interpreted this to mean that contrary to the WMA 'regulation', participants instead agree with the *principle* behind the WMA statement that ethical standards *should* apply equally in both conflict and peace. However, they also accept that pragmatically, this is difficult to achieve given the constraints and contextual differences between the two. In short, my participants almost universally agreed that the military context has a direct influence on EDM and impartial care, and challenge of the 2012 WMA statement seems to be the crux of their arguments:

> *"When you're in a war zone, you do things that you wouldn't normally do in NHS practice. […] I just don't think you can compare the two [contexts], I really don't. I think they're so different."* (P027)

> *"It's apples and pears. They are not the same, you cannot compare the two."* (P028)

It is these contextual and ethically constraining factors, and how they can influence EDM in military nurses, that will now be discussed.

The importance of context

A few participants reported feeling more involved in EDM in the NHS than in the deployed military space, because they believed their voices were heard more in that context. Comments were made about their work in the NHS environment, where managers, ED nurses, and doctors know each other so well after working together for so long that they are a fully integrated team, which made decision-making feel easier. This is also reflected in the literature, for example, in a recent report written for

the General Medical Council examining supportive teamwork in the NHS. This states that to improve decisions, patient care, and patient outcomes, "*there is a need for all professions to build familiarity, have continuity and build lasting relationships, rather than constantly working in teams with people they have not met before*" (Crampton et al., 2023, p.22). Moreover, a randomised controlled trial conducted by Iyasere et al. (2022) involving over 120 doctors and nurses found that increased familiarity and good working relationships in the care team translated to improved team performance, and an increased likelihood of nurses being involved or speaking up in the EDM process (Mawuena et al., 2024).

On this basis, my participants claimed that EDM in the NHS is therefore more likely to be a collegial activity than in the deployed context, based on their experience of the military practice of relying on the decisions of a single doctor or one limited professional group. This is interesting, because collegiality has its roots in the Roman practice of sharing decision-making responsibility equally amongst officials to prevent one member gaining power over the others (Burr et al., 2017). If the collegial approach failed, it would have created a hierarchy as exists in the NHS and the military today (Pearce et al., 2021), representing a potential barrier to effective decision-making.

Collegiality, translated to contemporary firm base practice in the NHS care teams in which military nurses routinely work, means leaders encouraging a flatter hierarchy, resulting in a reduction of barriers to open communication between team members of all levels (Green et al., 2017). Collegiality also means co-workers making shared clinical and ethical decisions grounded in the trust, respect, and support of

professional colleagues (Edmonstone, 2020). Participants described a mixture of EDM mechanisms in which they were involved on operational tour, with some collegial in nature. However, more reported EDM in hierarchy-based terms. This perhaps explains why participants feel more comfortable with the NHS decision-making model, which champions a flatter professional hierarchy. Collegial decision-making also came up in the first theme as a way of reducing paternalism and keeping the patient central to decision-making.

In contrast, UK military teams are subject to a strict hierarchy and are rarely used to working together, especially with deploying international colleagues. This is due at least in part to the geographically disparate nature of military nurses' peacetime NHS practice. In these situations, there is limited opportunity for teams to work together before deploying, and even less opportunity to conduct familiarisation training with international partners beforehand. Both factors reduce team decision-making performance (Moore and Geuss, 2020). It leaves very little time for commanders to discuss and prioritise critical issues like EDM policy and process, both in the various clinical departments and overall, which can cause uncertainty and friction 'on the ground'. This makes collegial EDM, at least based on teams being familiar with each other, potentially challenging until later in a tour. This led to the DMS creating a hospital exercise (HOSPEX) designed to familiarise teams with each other for a few weeks prior to deploying on the basis that, according to Chung (2021, p.52), "*teams that lacked this type of pre-deployment preparation required weeks to months to learn how to work together*."

The findings demonstrate, though implicitly rather than explicitly, that nurses perceive

this phenomenon of military healthcare teams' unfamiliarity with each other as a barrier to EDM and moral agency. It also represents a loss of the social interaction support mechanism, borne of the bonds of familiarity, that these nurses would have had as part of their personal resilience. Therefore, it would appear to be accepted by some participants that EDM in the NHS peacetime context is a more positive experience for nurses than EDM in the deployed context, and this is largely reflected in the literature (See e.g., Davies et al., 2022; Finnegan et al., 2016a; Kelly, 2013).

As mentioned in the introduction, in the military, deployed care is doctrinally considered to be 'consultant-led' by the DMS. This was specifically (and in somewhat bitter terms) reported by some participants, which left them feeling like their voices were not worth listening to in the EDM process on operations. It led to them describing feeling 'shut down' or otherwise excluded from EDM before they even got the chance to state their opinion. This is contrary to the collegial working environment participants reported experiencing in the NHS. Their inference, through their comments, was that the higher the military rank of the decision-maker, the more influence they have over EDM and ethical action. These synthesised comments from across the whole dataset mean that participants believe that nurses, junior NCO nurses in particular, do not have an equally 'valid' ethical opinion as more senior ranks (usually consultants, but sometimes also senior nurses) in the military context. In the NHS, however, such 'rank' disparity was not thought by participants to be so much of an issue for EDM.

This is a surprising finding, given that the NHS is also a hierarchical organisation that favours the decision-making of doctors, who traditionally wield the most influence due

to their ‘rank’ and position. This was highlighted in a 2014 consensus statement on the role of the doctor by several high-profile organisations such as the Academy of Royal Medical Colleges, NHS Health Education England, the British Medical Association, the King’s Fund, and the General Medical Council. This states that “*doctors alone amongst healthcare professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well-developed clinical judgement.*” (Medical Schools Council, 2014, p.1).

But it is important to bear in mind the discussion from theme 1 about the relation between expertise in CDM and that of EDM. It is one thing to know the clinical facts, but such facts are often entangled with values. This could suggest that doctors should assume the role of ethical decision-maker, having the technical knowledge of such evaluative facts, but it is unlikely that any one person has such moral expertise. And as far back as the mid-1980s, nurses, as well as bioethicists, philosophers, and legal scholars have been questioning whether it is morally right that doctors should be the majority ethical decision-maker (Murphy, 1984) and have “*the power to overrule the objections of a competent patient or nursing member of staff*” (O’Neill, 1997, p.74). *Inter alia*, the influence of military rank and position on military nurses’ experience of EDM is discussed in the next section.

Dual loyalty conflict (DLC) and the Medical Rules of Eligibility (MRoE)

Nurses who are deployed on combat or humanitarian missions typically face an interesting set of ethical challenges when navigating their daily practice. One of these is dual loyalty conflict (DLC) and another, which is closely related, is the Medical

Rules of Eligibility (MRoE). Gross (2008, p.1) states that MHCPs, including nurses, are an "*integral part of their nation's war-making machine*". In being so, their primary role as a nurse is often subject to pressures and influence from out with the healthcare field in the name of 'military necessity'. DLC is therefore an ethical conflict commonly experienced by nurses and other MHCPs on deployment which is a result of having to divide their loyalties. On one hand they have the obligations (real or perceived, expressed or implied) of their healthcare profession and to their patients (Atkinson, 2019), and on the other they have obligations to a third party, in this case their service as professional military personnel (Olsthoorn et al., 2013). This represents something of a 'clash of oaths', and trying to answer to two, sometimes opposing, masters can produce competing ethical tensions which the nurse must try to resolve, leading one of Agazio and Padden's (2024) study participants to call the duality of a military nurses' role 'very cruel and unkind'.

As described in the findings, many of my participants either explicitly or implicitly spoke of the moral challenges they experienced through DLC when delivering nursing care in a war zone or humanitarian disaster. Most commonly, their recollected feelings e.g., guilt, anger, shame, or feelings of professional betrayal by the chain of command seemed to perfectly describe moral distress as defined by Jameton (1984) in his seminal work in the field, with some commenting on the enduring psychological effects even across many decades. After significant reflection, this matches with my own deployed experience. As discussed above, rank pressure exacerbates the influence of DLC in EDM, with the findings demonstrating that this is an issue of considerable concern to my participants when it comes to deployed EDM.

This DLC concern may be at least partially explained by Chamberlin (2013, Para. 34; my emphasis), who says that the "*internal morality of **medicine** demands patient-centred consequentialism, driven by beneficence and non-maleficence.*" This means that HCPs are ethically obligated to act as advocates for their vulnerable patients and do their best to cure them, or at least alleviate suffering to the best of their abilities. She then goes on to state however (Ibid., my emphasis) that the "*internal morality of the **military** demands the protection of the nation, service to your fellow soldier, and an obligation to a mission-first mentality.*" A morally problematic situation identified in the findings is illustrative of such DLC concerns, that of military nurses ordered to undertake combat-related duties e.g., guarding operational bases or operating heavy machine guns in vehicle patrols.

Several participants described being compelled by the chain of command to undertake combat-related duties like those referenced above while deployed as nurses. This situation caused a significant and conscious DLC for some, which a few seemed to consider a betrayal of their non-combatant status as a nurse. This phenomenon was also commented on by Lundberg et al. (2019) who found that amongst deployed Swedish military nurses, and as discussed in theme 1, some would respectfully challenge or 'intelligently disobey' such orders (MOD, 2021b). This, however, did not seem to occur as a valid option to any of my participants. Lundberg et al. (2019) reported that some nurses' refusal to take up arms offensively rather than purely in defence of themselves and their patients (which the Geneva Conventions (ICRC, 1995) allow specific provisions for) was based on observing their professional regulatory code and principles of International Humanitarian Law (IHL). Others, however, would simply do as they were told because they believed that IHL

did not apply to them during their deployment (Lundberg et al., 2019). This is an echo of the non-medical Officers who told UK military nurses their regulatory body rules did not apply on deployment, which was mentioned above in theme 1.

This is morally problematic because military nurses are operationally employed as non-combatants, and are entitled to wear the Red Cross symbol as they fulfil a protected role governed by IHL and the Geneva Conventions. If a nurse chooses to remove the protections of their non-combatant role, as one of my participants (P004) explicitly mentioned having to do, they become a legitimate military target. This is enshrined in customary IHL, with Rule 25 stating "*Medical personnel exclusively assigned to medical duties must be respected and protected in all circumstances. They lose their protection if they commit, outside their humanitarian function, acts harmful to the enemy*" (ICRC, 2025). Chamberlin (2013, para. 34) concludes that serving as a MHCP is "*a morally problematic predicament, and a unique feature of the moral landscape of military medicine*."

DLC is not a phenomenon restricted to military nurses, however. Nurses working within the NHS and other 'closed areas' such as prisons and psychiatric institutions may also face DLC (Atkinson, 2019). However, this does not typically involve choosing the prioritisation of different professional identities, which demand different and sometimes contrary actions, like in the military nurse context. In their empirical study, Trapani et al. (2016, p.2468) found that "*nurses' dual agency relationship with patients and doctors may deter their moral obligation of keeping patients' interests their utmost concern"*, or doing the right thing for their patients, in the right place, at the right time. I reported in theme 1 that this was my participants' main perception of

what EDM is. For civilian nurses, navigating DLC seems to be less complicated than for their deployed military peers. This, *inter alia*, may be due to the wide multidisciplinary support network open to civilian nurses, who generally practice in less restrictive conditions, and therefore enjoy greater freedom to make decisions for themselves. This is because in the civilian practice context, they are not subject to the constraints borne of military necessity like their military peers, which can be "*a big and decisive hammer*" (Gross and Carrick, 2013, p.5) in deciding dual loyalty conflicts on operations. As one of my senior participants says, *"There's always going to be that ethical tension…that unavoidable collision between being a nurse or being a clinician and being a military officer."* (P021).

The DLC between professional identities in being a nurse in the military context was not lost on my participants, and the findings show that some had a reasoned and defined view of their professional identities in light of it. Highlighting the professional military identity, Madden and Carter (2003, p.271) state that the remit of a country's armed forces is "*defending members of a society by becoming directly involved with activities leading to the wounding or death of others."* Despite this, professional, civil, and criminal controls have long been in place to prevent MHCPs from being involved in such activities, leading to an interesting discussion with many of my participants. This is a classic example of a DLC as alluded to above - attempting to answer to two masters: the profession of nursing, and the profession of arms. The goals of the former are to heal, care for patients, and save life while the goals of the latter justify applying controlled violence to achieve military victories. As Lundberg et al. (2019) observed, the two are not always easy companions. This is because the two 'masters' which MHCPs serve (their chosen healthcare profession and the

‘profession of arms’) do not always agree on the ethical course of action to take in every situation (Atkinson, 2019; Meyer et al., 2021). As reported in the findings, for my oldest participant (P016), there is no internal professional conflict – the prioritisation of her professional nursing identity is clear. Despite serving as an Officer in the PMRAFNS, she does not identify as a military nurse, but as a nurse who happens to care for Servicemen.

For some participants, however, the distinction between which identity takes precedence between ‘nurse’ and ‘military’ is not as clear. This identity struggle may be because, as Eagan and Lederman (2022, p.95) comment (with me substituting the word ‘doctor’ with ‘HCP’ to reflect the wider care team), being an HCP in military service “*confers two sets of obligations on a single moral agent and ushers in a foundational ethical tension: are these moral agents [HCPs]? Soldiers? Both? And if both, which role is primary?*” In the literature about dual loyalty in military healthcare delivery, authors seem to prioritise healthcare professions over the military, using the term ‘physician-soldier’ to describe the role of a doctor serving in the armed forces. This trend was common amongst both academics (See e.g., Eze and Innoeze, 2024; Chamberlin, 2013) and those with lived experience as a MHCP (See e.g., Vaidya and Bobdey, 2021; Quinn and Wilkes, 2020), including a few concurring participants from this study. Occasionally, the term is weighted the other way, reversed to ‘soldier-physician’ (See e.g., Madden and Carter, 2003; April et al., 2017).

The same could be true of the terms ‘nurse-soldier’ or ‘soldier-nurse’, or indeed any other interchangeable MHCP (e.g., Operating Department Practitioner-soldier, Physiotherapist-soldier etc.). However, I could find no evidence of these terms, as I

mean them in the dual loyalty sense at least, in the academic literature, so these might both be novel terms in this context. I could find only two references to the term ‘soldier-nurse’ in the literature, both over a century old. The first was in a letter to the editor of the British Medical Journal (BMJ, 1894) lamenting the lack of ‘lady nurses’ to care for British soldiers in India (like my oldest participant P016, nurses who care for service personnel – ‘soldier nurses’ in the literal sense). The second was a valedictory piece, written after her death, about Florence Nightingale being the first nurse dedicated to caring for soldiers - again, a literal ‘soldier nurse’ (Hoff, 1911).

These terms are interesting because in basic military training, certainly in the UK from what some of my participants explicitly reported in the findings, MHCPs are told they are to think of themselves as service personnel first and foremost, and as healthcare professionals second. This also matches my own experience of both Army and Royal Navy basic training. Indeed, Henning (2009, p.84) states that “*it is often said that a military doctor is ‘an officer first, a doctor second’*”. This is perhaps in line with core Army values, which include ‘loyalty’ and ‘selfless commitment’, and something Henning (Ibid.) says if true, would present MHCPs with little in the way of conflict in some common ethical decisions, such as whether to treat civilian patients on deployment.

Selfless commitment, the Army says, translates to ‘mates and mission first, me second’ (MOD, 2024c), from which I infer that to the Army, the term would most appropriately be ‘soldier-nurse’. However, very few of my participants observed and accepted this ‘military first’ distinction in their own professional identities, and those few were nurses who had previously served in another, more combat-oriented

regiment before retraining as nurses. More participants preferred to think of themselves instead as ‘nurse-soldiers’, and preferred to try and find ‘workarounds’ in their EDM to defeat ethical constraints. A few others would internally switch the primacy of each identity, nurse and soldier, depending on the context of the situation. This implies that the militarisation phase of basic training is failing to influence military nurses’ psychological mindset away from prioritising their professional obligations, or ‘patient-centred beneficence’, and towards their military ‘mission first’ duty (Eagan and Lederman, 2022).

The term ‘physician / nurse-soldier’ captures the duality of professions and evokes a clear separation of the two roles, with some authors ironically using it as an oxymoron when discussing DLC, implying the mutual exclusivity of the roles. For example, Schwartz (2007, p.715), in a commentary, believes that acting as a nurse and a soldier at the same time is not ethically possible as the two professions are completely different, and that “*perhaps to do so is even reproachable*.” Similarly, Parrish (1972), recounting his experiences as a junior medic during the war in Vietnam, states in absolute terms that a nurse or doctor cannot be a soldier as well because the two professions have entirely different values. Indeed, Gross (2004) emphasises the distinctness of military ethics from ordinary ethics.

However, this is not say there is no ethical justification for war. There does seem to be a consensus which perhaps following Aristotle (and Aquinas’ use of Aristotle) that there can be a moral category of ‘just wars’ using the principles of *jus ad bellum* (the legal justification for states to go to war) and *jus in bello* (the just means of waging war, also known as the laws of armed conflict or IHL) (Gross and Carrick, 2013;

Bricknell and Miron, 2021). This might explain the lack of scholarly work explicitly claiming ordinary ethics and military ethics are completely distinct. Rather, it might be a case of ethical relativism in a strong sense understood as both having a normative ethical code and there being no way to compare them (Whetham, 2008). This will be problematic for EDM by military nurses who may seem to have two incompatible role obligations.

My findings show that some of my participants, instead of struggling to separate their military and nursing professional identities, embraced their military rank and experience as it made them feel more confident to make the optimal ethical decisions aimed at doing the right thing for their patients. This led to some limited discussion with my participants around how to manage conflict between a nurse of a higher military rank and someone of a lower rank, but with greater or more specialist professional nursing experience. Several participants described military rank often taking precedence in these situations, which they themselves had experienced. This may be explained, at least in part, by militaries employing nurses and doctors typically having those HCPs swear some form of oath of allegiance[2] upon enlistment to ensure they are aware of the expected balance of their loyalties. In the UK, nurses and doctors pledge loyalty to the monarch[3], to obey the orders of the Officers appointed over them, and to defend their countries (MOD, 2021c). In doing so, Eagan (2019, para. 7) states that they are then "*bound to the unique professional*

[2] In the UK, one is Christian, 'I swear by almighty God…', and the other suitable for all beliefs, 'I do solemnly, sincerely and truly declare and affirm...'.

[3] The oath of allegiance sworn by nurses and doctors is identical to the one sworn by non-medical military personnel. For the latter group, this oath creates no dual loyalty conflict.

morality of military service."

On the other hand, the various forms of professional oath or promise that many nurses and doctors may pledge when qualifying (albeit without the force of law), along with their professional guidelines, boil down to working solely in the interests of their patients and giving preference to that relationship (Olsthoorn et al., 2013). As earlier discussion confirmed, this is the expected obligation for nurses and doctors through their professional body guidelines, IHL, and domestic law. Eagan (2019, para. 7) also says that a professional oath or promise "*confers an impact obligation to act according to professional [healthcare] morality.*" Conflicting loyalties are most likely to arise for military nurses when trying to observe these two different ethics.

The WMA (2012) regulation discussed above, for instance, states that healthcare providers must give required care impartially, and that "*if, in performing their professional duty, [MHCPs] have conflicting loyalties; their primary obligation is to their patients*" (p.1). Further, it states that "*standard ethical norms apply"* (p.2) in military deployed service. Borow (2010, p.172), in a commentary, dissents - declaring that healthcare ethics are not identical in war and peace for two reasons: *"First, the hallmark principles that drive bioethical decision-making in ordinary clinical settings are largely absent, and second, the principles of contemporary just war may simply override bioethical concerns."* (and see Gross (2004) for a similar view).

This *inter alia* alludes to a unique principle of military healthcare in conflict, the morally contentious concept of reverse triage. This is only invoked in the direst of circumstances, and entails MTFs prioritising treatment for the most lightly wounded own-force casualties before tending to their more seriously injured compatriots or

those from other patient groups e.g. CPERS, to prioritise their rapid return to the fighting. Perhaps unsurprisingly, this is why none of my participants have described experiencing this phenomenon in practice during their deployments - a lack of suitably dire circumstances. A prime example of reverse triage in action is Churchill's use of penicillin in World War Two, a drug which was in its infancy and in very short supply in 1943. He opted to authorise its use only to treat troops with highly infectious venereal disease, contracted in 'celebrations' after winning the North Africa campaign, instead of those with wound infections from more significant ballistic injuries sustained during battle. Doctors knew that penicillin could quickly cure venereal disease, but its efficacy was still relatively unknown in trauma wounds (See e.g., Baker and Strosberg, 1992; MacFarlane, 1985). He did this so that they could bolster dwindling troop numbers for the planned invasion of Sicily. This is a prime example of DLC caused solely by military necessity. The high level of decision-maker needed in this case, i.e., the Prime Minister, is indicative of the high political and reputational risks of making such a decision, which runs contrary to the ethical principles of modern IHL and the WMA (2012) 'regulation'.

On the occasions that a conflict between professional healthcare and State interests occur, as decided by the (typically non-medical) military commanders on the ground, they can often cause individual nurses to involuntarily violate principles of their personally held code of ethics (see the related discussion above on moral distress). This is a situation which will be discussed in greater detail below. This makes military necessity morally problematic for military nurses, because as discussed in theme 1 their motivations are generally about prioritising patients' best interests or other similar moral goods, even if they are constrained from applying them in practice.

Gross (2006) is of the opinion that war transforms healthcare ethics. This is because, as stated in the introduction to this thesis, the situations that civilian nurses encounter in their practice are typically vastly different to the situations military nurses regularly experience. Civilian nurses can generally prioritise the best interests of their patients, unfettered by restrictions or constraints beyond the sphere of influence of professional healthcare ethics (Finnegan et al., 2016a). Military nurses, with their dual roles and obligations, cannot always guarantee to act in the best interest of every patient without incurring greater risks to themselves, their colleagues (Olsthoorn et al., 2013), or their organisation. This has been borne out by my findings, with many participants reporting significant constraints on their EDM and ethical actions because of the DLC inherent in serving as a military nurse.

This is a significant point, because Chen et al. (2023, p.935) found in their scoping review, and Wilson et al. (2020) concur, that "*the dual role of nurse and soldier was the most fundamental cause of […] core moral values that conflict with each other. […] This conflict is so intense and inescapable that it leads individuals to reflect on leaving the military altogether.*" Indeed, the moral distress felt by military nurses from decisions based on their conflicting dual loyalties and obligations has an enduring effect which may still be felt decades later (Norman, 1989). This is a phenomenon corroborated by several of my older participants, perhaps none more so than my oldest participant (P016) who at 88 years of age emotionally described the shame and guilt she still felt "*as though it were yesterday*" relating to one such care decision taken over 60 years previously.

Another way to view the problem of DLC for military nurses, seen in my findings,

relates to concerns regarding senior military personnel who are neither trained nor employed to deliver healthcare being placed in positions of command in medical units. They have significant decision-making power, which my participants have shown can directly influence clinical care and MHCPs' EDM, often in the name of 'military necessity'. My participants expressed alarm at the ramifications of the different approaches to EDM in healthcare between MHCPs, such as doctors and nurses, and non-medical administrative personnel such as Medical Services Officers (MSO). MHCPs are registered with a professional body and are accountable to their professional guidelines and obligations, while MSOs are not. The literature demonstrates that this is not a new phenomenon, which Eagan and Lederman (2022) report has been discussed by MHCPs as far back as the First World War. Indeed, they go on to say (Ibid., p.96) that as well as trying to observe their healthcare-related ethical obligations, MHCPs were "*also subject to military hierarchy, where they were often outranked by men with no medical training and had to adopt an almost utilitarian framework in order to "maintain the fighting force"*."

Participants referred to the perceived 'cavalier' decisions made by MSOs, who are not accountable to an external body for their actions - only to the military (Bricknell and Story, 2022). Participants seem to believe that the EDM thought process and ethical deliberations one might expect of a MHCP are largely absent in MSOs. This all but eliminates the potential for DLC in MSOs, as they do not have to worry about losing a professional registration (which provides nurses and doctors with the means to pursue their livelihood) in accountability for their decisions. This becomes problematic for an MHCP when an MSO is their Commanding Officer, and they are given a direct order or are otherwise coerced to do something which might put their

professional registration in jeopardy, or which violates their professional ethics (Orme and Doerman, 2001). Orchard et al. (2022) described a similar effect in professional sports teams, where coaches and managers are considered senior in the hierarchy to medical professionals and can overrule their ethical and clinical decisions.

Indeed, in this situation, it would be challenging for a nurse to adhere to their personal code of healthcare ethics, professional guidelines, and other ethical obligations. The literature confirms that these situations would cause ethical tensions which could easily lead to moral injury or moral distress, and adversely affect their ability to make ethical decisions. For example, Gibson et al. (2014, p.311) report that "*power differentials may act to constrain or enhance people's ability to make good ethical decisions*", while Grace et al. (2024, p.245) state that "*such power differentials can contribute to moral conflict and harm the nurse.*" Rank pressure is a significant factor in EDM for MHCPs (King and Snowden, 2020), and the military hierarchy is the dual loyalty conflict which seems to me, and in many respects my participants based on my findings, to be most apparent in the field of military healthcare ethics.

The fact is that MSOs (and other non-medical military leaders) can use their rank against a nurse at any time to override their ethical or clinical decision-making according to the needs of the service (Eagan and Lederman, 2022). And they have, according to my participants, done so without regard for their professional skills, knowledge, experience, or judgment. Howe (2016, p.718) believes that this is right, because military commanders may be privy to the wider strategic operational picture which MHCPs may not, and that *"at these times, service members, as opposed to abiding by their moral beliefs, should accept their Commanders priorities."* Such a

thing would either not be countenanced in the NHS, or at least could be easily challenged. However, there are limited routes of redress, challenge, appeal, or support to be found in these situations in the military, including an absolute prohibition on union membership, unlike the NHS. It is a clash of oaths indeed.

From the results of this study, a way was proposed to overcome the problem of DLC by focusing on professional skills and knowledge rather than rank, despite evidence suggesting that rank has one of the largest influences over nurses' EDM. This is perhaps to be expected, as Barnes and Doty (2010) found in their study that ethical behaviour throughout the chain of command is strongly influenced by the ethical behaviour of those at the top i.e., senior military leaders. They are considered the 'moral compass' of their units, yet several very senior UK Officers (of 1-Star rank, i.e., Brigadier and above) have been dismissed in recent years after being found guilty at Courts Martial of e.g., fraud and sexual misconduct (see e.g., Morris, 2021; Ferguson, 2024). This is not a phenomenon restricted to the UK, as 43 US Navy Commanding Officers were fired between 2010-2011 alone for unethical behaviour e.g., cruelty towards or sexual harassment of subordinates, and drunkenness on duty (Light, 2018).

As some of my senior participants indicated (P010, P012, P021), senior military leaders are perceived as successful in their careers regardless of specialism, and should therefore be role models for their subordinates (Finnegan et al., 2020). They have direct power over others, and subordinates tend to pay attention to their actions because they want to be able to emulate, at their leadership level, the behaviours which lead to career success (Barnes and Doty, 2010). A large consideration of this

role modelling is understanding how senior Officers' perceived ethical (or unethical) behaviour perpetuates down through the ranks.

In the case of nursing, and as stated above, one participant's solution to the DLC she faced as a military nurse was to strip away the issue of rank, reverting discussions to purely professional concerns. This, she says, normal de-escalates the situation because it is then no longer about rank. One concern I, and others in the literature seem to have about this is that nurses would need to have a) the strength of character, b) the moral courage, and c) the confidence of a relatively low power differential based on rank to do what this participant did, particularly when there is a risk of negative consequences for the individual challenging the decision (See e.g., Pajakoski et al., 2021; Mert and Holiev, 2024). This is especially difficult in the face of more senior professional colleagues, potentially in terms of rank, experience, or responsibility (Lachman, 2007). My findings confirm the reality that many participants (at least those not of high rank) do not always feel able to challenge the EDM authority of higher ranked personnel or those with greater professional responsibilities (such as doctors) in this way. In a scoping review examining the psychological suffering of MHCPs, Wilson et al. (2023) comment that practitioners compromising their moral integrity through perceived powerlessness in this way could lead to a cumulative cycle of moral injury or distress across a whole operational tour, or even a whole career.

Another ethically constraining element of deployed service which also has a high potential to cause moral distress are the medical rules of eligibility (MRoE). These are a set of eligibility criteria which dictate who is authorised to receive routine or

emergency treatment in a deployed MTF, and are a contentious part of mass casualty treatment (Gross, 2017). One reason for their contentious nature is that people are treated not primarily on severity of wounds but on which casualty category they fall under (Ibid.; Clifford et al., 2023). For example, normally injuries would need to have been caused by coalition action to admit a civilian casualty, or the fact that compatriots (for UK MTFs, this means coalition, e.g., UK / US, troops) merit superior care to allied host nation troops (Ibid.) under typical MRoE. Such rules may be strategically or politically decided, and become subject to change if the political will changes.

A prime example of this changing political will, which I have personal experience of, occurred during the early OP TELIC campaign in Iraq between 2003-4. During this period, the MRoE allowed for Iraqi civilian patients with severe burns not caused by coalition action, and their families, to be flown to one of three specialist burns units in the UK for definitive treatment (British Broadcasting Corporation, 2003). The UK government provided an extra £20m in funding for this policy (Ibid.) which was stopped in later tours when the circumstances changed, and was not repeated in Afghanistan. This may have been because of the political realisation that, as mentioned in the findings, one of my participants pithily summarised for his team on the way to their deployment: "*This is not [the] NHS out in Afghanistan, we are here to get the fighting force back to the front line"* (P003). This resulted in acknowledgement that there must be limits to eligibility for treatment to prevent a 'floodgate' effect as described in the findings, thereby prioritising the mission, safeguarding resources for those who are entitled, and saving money. The MRoE are commonly linked to DLC. Some participants described a perceived disconnect between the policymakers in

government, working from a political agenda, and the clinicians on the ground who are relying on their personal judgement and professional ethics to decide what to do with patients on a case-by-case basis.

As a unique example, a senior nurse participant (P012) spoke of providing reassurance to a pre-hospital care clinician who brought a seriously wounded civilian patient to the Role 3 hospital in Afghanistan that did not meet the eligibility criteria for admission. He was terrified that he was going to face a court-martial for breaching the MRoE, but still treated the patient as he believed that, morally speaking, it was the right thing to do. This exemplifies the role of moral courage in EDM in practice situations which was discussed in theme 1. This situation implies that pre-hospital clinicians in a deployed environment should favour professional over military obligations in certain contexts. As a commander, P012 believes that these clinicians should be trusted and supported by clinical leaders to make ethical decisions (Edmonson, 2010), and in the military context this includes treating casualties who may fall outside the MRoE without being second-guessed by commanders. Several other participants agreed with that sentiment.

The inference, in a synthesis of my findings, is that military nurses believe this is right because of the dynamic, hostile, and nuanced nature of the highly pressurised circumstances in which MHCPs typically practice ‘on the ground’, and for which the MRoE is not always adequate to guide EDM. This EDM should also be permitted to take place without fear of adverse personal or career consequences. It is acknowledged that MHCPs are accountable to their professional bodies for the ethical and healthcare decisions they make, as previously discussed. However, in the

situation discussed above, choosing to treat a casualty because an MHCP believes it to be the right thing to do in the heat of battle, rather than failing to treat them because of military-imposed eligibility rules, would not be a matter of professional healthcare accountability, at least as far as their professional bodies are concerned. This is because as alluded to above, the internal morality of the healthcare professions relates to practitioners treating all patients to the best of their professional ability. The risk is that MHCPs could instead be punished for breaching 'mission first' military rules, like the clinician above fearing prosecution at Courts Martial, which could harm only their military career as no professional healthcare rules have been breached.

This practical example of concerns of DLC related to the MRoE may indeed demonstrate a disconnect between planners and clinicians when working under a contextual set of MRoE. It shows that leaders' support of decision-making in this context can be dependent on the personality and ethical attitudes of commanders (Kimhi and Kasher, 2015; MOD, 2016), which could be a challenge to effective EDM through lack of consistency in application of the rules in this area.

Ethical tensions cannot usually be resolved to the complete satisfaction of all parties, creating a DLC for clinicians. For military nurses this often stems from admissions decisions under the MRoE. Consider for example a fully staffed MTF which is virtually empty, and a decision is made not to admit seriously wounded or sick civilians from an overcrowded refugee camp located across from the MTF, as occurred on OP TRENTON. My participants understand rationally that a deployed MTF is there to treat eligible personnel (soldiers and preferred contractors etc.) and that resources

should be saved for treating that group. However, they also reported their unease at seeing empty beds around them when there was obvious suffering so close at hand, and their professional and / or moral instinct is telling them that they should be treating those who need it most (See e.g., Gross, 2017).

However, the MRoE have always seemed to have an unwritten element of discretion which the chain of command can apply to override extant MRoE criteria, depending on the local situation and context. At least, that has been my experience of it as well as many of my participants, who quite often raised the associated ethical and psychological issues of having to treat children. These ranged from e.g., not expecting to treat paediatric patients or not being physically equipped or professionally trained and experienced to care for them, to e.g., the moral distress involved in having to discharge them (to a local hospital providing a much lower tier of care) while still in need of advanced care, or into the care of unrelated people. Some of these will be discussed in greater detail below. Participants in the findings commented specifically on the ‘stretch’ the DMD sometimes exercised in the MRoE. They generally put it down to them trying to avoid a reputational risk to the MOD amongst the local community and potentially the international press, or to defeat enemy propaganda, rather than as an independent exercise of their moral conscience. This matches the earlier comment on EDM in such situations often being personality-dependent, as what one DMD allows to circumvent the MRoE another may not, as the findings suggested.

MTFs are not routinely scaled with staff and equipment to care for children on deployment (Vasallo, 2015), and the findings confirm this. This is primarily because

doctrine tells MHCPs that they should not expect to treat children, as they fall outside the typical MRoE, and the military no longer employs specialist paediatric nurses or doctors in its regular force. However, this did not stop paediatric admissions in recent campaigns. Indeed, Greaves (2019, p.441) states that "*whatever the nature of the deployment, children will find a way into the military healthcare system regardless of eligibility rules.*" Around 40% of children presenting to deployed field hospitals spend time in ICU (Arul et al., 2012), and could occupy up to 30% of ICU bed occupancy at times (Harris and McNicholas, 2009). These breaches of the MRoE presented significant challenges to military nurses and led to difficult decisions for commanders in Iraq and Afghanistan (Greaves, 2019).

A question which came up in several of my participant interviews was, at what point does the EDM process begin in a civilian casualty's journey? There are also questions in these situations of where the ethical responsibility lies, and whether UK personnel are even obligated to treat these patients if they were not directly involved in them receiving their wounds. Is it when the first medically responsible person, e.g., a patrol medic, encounters or checks over a wounded civilian, or when they send a 9-Liner (request for casualty evacuation) to the next Role 1 or 2 MTF? Is it when they arrive at the MTF and first encounter healthcare professionals? Or is it when any coalition soldier acknowledges a casualty or calls for medical assistance, e.g., a guard at the compound's front gates? On my operational tours, these personnel used to call for hospital nurses or doctors to come and assess an injured or sick civilian every time they were thrown from passing vehicles at the main gates. Local families, with limited healthcare options, hoped that coalition forces would take them in and treat them.

Henning (2009) argues that it would be easier for MHCPs to have an MRoE operating a blanket refusal to treat civilian casualties, thereby avoiding the need to separate care by nationality. This is a contentious view both in the face of the WMA (2012) 'regulation' that demands parity in healthcare ethics in times of armed conflict as in times of peace, and in the face of those of my participants who favour their nursing identity over their military obligations. These are of course weighted towards treating casualties by clinical urgency alone, per the Geneva Conventions Act 1957 for military forces, which would largely render the point at which EDM begins irrelevant as anyone could be treated if their medical condition warranted it. However, an MRoE dictating a blanket refusal to treat local civilians would just shift the ethical burden onto the front-line combat medics mentioned above, as they are often the first point of contact. Indeed, Henning (2009, p.86) goes on to say that "*it is surely unfair to put this responsibility on [the combat medic], probably the least qualified person to make the decision."*

There was a feeling amongst some of my participants, however, that extant MRoE policy needs to be clearly communicated to not only MHCPs, but also the literal 'gatekeepers' who protect each camp to prevent unauthorised admissions to the MTF. If everyone knew the MRoE in advance, they argued, this would pre-empt the need to make difficult ethical decisions before the gate guards expose themselves, hospital staff, or ambulance personnel to the potentially hard ethical choice of whether to let someone through the gates for medical treatment. One would simply follow the guidance. However, knowing the clearly communicated MRoE policy does not necessarily limit the potential for moral injury, as one US nurse in exactly this situation reported in a study conducted by Agazio and Padden (2024). She was

compelled by the extant MRoE on her tour to refuse an injured child entry to her compound in Iraq to ‘protect the mission’, directly leading to her suffering moral distress.

This situation was also described by a few of my participants, and the findings describe the ethical tensions this caused amongst care teams. This is not normally a concern for peacetime practice, however, as the NHS operates an egalitarian ‘treat all equally’ policy, at least it did until the Covid pandemic (Germain, 2020) when ethical decisions on whether to treat moved, unprecedentedly, to concerns of likely prognosis based on age and co-morbidities. Denial of treatment based on MRoE therefore remains another unique and consistent complicating factor for nurses’ EDM in the deployed space, unlike in the firm base.

However, some participants suggested that having MRoE in place might make EDM easier in some respects. This is because it might give nurses treatment parameters to the effect that only life, limb or eyesight saving surgery is authorised on specific patient groups, e.g., civilians (Clifford et al., 2023; Henning, 2009). It may also limit treatment in this group to injuries caused as a direct result of coalition action (Clifford et al., 2023). But at the same time, the terms of the MRoE appear ethically biased in favour of ‘own troops’ and coalition partners (i.e., UK and allied forces first), because it is set with a fluid political and military landscape in mind (Messelken, 2023). However, this contradicts the demanded adherence to UK law, which includes the Geneva Conventions Act (1957). Military nurses are bound to uphold this law, of which Article 12 demands impartial treatment of only the sickest patients first regardless of e.g., race, gender, or political or military affiliation, rather than treating

by the bias of nationality towards which the MRoE is weighted.

Two-tiered care (2TC)

> *"The ethical context of providing [healthcare] in a challenging and hostile situation, where levels of healthcare provision were radically different from those of the United Kingdom, was inevitably complex*." (Greaves, 2019, p.458)

Two-tiered care was a highly emotive subject amongst my participants. They reported experiencing patterns and mechanisms of injury in deployed MTFs which were of a severity not often seen in their peacetime NHS practice, which is supported by Finnegan et al. (2016b) and Meyer et al. (2021). However, these injuries were not just suffered by soldiers, but by the civilian populace as well. Those entitled to care under the MRoE in a deployed UK MTF received care of a standard as close to prevailing UK care standards as possible, which the UK is doctrinally bound to provide despite the recognised constraints of scarce resources and lengthy supply chains etc. (Greaves, 2019). Indeed, the relevant applicable and extant doctrine which details this, the MOD and NATO's Allied Joint Publication-4.10 (MOD, 2019, p.1-28), states: "*The standard of clinical health care delivered by the DMS to the Defence population at risk, when deployed or in the firm base, is benchmarked against comparable NHS and international standards.*"

In most cases, these MTFs represented the best healthcare available in that country at that time. The local healthcare infrastructure during these deployments could not hope to match the standard of care to be found in coalition MTFs nor achieve the same treatment outcomes (Greaves, 2019). This knowledge caused concern amongst my participants, as well as other nurses and doctors, about likely poor clinical outcomes of civilian patients on discharge from the MTF (Ibid.) This

imbalance in medical capability in the same geographical area is known as two-tiered care (2TC). Indeed, issues of 2TC prompted Kondro (2007, p.134), a Canadian paramedic working in Afghanistan, to describe the transfer of his patients to a local hospital as a "*death sentence."*[4]

A synthesis of participants' comments in the findings describes nurses routinely being forced to hand over sick patients to local hospitals like this in Iraq and Afghanistan, knowing that they lacked the resources to cope with complex care, which I also experienced. In a contemporary reflective paper by a former Surgeon General of the UK (Bricknell, 2007) supported by Henning (2009), who visited these hospitals in a training and advisory capacity, a bleak picture is described. They report that many hospitals in Iraq had little to none of the medical equipment or consumable supplies necessary to provide adequate healthcare, very few drugs or medical gases, and nothing resembling a Western healthcare intensive care bed. I have used examples of reflective writing here because they convey powerful, cathartic examples of often negative lived experience of the sort which Artioli et al. (2021, p.12), in their systematic review of reflective writing, conclude are useful in medical education. They go on to comment that "*professionals appeared genuinely amazed at how learning can be generated out of negativity*."

My findings also show that while a few participants wanted to treat local civilians to the highest possible standards for as long as possible, to give them the best chance of survival, others were more pragmatic. Limiting treatment of civilians in their MTFs to a level at which the local hospitals could cope was frequently experienced, in

[4] For a further contextual description of 2TC on the battlefield, see also Sokol (2011).

effect a policy of ‘treatment protocols by nationality’. The literature reports evidence of this too, with Sokol (2011, p.1) describing MHCPs being told during a mass casualty incident involving both coalition soldiers and civilians “*not to intubate any of the Afghans with burns exceeding 50% [as] without a [local] burns unit, those patients would be doomed*.” Conversely, they were told to do everything possible to quickly repatriate coalition troops to their home countries for advanced burns treatment.

This is demonstrated in the findings, with nurses specifically reporting limiting of treatment in civilian patients based on the disparity in levels of care between their MTF and local hospitals, while evacuating their comparably injured compatriots back to the UK, usually within 24 hours, on a dedicated critical care aircraft. Community health services also do not exist in these countries to the same standard as the UK. This meant that outcomes would be poorer for those requiring complex follow-up care after discharge from a coalition MTF when considering e.g., chronic pain management, infection risk, and quality of life. This was also a frequent source of angst for my participants which is reflected in the findings.

Problematically for military nurses, most trauma patients entering a deployed MTF cannot express their autonomous wishes e.g., to be treated or not, or whether to be treated at the MTF or in their own healthcare system, as they are typically unconscious or already under the influence of strong narcotics (Henning, 2009). Thus, decision-making usually defaults to the ‘best interests’ principle familiar to all HCPs. Decision-makers must then consider some difficult ethical questions, being careful to avoid assumptions as cultural differences may exist which could affect the

decision (Ibid.). One such question might be, is it ethically justifiable to not commence resuscitative treatment on badly injured civilian patients, and just palliate them, knowing the high resource drain involved and the lower standard of healthcare services into which they will eventually be discharged?

This is a question pondered by some of my participants, the experience of whom is detailed in the findings. As above, participants' concerns seemed to largely revolve around the fate of paediatric patients, describing the ethical tension and moral injury involved in regularly having to decide between palliation and discharging them to a lower tier of care. The literature echoes these findings, but demonstrates that providing dignity in death is an important factor for military healthcare teams to consider as a hard, but viable ethical choice:

> "*Patients who have little chance of survival under the current conditions and whose treatment would consume a significant amount of human and physical resources […] should receive strong opioid analgesia and palliative care and be left to die in peace and with dignity.*" (Anagnostou, et al., 2020, p.e660)

Another question might be, is it ethically preferable to exercise treatment protocols based on beneficence, even if there is reasonable cause to believe that the civilian patient may suffer harm because of this further down the line? Practically, on one hand this means respecting the ethical principle of beneficence, treating such patients at UK gold standard right from the start, only to be compelled to withdraw it upon their discharge to a local hospital. This decision could potentially cause future harm in terms of protracted pain and suffering due to deficiencies in the local healthcare infrastructure, breaching the ethical principle of non-maleficence. Or, respecting the principle of non-maleficence, it could mean treating them at a more

basic level right from the start to match local healthcare capabilities, like a more basic (or more drastic) surgical approach (Lamblin et al., 2021). My findings show that this is an ethical dilemma which my participants have also experienced, with some reporting active treatment limitation in civilian patients on admission due to the lack of expertise and supplies in local hospitals, compounded by the absence of follow-on care. This constant and 'dangerously schizophrenic' adjustment of mind-sets between UK and local treatment models and standards was also demonstrated as an ethical concern for military nurses in the findings.

Some in the literature controversially argue that practicing different treatment protocols in deployed MTFs because of issues of 2TC is morally right, despite contravening established principles of IHL. For various reasons, standards of care differ between countries, leading Henning (2009, p.85-6) to state (in terms of intensive care provision, at least): "*society therefore defines a standard of care, and it would not be right for the field hospital ITU to provide care to a different standard. […] There has to be an acceptance that these patients will, at some point, be placed back into their own healthcare systems.*" Indeed, Gross (2022) defends this EDM approach from the perspective of scarce resources, in terms of an MTF having limited beds, supplies, and personnel. He comments that this makes it morally 'impossible' to provide, in the same MTF, the same standard of care to civilians that Western soldiers enjoy. Others in the literature, however, disagree with his view on the absence of a moral obligation to provide impartial or equitable care in MTFs (Rhodes and Danziger, 2017; Miller, 2017). This will be discussed in greater detail in the section on impartiality and cultural issues below.

In situations of 2TC, I found that my participants believe that there is a strong potential for military nurses to experience moral injury or moral distress. This is because personnel reported believing they 'knew' what they ethically *should* do for their patients to achieve the best outcome, such as arranging critical care air evacuation to the UK, but are prevented from doing so e.g., by internal or external ethical constraints (Wilson et al., 2023). The risk of moral injury is also high if nurses are forced to do or see others doing something they deem as 'wrong' or otherwise inconsistent with their professional values, or witnessing severe human suffering. This could be, e.g., having to palliate their patients without ever being allowed to start active treatment or aggressive life-saving resuscitation (Epstein et al., 2019). This is in concurrence with my findings, in which military nurses reported experiencing both phenomena and being unable to challenge ethical decisions they saw as incompatible with their moral or professional values. This refers to their lived experience of MSOs overriding their professional judgement to discharge critically ill patients, and facing large-scale human suffering on combat and humanitarian missions without being able to help, despite low occupancy in their MTF.

2TC was also a concern within the wider coalition care teams. Most of my participants reported experiencing a disparity of care provision and ethical attitudes between UK and international partner nursing teams, particularly US military nurses, towards Captured Persons (CPERS) and local national civilians. US teams were perceived to practice a completely different level of care and consideration to the patient when it was not a coalition soldier, sometimes to the point of refusing to treat or care for a patient on that basis. For example, the struggle of US nurses to reconcile their use of limited resources on enemy combatants and local nationals

instead of keeping them for their compatriots was reported in a study by Kenny and Kelley (2019), which is in concordance with the findings of Agazio and Goodman (2017) and Agazio and Padden (2024). This is, in practice, another form of 2TC, as it is not a case of a disparity in capability - rather it is a wilfully applied disparity of care provision. It is also a violation of Article 12 of the Geneva Conventions Act 1957. This defies the notion of impartiality in deployed care delivery, a discussion of which follows in a later section.

The literature review, my findings, and this discussion suggest that the quality of EDM based on principles of 2TC (or indeed any of the other contextual ethical constraints addressed in this thesis) would benefit from collegial deliberation before acting, to avoid ethical harms wherever possible. This is where a decision-making tool like the MOD's Four Quadrant Approach (4QA), aimed at "*ensuring that key ethical issues are addressed, allowing the user to come to a considered decision*" (Greaves, 2019, p.462), would be useful in ensuring all relevant factors are addressed in an ethical discussion.

Scarce Resource Allocation (SRA)

> *"Clinical need is indeed a defensible principle on which to allocate resources, but it is neither the only, nor always the most important principle for allocating scarce resources." (Evans and Sakkarie, 2017, p.2)*

Practicing 2TC in a deployed MTF as described above is necessary often because of the limited resources that they hold. Participants were aware of this externally imposed ethical constraint, and sensitive to how it affects the ethical decisions they or others make, in a range of circumstances. This is known in the military healthcare ethics literature (and increasingly in the civilian literature after the advent of Covid) as

‘scarce resource allocation’ (SRA). Participants are also cognisant of an underlying ethical theory which influences SRA decisions in the military context, both doctrinally and traditionally (Eagan and Messelken, 2023). This is utilitarianism, which a few participants referenced by name, or as it was more popularly referred to, the principle of ‘the greatest good for the greatest number’ in guiding EDM. Their SRA concerns revolved around a consistent lack of physical kit and equipment such as medical machinery or consumables e.g., drugs and dressings etc., along with poor or unreliable supply lines. Pressure upon these resources commonly increases in periods of high clinical tempo during combat and humanitarian missions (Evans and Sakkarie, 2017; Greaves, 2019).

However, SRA concerns can also involve personnel issues e.g., lack of relevant specialist expertise or the ability to augment the healthcare team in busy periods (Rawlings et al., 2021; Anagnostou et al., 2020), as was demonstrated at the start of this theme by my first participant. This means that nursing care, staff resilience, and efficiency could degrade quickly to the point of exhaustion in the short term, or burnout over a longer period potentially leading to an unsafe care environment and poor outcomes for patients, particularly civilians (See e.g., Cho and Steege, 2021; Ma’mari et al., 2020; Jun et al., 2021). This is because doctrinally, resources should be conserved wherever possible to meet mission objectives, at the heart of which lies caring for the deployed force as the priority (Eagan and Messelken, 2023). Moreover, as my participants mentioned, resource management in the military context is complicated by the difficult nature of maintaining logistic resupply lines in a combat zone, which are often contested or disrupted, making resources both scarce and insecure (Hodgetts et al., 2023). These are some of the reasons that my participants

believe decisions on how to ration care based on limited resources are ethically challenging for military nurses and other healthcare professionals.

A civilian study undertaken by Christianson et al. (2023) demonstrated striking parallels with the resource-limited military operational working environment described in the findings and at the start of the discussion about this theme. It showed that similar conditions of the chronic stress caused by overworking in an under-resourced environment during the Covid pandemic led to civilian nurses suffering from significant physical, mental, and emotional strain. This is a manifestation of the issue of personnel as a scarce resource, which a few of my participants identified as a barrier to challenging observed poor ethical standards or engaging meaningfully in EDM. I found that more of my participants, though, thought that EDM became more important in deployed military nursing *because* of finite resources, in terms of both personnel and equipment.

Participants also referred to a regular phenomenon which occurred in deployed MTFs in cases of EDM around SRA. This was known as the ‘command huddle’. This was usually a small group of senior military doctors, led by the DMD, comprising of the anaesthetist and the senior surgeon, and sometimes the ED consultant (Arul et al., 2015). Its stated purpose was to debate difficult ethical questions like deciding whether care was medically futile, and prioritising resources including personnel, time, and cold chain consumables like blood and blood factors (Ibid.). Matching the description my participants gave of the command huddle in the findings, during my operational tours, command huddles actively excluded the rest of the care team, preventing them from becoming involved in such discussions. This went as far as to

move to an area away from the bedside to prevent the care team from overhearing.

In addition to my own feelings of disenfranchisement as described in the introduction, this practice compelled some of my participants to comment on the exclusionary nature of the command huddle as it pertains to EDM. Their existence and ostracising nature is supported by Greaves (2019, p.462; his parentheses), himself a former senior military doctor, who says, "*while there are reports of these [ethical] decisions being multi-disciplinary (even including non-clinicians such as chaplains), decision-making still seems mostly to be undertaken by a small 'elite' group (sometimes referred to as a 'command huddle')*." It is an interesting comment on the nature of deployed EDM that this phenomenon is referred to as a 'command huddle' and not as an 'ethical huddle'. The closest equivalent I could find in the NHS was the concept of multidisciplinary safety huddles (See e.g., Montague et al., 2023), although like me and the participants I referred to above, some staff groups in one study reported feeling excluded from these huddles and consequently felt as though their voices were not being heard (Clarissa et al., 2021).

In a study on the main ethical and non-ethical challenges experienced by DMDs, issues of resource constraints and rationing were regarded as the most common, followed by DLC (Bernthal et al., 2017). This echoes many participants' concerns, which when synthesised, relate to deploying at various points forward of Role 3 in the operational patient care pathway with greatly limited consumables. A few participants said that scarcity of resources in these conditions had the effect of sharpening their focus on resource-based EDM, particularly in remote MTFs with experienced specialist nurses but very junior doctors. They stated that they felt more comfortable

getting involved in EDM in that scenario. However, a few nurses in bigger, better resourced MTFs reported never organically seeking to get involved in the EDM process, but equally not feeling as though they were excluded from it either.

One potential explanation of this *laissez-faire* attitude in bigger MTFs is perhaps because participants were used to seeing 'command huddles' take place in deployed MTFs. This may have routinely conditioned them that this was the correct EDM process, i.e., the senior doctors' responsibility to make ethical decisions, potentially meaning that they in turn never felt as though it was necessary for them to be involved in the decision in the first place. The 'captain of the ship' attitude with the idea of the senior doctor as the sole decision-maker has been challenged extensively since the 1970s due to increasing professionalisation within other healthcare disciplines (Holm, 2011). For example, collegial, or multidisciplinary EDM is now expected by HCPs and patients alike to improve decision-making quality and improve patient outcomes, as discussed in greater depth in theme 1 (See e.g., Kim et al., 2010; Quenot et al., 2017). However, and as alluded to previously, there is evidence in the literature that nurses may still feel reluctant to become involved in EDM, and of doctors actively attempting to retain absolute decision-making power. This is principally based on an argument which rests on claims of the epistemic (greater medical knowledge) and deontic (greater ethical duty or obligation) superiority of doctors:

> *"Nurses do not have epistemic authority, deontic authority or rights in decision-making that are equivalent to those possessed by doctors, let alone by consultants/specialists. […] Hence also they do not have the same rights as doctors to decide 'what should be done' concerning patients' treatment in hospital. […] These are the principal respects in which nurses are lower than doctors in the medical hierarchy, and which account for the reported passivity*

> *of nurses in ward round or multi-professional discussions."* (Kurhila et al., 2020, p.1710)

Some nurses reported that their awareness of the MRoE and issues of SRA was much less acute in their first tours when compared to their later tours. This implies that synthesis and use of experience and ethical sensitivity accrued in the deployed environment to inform EDM is important, as Kirwan (2023) found in frontline civilian nursing. But this awareness from experience means they are feeling the effects of SRA as problematic. I conclude from this that PDT featuring real-world ethical content provided by nurses who have lived experience could be important in raising awareness and experience of such issues prior to deployment. This is supported by Parnell et al. (2023) in the more general sense that this pedagogical approach helps HCPs to develop collaborative, compassionate, and person-centred practice. This would also allow 'front-loading' (as a few participants referred to it) of nurses' experience of ethically challenging situations and EDM, but in a risk-free environment. More experience may allow for more rapid assimilation of a specific set of contextual circumstances, leading to quicker rationalisation of decisions 'on the ground' (Kirwan, 2023). This is preferable to nurses risking 'ethical paralysis' through lack of knowledge and experience of EDM when faced with an ethical dilemma in practice, as described by Rivers and Gordon (2017), and one of my participants (P015).

Preparing nurses for EDM in this way may have the additional advantage of offering a protective effect on nurses' mental health (Parnell et al., 2023). Some participants described their mental health, or that of their colleagues, as being compromised by the cumulative effect of not being prepared for making SRA-based ethical decisions

which might cause severe suffering or even death. Indeed, one participant reported that a friend of hers "*probably should never, ever have been on HERRICK [in Afghanistan]*" (P002) because of the psychological damage she suffered on an earlier tour in Iraq, due to the need to constantly make ethical decisions based on constrained resources.

Bricknell and Story (2022) say, and my participants agree, that preparing nurses to face these ethical dilemmas and practice within common ethical constraints is something for which case-based learning (CBL) is ideally suited. For example, one participant said that predeployment CBL is useful because "*having a sophisticated degree of reflection to learn from situations, to be able to unpick those situations and learn from them [helps nurses to] understand what it is that drives that ethical and moral decision-making*" (P015). When we were talking about CBL as a means of preparing nurses for potential involvement in making ethical decisions on tour, another participant reflected that:

> *"There's definitely a place for ethical decision-making [in PDT education]. Do we do it right in the military? I think we do. I think we prepare people correctly for the ethical decisions that they're gonna make with all our pre-deployment training, and the scenarios that we can throw at people. Could we do it better? Actually, we can always do things better. But I think we do it pretty well at the minute."* (P029)

In my own practice as an educator and ethics researcher, CBL has helped me effectively to strive for these goals. In an AHRC-funded 'Phronesis and the Medical Community' study, in which I was a co-investigator (Conroy et al., 2018), we developed both a video- and app-based form of CBL as a moral debating resource. This was found to be highly effective for accumulating practical wisdom through

experience in recognising and navigating ethical decisions in the clinical space, and developing the courage to take the right course of action, leading to virtuous and ethically wise practice (Ibid.; Conroy et al., 2021; Malik et al., 2020). I have also used CBL on many military medical courses over the last decade, such as the Military Operational Surgical Training course, the General Practitioner Specialist Training course, and the Defence Deanery Senior Trainees course, which are mainly medically focused. I have also used the technique in ethics workshops for military nurses, both in the UK and internationally on OP PANAKA in Pakistan for example, but to a lesser extent as the DMS focus tends to be on preparing doctors for deployed EDM.

Finally, I come back to the notion of impartiality in EDM mentioned throughout themes 1 and 2 so far, but not discussed in detail.

Impartiality and cultural issues

> *"I think it's easier to make the [ethical] decisions if you've got a British guy coming in that needs treatment versus a local, we're probably going to treat the British guy because he's one of our own."* (P029)

I have, so far, established that military nurses are deployed to support their country's soldiers in the execution of their duties. I have also demonstrated that this has obvious implications for EDM involving ethical constraints such as DLC, application of the MRoE, SRA, and in situations of 2TC. However, although it is a morally contentious area well documented in the academic theoretical literature, there is limited empirical evidence of the phenomenological experience of military nurses delivering impartial care (or not) on operational deployments. For example, a systematic review of nurses' views and experience of delivering care in war and

conflict areas was conducted by Sadhaan et al. (2022). Although some mentioned cultural issues in deployed care delivery, of the 25 papers included in the final review, none discussed military nurses' experience of impartial care. As stated above the requirement to deliver medical and nursing care in conflict, humanitarian, and disaster relief should be guided by the principle of impartiality. This is described in the Geneva Conventions Act (1957) in UK law, and the rules of IHL (ICRC, 2025) internationally. Most of my participants reported experiencing alarm, anger, or frustration with, or at least a strong emotional response to, challenges in impartial care delivery during their operational service. These challenges included friction when working with international partner nations, with cultural issues both external and internal, and considerations of Gross' (2013) 'ethics of comradery'.

A detailed examination of an illustrative incident experienced by one participant will serve as a synthesis of a central issue raised by others. The ethical failure of an international partner nation's team to deliver care impartially to a CPERS in Afghanistan led P002 to recount her memory of US colleagues walking out of ED and refusing to treat him. It is the event early in the fieldwork which prompted me to add 'international working' as a coded element in my analysis. It is clearly an event which still emotionally affects her, even over a decade later. It also resonated strongly with my own experience of working with other nations, particularly the US. They tended to have very strong views, either negative or unethical, when it came to looking after or caring for wounded enemy combatants and local national civilians.

What the US team did in P002's example is in violation of the Geneva Conventions (ICRC, 1995) as well as the rules and principles of IHL. These dictate that medical

teams of countries signed to these conventions (like the UK and US) are supposed to remain impartial, and treat patients only according to the severity of their injuries. In this case, the US care team unanimously ignored a deontological obligation to treat the Taliban fighter when he arrived in the British-led Role 3 hospital. They did this consciously and deliberately with no apparent later regret or sense of shame. It appears they felt morally justified in their actions, even though the CPERS had not killed a US soldier but one from the UK, yet even this was a strong enough reason for them to 'down tools' and refuse to care for this casualty. This forced the remaining care team to call in off-duty UK personnel to manage that casualty and others, whose attitude was apparently more impartial than those of the US, with P002 reporting "*the British all did their job, and that's what we were there for was to save lives regardless.*"

The US nurses clearly expected the UK staff to walk out with them in a 'solidarity protest'. This highlights a fundamental difference between UK and US nurses' attitude to ethical care delivery, which created divisions amongst the care team for the rest of that tour. The US care team employed a reactive response to the situation, deviating from Aristotle's phronetic 'golden mean' and displaying, arguably, a deficit of the empathy and compassion which are central to a nurse's professional identity (Raustøl and Tveit, 2023; Moudatsou et al., 2020; Traynor, 2022). It is also suggestive of an excess of aggression or temperament. There must be a question about the ethical culture in US military nurse training which allows them to think or react this way in relation to combat patient care, as it makes trust very hard to form between nations with such different approaches (Hughes et al., 2024; Brockie et al., 2024). Trust in professional colleagues is an important integral factor in nursing

(Sutherland et al., 2022), perhaps even more so in the high-pressure environment of operational combat tours. Nurses work closely with each other every day for several consecutive months without a day off, and often live together as well in integrated accommodation on-site. This is why teams should work together in mission-specific PDT, to get to know each other in advance of deployment and learn as much as possible about each other's ways of working and agree a unified approach, including the ethical expectations of care (See e.g., DaCambra et al., 2018; Datta and Khanna, 2017; Curtin et al., 2021).

Further into the hospital from the ED ‘front door’, in ICU and the wards for example, many participants did not feel comfortable perceiving fellow UK soldiers to be judging them or ‘questioning their loyalty’ because they were treating an enemy combatant in the same clinical space as them or their coalition colleague. This patient positioning is often a practical necessity due to a shortage of space in a field hospital in which to place beds and provide total privacy, so patients and visitors can often see what is happening with other patients. I have personally seen situations where an enemy combatant has been placed in the ICU bed opposite a UK patient, often after wounding each other in the same firefight. They glare, gesticulate, and make the universal ‘I'll kill you' sign (finger drawn across the throat) to each other across the department because they both have tracheostomies in place and cannot speak or get out of bed. International nurses also reported experiencing ethical challenge in nursing compatriots and enemy combatants in the same clinical areas (See e.g., Kenny and Kelley, 2019; Agazio and Goodman, 2017; Agazio and Padden, 2024).

Military nurses must show impartiality, on the surface at least, in how they deliver

nursing care. That is what their professional ethical guidelines (NMC, 2018), domestic law (The Geneva Conventions Act 1957), and principles of IHL (ICRC, 2025) demand. This is reflective of the findings in the first theme which stated the importance to military nurses of *doing* the right thing regardless of patient group, explaining *why* it is the right thing, and to some extent being *seen* to do the right thing. As some participants stated, implicitly supported by e.g., Hill (2010), the skill in nursing in these situations is being externally non-judgmental, even if they feel judgmental internally. I understand how this might trouble nurses delivering care in these situations, having experienced this situation before myself.

There was a great deal of discussion with my participants around the subject of personal bias in altering what should be impartial ethical care decisions. For example, Gross (2011) describes the natural affinity of the MHCP with soldiers of their own nation over that of the allied or local forces, prisoners of war, CPERS or local national civilians on a deployment. He even suggests that it is ethically right that home nation soldiers should expect to be prioritised over these other groups, even if less severely injured, calling it the ‘ethics of comradery’. In fact, many of my participants, often without prompting, commented that they felt a strong pull towards preferential treatment of their compatriots. It is a concept which complements the moral cohesion of the fighting force and forms the ethical foundation of the moral component of fighting power (MOD, 2011).

It also represents a form of motivation for ‘own force’ troops to risk their lives fighting at the front line. If they had no realistic prospect of excellent medical care should they be wounded fighting, or not be confident of being prioritised for evacuation or

treatment after injury, then the morale of the fighting force would collapse and military objectives would be compromised (Ibid.). Thus, Gross can be said to favour a 'partialist' view (in philosophical terms) of morality. The ethics of comradery holds that this prioritisation for treatment and reasonable expectation of it by own force troops is not only ethically justifiable, but an ethical obligation of the military healthcare apparatus. This is because there exists a natural inclination towards loyalty to "*one's own family, tribe or people*" over others, which certainly includes fellow soldiers (Olsthoorn and Blom-Terhell, 2022, p. 59-60).

This reflects general academic debates within normative moral theory as to the role of impartiality and role obligations. Extreme versions of either do not seem plausible, yet providing moral justification for partiality at the right time, to the right extent, to the right people, in the right place etc. is notoriously contested. This relates to what the noted philosopher Susan Wolf, in a seminal work titled 'Morality and Partiality' (Wolf, 1992), calls the 'impartialist-partialist' debate. As the name implies, this focuses on the core role of impartiality in morality (Ibid.). In a critique of this debate, Lord (2021) argues that Wolf 's view is that the moral perspective is the impartial perspective, like traditional Kantian and consequentialist views, which equates to treating each agent equally. However, he prefers to seek the centre ground, and his work attempts to harmonise how the impartial and partial interact while narrowing the contentiousness of the debate (Ibid.). At the other extreme of the 'impartialist-partialist' spectrum, Copeland (2019, p.4) argues for the ethics of care as a partialist theory, which concurs with Gross' view: "*In direct opposition to the utilitarian call to remain impartial, to count everybody's interests equally, care ethics gives permission to think of those with whom we have a relationship first."*

Partial, or preferential treatment of military colleagues over others who might be in equal or greater clinical need seems to rest, for Gross at least, on associative obligations or duties. There has been extensive discussion of the nature of associative obligations and duties in the philosophical literature. The general premise seems to be that associative duties go beyond the general duties a moral actor owes to other people, by virtue of the 'closeness' of some special relationship they share with a specific group like family or peers (Lange, 2022). Gross (2017, p. 45) states that this applies to comrades-in-arms, who are uniquely bonded "*into a 'primary group' and unique moral community.*" It follows that this reasoning would impose associative duties on e.g., the patrol medic to prioritise his fellow soldiers for treatment, and the platoon Sergeant to ensure that this happens.

However, Rhodes and Danziger (2017, p.57) argue that the 'closeness' which typifies primary groups is not unique to the military, stating that there is "*no obvious reason to presume that people working in close quarters […] do not also form primary groups in the same way.*" They cite the examples of police, catering teams and deep-sea fishermen to support their view. Their conclusion was that if every primary group acted on its implied or perceived associative obligations to treat its members preferentially over other people, this would be morally and practically untenable (Ibid.) And as Miller (2017) points out in a relevant critique, though she agrees somewhat with Gross' view, she comments that his defence of his position lies on shaky ground, based as it is on empirical and anecdotal evidence including the findings of a few studies in soldiers' motivations, a novel, and the proceedings of some ethics workshops he has conducted. Rhodes and Danziger (2017) agree, commenting that this means he 'struggles' to justify his claims. Miller (2017, p.61)

goes on to argue instead for a ‘care ethics’ justification for preferential treatment and eligibility in the military context, stating: “*Associative obligations are not justified by their instrumental value or by an implied social contract. Rather, they carry moral weight because the relationships that generate them have intrinsic value*.” However interesting, this philosophical debate is of course unlikely to be of use to military nurses and their EDM in any practical sense. This is where experiential learning like CBL is useful to bridge the gap between theory and practice to have a real-world effect (Wyllie et al., 2020).

Some nurses described cultural differences from their own experience in Afghanistan that made it hard to provide a level of care they though was right. Agazio and Padden (2024) concur, reporting their participants experiencing ethical challenges with cultural customs, gender issues based on the dominant role of men as primary decision-makers over females (Agazio et al., 2016), and communication on deployment. For example, sometimes nurses could not be sure of the identity of the adult bringing in or taking out a child from their MTF. Most times they did not know if they were even related to the child. This was often difficult for British and American nurses to rationalise, as it is such a different model of care from the UK or US. Quite often, on my tours, hospital interpreters would tell us that it was culturally expected that a village elder would take responsibility for a child in the MTF rather than the parents. This is because they were regarded within their communities as the ‘wisest’ of them, trusted to make the right decisions for the children he was ‘responsible for’. Many of the children themselves seemed confused or even scared when this occurred, crying and calling out for their parents or clinging on to the nurses who had been looking after them in the hospital complex, often for a considerable length of

time. Some younger patients had even started to learn to speak some English by the time they were discharged.

Agazio and Padden (2024) report that multiple studies show that US military nurses were unprepared to encounter the ethical challenges posed by cultural differences on deployment. The findings demonstrate that my participants also encountered difficulty in overcoming their habit of unconsciously applying their own (western culture) beliefs and mores to this kind of challenging situation. The associated constraints on their moral agency created classic conditions for the development of moral distress in these nurses (Jameton, 1984). A few reported that their feelings of distress in these situations were often exacerbated by 'mentally superimposing' thoughts of their own children of a similar age far away at home, amplifying their shame and guilt. One participant powerfully conveyed the depth of her moral distress at her experience of these cultural circumstances, saying that when nurses must discharge these children into the care of, essentially, a stranger:

> "*You're blown, you feel like your soul's been damaged, you feel...you've been made to do something that you didn't necessarily agree with. And it's left you with a, you know, long-term bad feeling…erm...something that you'll never be happy with.*" (P009)

This is an explicit indication of how deeply these events can impact upon people, and a comment upon the enduring nature of such strong emotions or feelings. Indeed, the emotional impact of regularly caring for critically ill children was high, especially when staff were told (like my participants) that they should not expect to have to do so. Some nurses were reported to find engaging in what amounts to *in situ* informal restorative clinical supervision as a coping mechanism, useful to reduce stress and

prevent burnout (Featherbe, 2023), which Agazio and Padden (2024) state also helps nurses engage in effective EDM and improves nursing actions. Others needed psychological or psychiatric support from internal DMS assets like the Field Mental Health Team (Inwald et al., 2014). Reach-in to these services reached a point where a policy of a two-day mandatory 'decompression' stop in Cyprus on the way home from deployment was introduced, to allow staff to mentally readjust for reintegration to home life (Ibid.).

Encountering significant cultural differences affecting EDM was an incredibly challenging situation for some of my participants, and raises again the contested issue of ethical relativism. Velasquez et al. (1992, Para. 4) explain that moral practices differ between cultures and people, and that ethical relativism is "*the theory that holds that morality is relative to the norms of one's culture*", although this claim is contested. Tosam (2020, p.611) states that many ethicists believe that "*culturally sensitive bioethics is unachievable because of intractable moral differences between cultures*", while most ethicists reject ethical relativism, arguing that no matter the moral practice, the underlying moral principles do not change (Velasquez et al., 1992).

If we accept the fact that some moral practices are different from the UK in places like Afghanistan, then no matter the underlying moral principles, it holds that military nurses will experience a practical form of ethical relativism 'on the ground' in their deployed practice. However, if it is a strict from of ethical relativism where the views are in fact incommensurable then it might not be so puzzling as to how nurses could feel such regret, as it would seem the others did not have a morality at all. Or if, more

likely, the nurses could see both sides were as good as each other from an ethical perspective, then it becomes more problematic as to why they need to be so concerned. It also may follow that the extreme feelings related to e.g., the phenomenon described above are indicative that the military has failed to prepare its nurses (and other MHCPs) to experience and effectively process the effects of this experienced ‘practical ethical relativism’.

I suggest, supported by Agazio and Padden (2024), that CBL would be a potent tool to support educators in improving PDT to develop deploying military nurses, by incorporating case studies and practical moulage scenarios involving jarring or complex cultural situations. Even if it does not make nurses think about the theoretical aspects of universal moral principles, it would at least raise their awareness that what they might condemn as morally wrong may be acceptable, or even the norm in another culture and improve their EDM as a result (Ibid.).

Use of an ethical tool or template

Some participants suggested that a written framework, template, or tool of some description was necessary to help nurses overcome the extreme contexts in which they may find themselves delivering nursing care during their careers. They commented that this might help shape a more standardised format of, and approach to EDM within Defence Nursing. It was suggested that such a tool would optimally take a non-prescriptive format, with the caveat that it must be simple enough for a wide range of healthcare personnel to use on the front line. The DMS recommends such a tool for its personnel to assist with both qualitative and quantitative EDM, published in their Clinical Guidelines for Operations (MOD, 2022) - the Four

Quadrant Approach (4QA).

The 4QA is derived from a Scandinavian EDM model from 1982 (Jonsen et al. 2006), which is designed for end-of-life decision-making in critical care. It was adapted for the MOD by Sokol (2008), an expert member of the DMS Ethics Committee, to make it more relevant to the ethical landscape of the deployed context. A visual representation of the 4QA can be seen at Fig. 2. It is designed in an aide memoire format to assist MHCPs in gathering their thoughts, following an easy process to ensure that the key ethical aspects of a case are not missed, and adding structure to such discussions (Greaves, 2019). It is presented in a pseudo-algorithmic approach, instantly recognisable to any HCP, like a resuscitation flow chart or similar but with suggested discussion points rather than prescriptive actions to take.

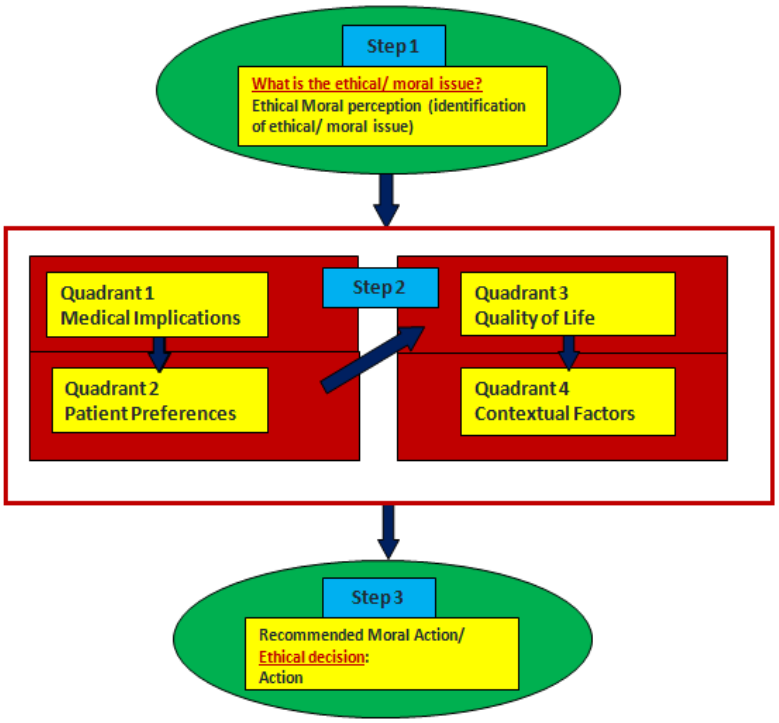

Fig. 2: The Four Quadrant Approach to EDM (Sokol, 2008).

This simple model supports team or collegiate EDM, can be used anywhere, and is easy to remember and reproduce. It has been used with increasing degrees of success in DMS PDT since 2010, although as Greaves (2019) states, its use was typically restricted to the senior doctors involved in a ‘command huddle’. Its use on deployment has also been studied by Bernthal et al. (2014), who concluded that the 4QA has high value to healthcare teams as a tool to assist EDM, but still needs development and further study. This is because a limitation of their study, unacknowledged by the authors, is that it was restricted to male senior doctors. Conclusions on its value may vary with a more inclusive population from the ‘wider healthcare professions’ in any future study. Greaves (2019) concurs, commenting that while the deployed value of the 4QA is acknowledged, he also believes further research is required into the way in which it is used in practice. In a co-authored peer-reviewed paper therefore, I assert that any extension of this research should include expanding its use across all DMS professional disciplines to avoid feelings of disenfranchisement, and make military healthcare ethics relevant to the wider healthcare team (Lin et al., 2022).

Other EDM tools exist, many of which are discussed in a systematic review by van Bruchem-Visser et al. (2020). However, these are designed to be used in civilian practice, which as I have established seems to be less ethically challenging than the deployed military context. There are several EDM tools and templates which claim to be more suitable to use in the contexts of military conflict or humanitarian crisis, or educating to prepare for those. However, many of these seem to be too complicated to recall in an emergency (e.g., Fraser et al.’s (2014) Humanitarian Health Ethics Assessment Tool). Alternatively, they are reliant on detailed knowledge of multiple

ethical theories (e.g., University of Santa Clara's (2021) 5-step framework), and thus likely to be unsuitable for many military nurses to use given the finding in this study of a lack of adequate pre-deployment ethical education. Beardmore et al. (2024) propose a model of their own design, the King's Military Healthcare Ethics Analytical Framework. Unfortunately, this framework appears, like some others, to be merely a 're-packaging' of the 4QA. The authors detail a process which while named differently, has the same purpose – 'identify' the dilemma (4QA step one), 'analyse' the problem against guidance, theory, and IHL etc. (4QA step two) then 'fuse' the analysis (a continuation of 4QA step 2) and 'decide' on the ethical course of action and carry it out (4QA step three).

An argument for using Case-Based Learning (CBL)

In addition to using the 4QA more widely as an EDM tool in the deployed space, participants also expressed an opinion that combining an EDM tool with scenario or case-based learning would be the best way to familiarise nurses with EDM. This was felt to be delivered most effectively in a classroom environment in the pre-deployment space, with participants believing it important to 'front load' such ethical education. There are those in the literature who agree:

> *"It is important to […] consider how [military healthcare ethics] should be taught to military health care professionals. The essence of ethical practice is ethical decision-making. This is best taught through small group discussions in which relevant scenarios are examined." (*Beardmore et al., 2024, p.1)

Learning lessons from previously encountered real-world situations and the ability to synthesise and apply these to future events is indicative of a strong reflective approach to EDM (Seshan et al., 2021). Personal reflection and reflective practice is

something that nurses have been trained to do since they started working in the profession. It is also mandated, as alluded to in the literature review, that nurses prepare *inter alia* five reflective discussion pieces and hold a 'reflective discussion' with a fellow nurse each time they validate their registration every three years (Brockie, 2017). This is because their practice and professional development is subject to scrutiny from their governing body (the NMC). The NMC (2024, p.1) says that this is because reflection helps nurses to "*make sense of a situation and understand how it has affected them […] [and] helps them to identify areas for learning and development.*"

CBL as a teaching method has been shown to improve student performance and perception of learning gains (Bonney, 2015), is more effective than lectures or high-fidelity simulation training (Farashahi and Tajeddin, 2018), and improves students' perspectives on the need for interprofessional collaboration, teamwork, and communication (Lairamore et al., 2013). It has also been shown internationally as a learning method of benefit to nurses, including skills acquisition (See e.g., Malesela, 2009 (South Africa); Majeed, 2014 (Saudi Arabia); Clarke, 2010 (China)). Mission-specific CBL exposes personnel to the ethical dilemmas they are most likely to encounter in their forthcoming deployment, as disseminated from the recent lived experience of their nursing colleagues. In the safety of the classroom environment, students can learn in slow time how to navigate these real-world ethical dilemmas through use of an analysis tool, such as the 4QA, without the associated stressors of being in the deployed area.

Used in conjunction with the 4QA, and taught more widely, I argue that CBL will be a

valuable approach to forewarning and safeguarding military nurses - the future ethical gatekeepers of the DMS - against making poor quality ethical decisions. It might also potentially contribute to mitigating against moral injury and stave off moral distress by raising nurses' understanding and acceptance of the realities of the deployed ethical landscape.

Discussion chapter conclusion

This chapter has drawn on findings from the literature review and utilised the wider literature to discuss them in the context of the synthesised findings of this study. I have maintained a transparent approach throughout, sometimes applying my subjective but reflexively managed insider knowledge and experience to enrich the discussion, which like the findings is presented thematically for ease of reference. It is acknowledged that most of the information related to EDM in the literature review was from civilian and international sources. However, with the lack of significant military nursing evidence originating in the UK, it was appropriate to discuss relevant civilian nursing literature in this thesis because of the intersecting areas between military and civilian nurse practice. Many UK secondary care military nurses, for example, work within NHS Trusts in England, with deployment being the exception rather than the rule.

It was also appropriate to discuss international military nursing literature in this thesis because of the history and current practice of close deployed interoperable working with NATO nations, meaning that UK military nurses typically now deploy and work with partner nation nurses e.g., US, Danish, and Estonian (Brockie et al., 2024). Keeping my research question firmly in mind and following my themes has led to

several key implications becoming apparent. These are presented in the next chapter, along with a consideration of strengths and limitations of the study, impact and routes for dissemination of the findings and implications of this thesis, and identification of topics for further research. The next chapter also includes a reflective account of my conduct of this study in the form of a Reflexive Thematic Analysis quality check, as described by Braun and Clarke (2022).

Chapter 6

CONCLUSIONS

Contributions to the field of healthcare ethics in military nursing and implications

Prior to commencing this study, it became apparent in my preliminary reading that there was a research gap relating to UK military nurses' understanding and experience of EDM on operational service. As far as I am aware, this empirical study therefore represents the first in-depth qualitative exploration of UK military nurses' experience of operational EDM on multiple combat and humanitarian missions around the world, from a wide chronological range incorporating deployments from the 1950s to the present.

My findings overwhelmingly support the conclusion that the deployed military context has a strong potential to influence nurses' EDM. They showed clear evidence that the UK military nurses in my study almost universally and emphatically disagreed on practical grounds with the WMA's (2012) assertion that healthcare ethical principles are identical, regardless of context, even if they abstractly agreed that this *should* be the case. As theme two demonstrates, this is because participants pragmatically recognise that, as military nurses from other countries have also shown, many constraints exist, both intrinsic and extrinsic, which prevent this direct translation of peacetime ethical principles to the battlefield context from being applied in practice.

PDT has been identified as a weak link in preparing nurses to experience the often-brutal reality of EDM on deployment, leaving many nurses feeling unprepared to cope with its unpredictable nature. The findings suggested that ethical education at

the point of PDT is critical to allow pre-exposure of military nurses to EDM, so that they feel better prepared to face it in practice. This has not been happening on the scale that it needs to, as discussed above. This is an important implication for the DMS. As one of my participants says, "*a lot of the hard work in respect of the ethical piece is 'front-loading' it*" (P021), and others agreed.

This study has demonstrated that military nurses' understanding of their ethical role obligations is complex and nuanced. There is often internal conflict over which role obligations assume priority in the deployed context – those of a nurse, or those of a soldier. This dual loyalty conflict creates a blurring of the normal ethical role boundaries they observe in their firm base practice, and thus represents a blurring of their role obligations. This is likely to be problematic for deployed military nurses, not least because this dual loyalty conflict is exacerbated by confusion over the parallel considerations of combatant and non-combatant status, the distinctness of which IHL conversely considers unequivocal. It seems that the nurse and soldier roles are intimately linked when deployed, rather than distinct, and nurses therefore cannot rely solely on the obligations of their professional nursing ethics to guide ethical practice. This has implications for the literature in the field of ethical role obligations, as the 'soldier-nurse' phenomenon appears to confound current knowledge. This will be examined further in post-doctoral work.

Conclusions in the literature about whether doctors or nurses have the higher level of moral sensitivity are mixed, often dependent on the profession of the author. However, through the explicit and implicit words of the military nurses who participated in this study, I identified a perceived 'moral sensitivity gap' between

military nurses and doctors. The tentative implication and novel contribution from this study, therefore, is that some military nurses believe their ability to separate CDM from EDM is superior to that of military doctors.

The literature (See e.g., Sokol, 2008; Bernthal et al., 2014; Teven and Gottlieb, 2018) and this study's findings have suggested that CBL used in conjunction with the 4QA is the optimal course of action to deliver ethics education to military nurses and other MHCPs. It is therefore recommended that the DMS both adopts this pedagogical method more widely to include more professional groups, and acknowledges the corollary implication to create more funding for practice development in military nursing education to achieve this. The 4QA is already used in some military courses, with inconsistent use of CBL (in terms of CBL origin - some is academic in nature, some is operational) depending on the facilitator, but these courses are limited in their scope of delivery. They tend to be either restricted to doctors or only include nurses of certain specialities like ED or Operating Theatres, missing out the bulk of the nursing workforce who still must make ethical decisions in the operational space. This means that the 4QA as a decision-making tool is not familiar to all nursing groups involved in deployments. Moreover, while acknowledging the lack of relevant literature, both my participants and I note the importance of, and recommend, drawing case studies from real-world operational experience. This recommendation will allow the cases analysed using the 4QA to have the most impact, relevance, and resonance with deploying nurses.

It is also recommended that education on application of the extant operational MRoE goes further than clinical personnel in future deployments. Non-medical personnel

(e.g., gate guards) who will be able to control admission of people into the military camp with an MTF collocated must be included in this education.

Need for further research

This study has demonstrated that there are intersecting interests with the work of Professor Janice Agazio in the US. She has written extensively on US military nurses' experience of ethically challenging situations and EDM on deployment. I have proposed an international comparison study of military nurses' experience of deployed EDM to her, which we have agreed to work on together in 2025. This could also involve international comparison of moral distress or moral injury related to EDM suffered by military nurses, about which she has also published.

Further investigation of the role of character and values in EDM is recommended in deployed military nurses, extending the work of Finnegan et al. (2016b; 2020) and Brockie (2022). This is something which was touched upon by many of my participants, but which I did not include in the final thesis as it did not contribute directly towards answering the research question. This is a topic I intend to follow up in post-doctoral research.

An interesting phenomenon raised in this thesis was nurses' perception of the role of 'intuition' in EDM. While more weight is being given to civilian nurses' prudent judgment in hospital-based Early Warning Score documentation, this is apparently not translating to military nursing. Further research could offer a deeper exploration of military nurses' attitudes towards 'nurse intuition' in the EDM of clinical care and how this relates to patient outcomes.

The National Institute for Health and Care Research (2019, Para. 3) highlights the importance of effective dissemination of research, quoting Professor Chris Whitty, then the Chief Scientific Adviser for the Department of Health saying, "*Research is of no use unless it gets to the people who need to use it.*" Since I started this study in 2017, I have been invited to speak at national and international conferences to present a snapshot of my study and its progress at that point. These included several ICMM conferences in Switzerland, Belgium, and Australia, the Defence and Security Equipment International conference in London, and a large South American military nursing conference in Brazil.

I have also spoken at numerous internal DMS academic and research conferences in the UK at various points during this study, including the DMS Ethics Symposium. Further, I presented my study to nursing leadership scholars in the Florence Nightingale Foundation, and to international academics at a conference on character and values at Oxford University's Oriel College with my primary supervisor in attendance. I have even organised learning periods on board warships deployed at sea and in tents on field medical exercises, in which the ethics of nursing practice were discussed in relation to my study. This face-to-face activity allowed me to source valuable collaborations, some of which have resulted in publication, and helped me network with nurses, bioethicists, and academics to raise the profile of military nurses in the EDM process. I will continue to present my study's findings and conclusions at civilian and military conferences as the opportunities arise.

However, it is anticipated that greatest future impact of this work will be felt in

deployment practices. This includes development of pre-deployment training to improve nurses' ethical awareness and familiarisation with common ethical dilemmas, and to give them experience of, and a practical means to assist them with, EDM.

Strengths and Limitations of the study

A researcher is obligated to the academic community to identify and honestly report the limitations within their research design (Ross and Bibler Zaidi, 2019). This is because these limitations may exert an influence on its findings, interpretations, outcomes and conclusions (Ibid.; Puhan et al., 2012). I have identified some limitations in my study, but as Chasan-Taber (2014) recommends, they were mitigated as far as was practicable. Some of these even became strengths.

For example, my fieldwork took place in an era of global pandemic, with the Covid virus in the UK leading to a series of tiered lockdowns being imposed to limit people gathering, severely restricted travel, and represented a cessation of normal social functioning. Lockdowns forced many people to isolate within their homes, and where possible, to work from home. This made the traditional face-to-face approach to collecting data in semi-structured interviews all but impossible until restrictions were relaxed, making it a significant limitation. However, video calls rapidly became the standard method of communicating in the workspace, and this extended to research (Thunberg and Arnell, 2021). As I described in the research design chapter, I embraced this shift to digital interviewing and felt that it enhanced the experience for both me and my participants. This is because we were all immersed in the comfortable surroundings of our home environments, in civilian clothing to reduce

barriers of rank, which likely yielded more rich data; turning it into a strength (Weller, 2017; Abrams et al., 2014; Alkhateeb, 2018). Reducing rank barriers is critical for encouraging military participants to speak openly, as the perceived power differential and rank relationship might otherwise lead to a more guarded and less frank conversation (Bernthal, 2015), impacting adversely on participant candour and subsequent data quality. Video interviewing meant that I was even able to conduct some long-distance interviews with serving and retired participants who lived abroad, as far away as Australia, which could never have taken place face-to-face because of financial limitations.

My findings were similar (e.g., in that they identified common ethical constraints on deployment), but not identical, to those of Agazio and Padden (2024) who conducted a grounded theory study with US military nurses examining ethical issues they encountered on wartime deployments. However, their inclusion criteria were quite narrow, meaning that any nurse who did not serve operationally between 2003-2012, or served anywhere other than in two specific operations in Afghanistan, was excluded from their study. This means that my study gives a much broader perspective on military nurses' EDM chronologically, geographically, and operationally (i.e., both combat and humanitarian deployment experience was included), making it a novel contribution to the field. As they published their study (Ibid.) after my review, data collection, and analysis was complete and write-up was well underway, it served as a serendipitously corroborative international source rather than an influencing source.

Another limitation is the fact that the data is now over three years old. The nature of

my busy job as a deployable Nursing Officer in the Royal Navy, and an authorised four-month leave of absence from the PhD pathway due to my military activity during the early waves of Covid in 2020, have had an impact on the analysis and write-up phases of this study. However, I am not concerned that use of my data is time-sensitive, as the span of my participants' experience of deployed EDM ranges from the mid 1950s to 2021. There have not been any significant deployments (i.e., above Role 1 capability) of military nurses to conflicts or humanitarian disasters since 2021. Recent Role 1 operations include the Afghanistan (and other) civilian air evacuation operations and standing sea patrols looking for refugees in distress. So, the possibility of any new experience of deployed EDM is limited.

My study has a wide demographic variety, which is acknowledged as a significant 'good' and a strength in research (See e.g., Stewart, 2021). My participants came from diverse backgrounds, in terms of e.g., age, clinical roles and specialities, military rank and command or leadership responsibilities, deployment profiles, education levels, and experience. This offered richer perspectives on military nurses' experience of deployed EDM.

15-point Reflexive Thematic Analysis quality check

Braun and Clarke developed a 15-point thematic analysis quality check in 2006, which they later updated to situate specifically around RTA in 2022. Braun and Clarke are clear to point out that their 15-point RTA quality check (2022) is not designed to be followed prescriptively. They intend it to be more of a set of guidelines for researchers to use as a handrail for conducting methodologically congruent or coherent qualitative RTA research, which is how I have approached the analysis of

this study. In assessing the quality of ‘Big Q’ research, Braun and Clarke are careful to steer researchers away from terms and ideas which they state are indicative of ‘positivism creep’ (Braun and Clarke, 2023), such as reliability, consensus, saturation, etc. For them, quality of analysis is characterised by a contextually situated researcher, fully immersed and reflexively engaging in artfully interpreting the data to find meaning beyond the semantic (superficial, expressed, or descriptive) level, reflecting the underlying ideas, assumptions, and value of the data at a latent (deeper, implied, interpretive) level (Byrne, 2022).

I have listed below the 15 points of Braun and Clarke’s (2022, p. 269-270) RTA quality check verbatim (*in italics*), and reflectively reviewed my study within that framework (in normal type). This is to demonstrate that I have undertaken an appropriately rigorous, systematic, and reflexive analytic process as Braun and Clarke intend (Ibid.):

1. *Transcription: The data have been transcribed to an appropriate level of detail; all transcripts have been checked against the original recordings for ‘accuracy’.* All interviews were transcribed either manually by me, or by using the built-in transcription tool in Quirkos, my chosen qualitative data analysis software. Regardless of method of transcription, I checked and edited all transcripts line-by-line against the audio and video recordings several times to ensure their word-for-word accuracy. After all transcription was complete, there were a few words or short sentences in some online interviews which were still not clear after repeated listening. However, these were not important to the flow of the transcript and did not

result in the loss of any critical data. These are clearly reflected in the transcripts for transparency of process.

2. *Coding and theme development: Each data item has been given thorough and repeated attention in the coding process.* ***3.*** *The coding process has been thorough, inclusive and comprehensive; themes have not been developed from a few vivid examples (an anecdotal approach).* A meticulous, line-by-line, reflexive thematic analysis was conducted on each transcript over a long period and repeated several times to fully immerse myself (or re-immerse myself after deployed time away) in the data. I reviewed each transcript in conjunction with its associated video recording and audio recording in turn, and often referred to my field notes to give me a fuller picture of latent meaning. I gave no more weight to the words of one participant over another, which allowed for comprehensive semantic and latent coding of the data. Through this process, I developed two main themes, and one sub-theme.

4. *All relevant extracts for each theme have been collated.* All relevant extracts from the data have been collated and presented appropriately within each theme to develop the narrative flow of the findings.

5. *Candidate themes have been checked against coded data and back to the original dataset.* Candidate themes were progressively developed, re-developed, checked and re-checked against the coded data, right back through to the original dataset. Candidate themes changed several times through the analysis, which is consistent with Braun and Clarke's (2022, p.268) philosophy that TA is "*an adventure, not a*

recipe." This means that analysis and thematic development can change, sometimes unexpectedly, which I experienced in my analysis, rather than being rigid, inflexible, and done the same way every time.

6. *Themes are internally coherent, consistent, and distinctive; each theme contains a well-defined central organising concept; any subthemes share the central organising concept of the theme.* Final themes were developed following the analytic process described above. As the analysis took place over a long period, there was plenty of time to think over the names of the themes and move codes around to check their positioning within these. It also allowed time to consider and dissociate coded data from my themes which had no relevance to answering my research question. The final themes are coherent, consistent, and distinctive, with each organised around a central organising concept. The single sub-theme is highly relevant to the central organising concept of the first theme within which it is included.

7. *Analysis and interpretation – in the written report: Data have been analysed – interpreted, made sense of – rather than just summarised, described or paraphrased.* As mentioned above, the time taken to code and develop final themes allowed for a great deal of time immersed in the data. My reflexive and reflective insights into the latent meaning in my participants' words proved valuable over this time. This led to a much deeper, richer quality of interpretative sense-making in my analysis, which also acknowledges, but is not a slave to, the surface-level semantic, descriptive meaning. Consequently, if feels to me like a clear picture of how my participants made sense of EDM, particularly on deployment, has been presented.

8. *Analysis and data match each other – the extracts evidence the analytic claims.* Analysis and data are consistent, and match each other throughout. Relevant extracts are used appropriately, and in enough detail to convey their meaning and support the analysis.

9. *Analysis tells a convincing and well-organised story about the data and topic; analysis addresses the research question.* The flow of the analytic narrative is well-organised and convincingly conveys my participants' words and meaning, and their importance and relevance to military nursing, to the reader. The research question of 'How do UK military nurses experience ethical decision-making on combat and humanitarian deployments?' has been thoroughly addressed and answered by the analysis.

10. *An appropriate balance between analytic narrative and data extracts is provided.* There is a good balance of illustrative data extracts and analytic narrative throughout.

11. *Overall: Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase, or giving it a once-over-lightly (including returning to earlier phases or redoing the analysis if need be).* I started this part-time PhD pathway in 2017, knowing that with a busy job as a deployable Royal Navy Nursing Officer there would be times of operational constraint when I could not devote the attention I wanted to progress my study and analysis. This was compounded by periods of deployment at sea and the emergence of the Covid

pandemic. For instance, I always intended to travel to conduct face-to-face interviews with my participants, but due to lockdown travel and gathering restrictions I was forced to turn to video calls. I also developed other workarounds, e.g., I was able to take printed journal articles with me to sea so I could at least keep up to date with the literature, as there was no internet connection available to us on board the ships. I have been able to devote a great deal of time from late 2022 to completing this study, as I was serendipitously assigned to an academic job role which has afforded me the opportunity to work at home and focus on concluding the analysis and writing up this thesis. Therefore, no phase of the study has been rushed, and some of it has even been frustratingly slow to progress because of surrounding circumstances.

12. *Written report: The specific approach to thematic analysis, and the particulars of the approach, including theoretical positions and assumptions, are clearly explicated.* The research design chapter describes the methodology and underpinning theoretical and philosophical positions, and assumptions, of this thesis.

13. *There is a good fit between what was claimed, and what was done – i.e., the described method and reported analysis are consistent.* The described method and the reported analysis are consistent. The analysis based on my methodology reflects my sympathetic and reflexive interpretation of the lived experience of my participants, and sense-making was enhanced by taking account of the particulars of each individual participant.

14. *The language and concepts used in the report are consistent with the ontological*

and epistemological positions of the analysis. The language and concepts used throughout this thesis are consistent with the interpretivist research paradigm I adopted, including its relativist ontology and subjectivist epistemology. The thesis has been checked to ensure the language used throughout is consistent with what Braun and Clarke (2023) call 'qualitative sensibility', and avoids 'positivism creep'. With a background in qualitative analysis, this was a natural process.

15. *The researcher is positioned as active in the research process; themes do not just 'emerge'.* With my *emic* researcher position, I was very much active in the research process of this study. I am cognisant that data is not 'hidden', waiting to be 'unearthed' and revealed like a truffle by some sort of data-snuffling researcher. I took an active role in analysing participants' meaning, coding data both semantically and latently. I actively made sense of participants' own sense-making about their memories, emotions, and feelings (a double hermeneutic process), and reflexively thought about theme development. I constructed a data-supported narrative which answered my research question and built my conclusions, which stayed true to the original data, presented alongside my carefully developed analytic assessment.

The reflective account of my analysis above indicates that it has been successfully conducted within the guidelines of Braun and Clarke's (2022) 15-point RTA quality check. Accordingly, I am satisfied with the quality of my analysis and confident about the conclusions drawn from it.

Conclusion

To the best of my knowledge, this empirical study represents the first in-depth analysis of how UK military nurses understand and experience EDM on combat and humanitarian deployments, which they reported from a variety of perspectives. These perspectives seem to have been most influenced by contextual factors which I have called 'the Four Ps' of deployed service'. These are: their **proximity** to hands-on clinical care, their **position** in the hierarchy, the **period** in which they trained as nurses or deployed, and the **place** they served on combat and humanitarian deployments. However, the overall message is resoundingly clear - EDM in military nursing should always remain patient-centric and impartial, aiming to do the right thing for patients, wherever operational circumstances allow.

I conclude that EDM in an operational setting is far more complex that EDM in a firm base hospital for many reasons. All the ethical constraints and complicating factors of operational service stated in this thesis, many of which would not be identical, similar, or even simply not feature in EDM in an NHS hospital, make it very difficult for military nurses to practice impartially in the deployed context. As a result, I further conclude that the military deployed context does indeed affect the EDM of military nurses, despite what the WMA (2012) says. It exerts a heavy influence on the ethical deliberations they experience and undertake, some of which are potentially morally injurious, and which live on vividly in their memory - sometimes for decades - afterwards. The evidence from this study suggests that the combination of an ethical template or EDM tool such as the 4QA and CBL, through scenarios of common ethical challenge drawn from sources of real-world experience, would be of practical

use to military nurses ‘on the ground’ to assist their EDM. Accordingly, this will be recommended to the DMS through the DMS Ethics Committee and other training provision channels.

With nurses advancing to become the ethical gatekeepers of the future forward operational medical space, it is essential that the DMS acts now. Military nurses cannot rely solely on reflecting on the past and thinking about now, today, the immediate. They must use those as a lens to help them look outward to prepare for tomorrow’s conflicts. However, given ongoing world events and the reported lack of preparedness of the UK’s MOD and NATO for a large-scale conflict (See e.g., Geiger, 2024; Adler and Davies, 2024), tomorrow may come sooner than Defence would like. As the character of conflict continues to change, so does the future ethical landscape for military nurses.

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Appendix 1: Ethical approval for this study

Lt Cdr Alan Brockie
HQ Joint Hospital Group (South West)

Tel:

Email:

Dear Alan,

Our Reference: **1009/MODREC/19** Date: 16th March 2020

MODREC Secretariat, Building 5, G02,
Defence Science and Technology Laboratory, Porton Down, Salisbury, SP4 0JQ

Telephone: e-mail:

How do UK military nurses experience ethical decision-making in operational clinical practice?

Thank you for submitting your revised application (1009/MODREC/19) with tracked changes and the covering letter with detailed responses to the MODREC letter. I can confirm that the revised protocol has been given favourable opinion ex-Committee subject to confirmation that any recruitment emails are sent by an independent/neutral contact (e.g. administrator).

This favourable opinion is valid for the duration of the research and is conditional upon adherence to the protocol – please inform the Secretariat if any amendment becomes necessary.

Please note that under the terms of JSP 536 you are required to notify the Secretariat of the commencement date of the research, and to provide copies of the consent forms and submit annual and final/termination reports to the Secretariat on completion of the research.

Yours sincerely,

Dr Simon Kolstoe MODREC Chair

From: Samantha Waldron (Research Support Services)
Sent: Monday, March 23, 2020 8:48 AM
To: Alan Brockie (PhD HSMC PT)
Cc: Roger Newham (Nursing); Mervyn Conroy (Health Services Management Centre)
Subject: RE: Application for study ethical review - ERN_17-1414-BROCKIE

Dear Alan,

I'm pleased to say that we are happy to accept this in lieu of you also applying for internal UoB ethics.

Best wishes

Sam

Ms Sam Waldron

Research Ethics Officer
Research Support Group
[redacted]
Tel: [redacted] (if you leave a voicemail message and number I will get back to you)
Email: [redacted] (also available on Skype for Business)

Please remember to submit a new Self-Assessment Form for each new project. Click Ethical Review Process for further details regarding the University's Ethical Review process.

Click Research Governance for further details regarding the University's Research Governance and Clinical Trials Insurance processes, or email researchgovernance@contacts.bham.ac.uk with any queries

From: Alan Brockie (PhD HSMC PT) [redacted]
Sent: 17 March 2020 12:15
To: Samantha Waldron (Research Support Services) [redacted]
Cc: Roger Newham (Nursing) [redacted]; Mervyn Conroy (Health

Services Management Centre) [redacted]
Subject: Re: Application for study ethical review - ERN_17-1414-BROCKIE

Sam,

PSA email from MODREC confirming 'favourable opinion' from their committee to proceed with the recruitment protocol and fieldwork for my PhD study. As per your original email below, can I take it that UoB accepts this MODREC ethical approval for my study and grants me institutional REC ethical approval to proceed as well? I will not start my fieldwork phase until I hear back in the positive from UoB REC.

I have confirmed to the MODREC Secretariat that I will use an independent / neutral agent to send out my recruitment emails to minimise potential bias.

Thank you.

Regards,

Alan

Lt Cdr Alan Brockie, Royal Navy | PhD student | Health Services Management Centre | University of Birmingham | Tel: [redacted]

Appendix 2: Recruitment email

UNIVERSITY OF BIRMINGHAM

Health Services Management Centre

Dear colleague,

INVITATION TO PARTICIPATE IN A STUDY ENTITLED:

'How do UK military nurses experience ethical decision-making in operational clinical practice?'

My name is Alan Brockie, and I am a qualified military nurse, with extensive experience of deployed military healthcare, currently working towards my PhD with the University of Birmingham. As a part of that educational pathway, I am conducting the above research project. The research aims to explore what it means to military nurses to approach, rationalise and make ethical decisions in operational clinical practice. I am also interested in studying the concepts of moral distress and moral injury as they apply in this context. In order to do so, it is necessary to hear your stories about encountering and being involved in making ethical decisions in both every-day and operational clinical nursing practice. To achieve this, one-to-one interviews will be conducted in a location and at a time convenient to each participant.

To participate in this study, ***you must be a currently or previously serving qualified and operationally experienced military nurse.*** The participant information sheet (attached) will explain the aims of the study and what it will involve. Please take the time to read this through.

If you have questions or are interested in volunteering to participate in the study, please contact me using the information provided below. If you are a volunteer, please include in your reply a brief statement of your eligibility (e.g. a list of deployed clinical roles / operational tours and approximate dates). All contact will be kept strictly confidential. I have attached a copy of the study consent form (for information only) which you will be asked to sign when we meet to indicate your consent to

proceed to interview. A minimum ‘cooling off’ period of 48 hours between reviewing the attached paperwork and deciding whether to volunteer to participate in this study is required. There is no requirement to contact me should you NOT wish to take part in the study.

I hope to hear from you soon.

Yours Sincerely,

Alan Brockie
PhD student & military nurse
HSMC, University of Birmingham [redacted] Tel: [redacted]

Attachments:

1. Participant information sheet.
2. Consent form (for information only).
3. Arrangements for the payment of no-fault compensation to research participants.

Appendix 3: Specimen MOD Consent form for participants in research studies

Title of Study: How do UK military nurses experience ethical decision-making in operational clinical practice?

MoDREC Reference: 1009/MODREC/19

Please Initial or
Tick Boxes:

1. The nature, aims, and risks of the research have been explained to me. I have read and understood the content of the participant information sheet and what is expected of me. All my questions have been answered fully, and to my satisfaction. ☐

2. I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researcher and be withdrawn from it immediately without having to give a reason. I also understand that I may be withdrawn from it at any time, and that in neither case will this be held against me in subsequent dealings with the Ministry of Defence. However, I understand that once analysis begins, data cannot be withdrawn. ☐

3. I understand that if I say something that potentially indicates that I or someone else is at risk of harm, or a crime or other serious misconduct has been committed, the researcher may be obligated to disclose this information to the relevant authorities. I further understand that if I do something of this type

the researcher will indicate it to me and I may choose to continue the discussion or end it. The researcher will also discuss what the next steps would be in this case. ☐

4. I understand that the interviews will be audio-recorded, and I consent to this recording taking place. I also consent to the time-limited storage and destruction of the same audio recording as confidential waste according to the University of Birmingham's policy on confidential information held for research purposes. ☐

5. I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 2018. ☐

6. I agree to volunteer as a participant for the study described in the participant information sheet and give my full consent. ☐

7. This consent is specific to the particular study described in the participant information sheet attached and shall not be taken to imply my consent to participate in any subsequent study or deviation from that detailed here. ☐

8. I understand that in the event of my sustaining

injury, illness or death as a direct result of participating as a volunteer in Ministry of Defence research, I or my dependants may enter a claim with the Ministry of Defence for compensation under the provisions of the no-fault compensation scheme, details of which are attached. I confirm that I understand the compensation arrangements. ☐

Participant's Statement:

I, **……** (write your name here)

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the participant information sheet relating to the project, and I understand what the research study involves.

Signed: **Date:**

Investigator's Statement:

I, Alan Brockie, confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the participant.

Signed: **Date:**

Authorising Signatures:

The information supplied above is to the best of my knowledge and belief accurate. I clearly understand my obligations and the rights of research participants, particularly concerning recruitment of participants and obtaining valid consent.

Signature of Principal Investigator

…… **Date:**

Name and Contact Details of Principal Investigator:

Name: Alan Brockie
Address: c/o Birmingham Medical School, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT.
Tel No:
E-mail:

Appendix 4: Participant Information Sheet

Study Title: *How do UK military nurses experience ethical decision-making in operational clinical practice?*

Invitation to take part

You are being invited to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it involves. Please read this information sheet carefully. If you have any questions, or anything is unclear and you would like further information, please discuss it with the researcher before you decide to be part of the study. You are also required to take a minimum 'cooling off' period of 48 hours between reviewing this information sheet and sample consent form and deciding whether or not to volunteer to participate in this study. There is no requirement to contact me should you not wish to take part in the study.

What is the purpose of the research?

The research aims to explore how UK military nurses experience ethical decision-making in operational clinical practice. In order to do so, it is necessary to hear your stories about encountering, observing or being involved in ethical dilemmas or making ethical decisions in operational clinical nursing practice; be it combat or humanitarian in nature. I would also like to explore the role of moral injury and moral distress in this process. Interviews will be conducted with a group of at least 25 operationally experienced military nurses. You will be eligible to be a participant in this study if you are a qualified military nurse with operational experience in at least one clinical nursing role during your current or former career. Application to become a participant in this study does not mean that you will automatically be selected as a final participant – some of those who apply may not be selected to progress to the interview stage.

Who is doing this research?

This research is being conducted by Alan Brockie, a qualified military nurse with extensive experience of deployed military healthcare. He is undertaking this study as part of an academic programme at the University of Birmingham's Medical and

Dental School, leading to award of the Degree of Doctor of Philosophy (PhD).

Why have I been invited to take part?

You are being invited to take part in this study because you are a serving or retired qualified military nurse with operational experience in a clinical nursing role during your current or former career. I would like to understand your exposure to and views on ethical decision-making in your career as a military nurse.

Do I have to take part?

No, you do not have to take part. It is entirely your choice whether or not you decide to join the study. If you do agree to take part, you will be asked to confirm your consent by completing a written consent form before you are interviewed. If you decide to take part, you will still be free to withdraw from the study at any time, without giving a reason. The things that you say during your interview, your decision to take part in, not take part in or withdraw from the study at any time will not affect your military or professional career in any way (including pay, promotion etc.).

What will I be asked to do?

If you decide to take part, you will be interviewed on a one-to-one basis. These socially-distanced interviews will be arranged to take place at the University of Birmingham, at your Unit or at a suitably private meeting space in another part of the UK – whichever is most convenient for you. Interviews will also take place at times that are most convenient for you. With the recent advent of COVID-19, interviews may be conducted remotely via video or telephone call if that is your preference. I will explore relevant issues around your experiences with ethical decision-making in military nursing. Your interview should last for around 45 minutes. With your permission the interview will be audio-recorded, and then transcribed verbatim for further study. Both the audio recording and the transcription will be used to analyse the data. The consent form you sign will be destroyed within seven years, and the electronic files of your interview and its transcript will be destroyed after 10 years of secure storage in line with Ministry of Defence instructions relating to research data management.

What are the benefits of taking part?

There are no direct benefits to you for taking part in this study. However, the research aims to contribute to the education and pre-deployment training of military nurses in order to further support those in the position of making ethical decisions. This may become especially true as nurses take on more responsibility and advanced practice roles and deployments in the future. Some participants in previous ethical studies have reported their interviews as a cathartic experience.

What are the possible disadvantages and risks of taking part?

There is a possibility that you might recall distressing or traumatic memories, although the focus of this study is on morals and ethical decision-making rather than the specifics of the events you relate. However, should you become visibly distressed or otherwise upset during the interview process, the researcher will stop the interview and you can choose whether or not to continue. If you choose to stop the interview, the researcher may then signpost you to the relevant support mechanism, for example your Unit Welfare Officer, Chaplain, medical centre etc. If you were to say something that potentially indicated that you or someone else was at risk of harm, or if it becomes clear that a crime or serious misconduct has been committed, the interviewer may be obligated to disclose some of this information to the relevant authorities.

Can I withdraw from the research and what will happen if I withdraw?

Yes. You can voluntarily withdraw from the study immediately at any time, for any reason, by communicating this wish to the researcher either verbally or in writing. Withdrawal from the study will have absolutely no bearing on your military or nursing career. However, once analysis has begun, data cannot be withdrawn.

Are there any expenses and payments which I will get?

No. There are no expenses or payments available for participating in this study. The researcher will travel to meet with you at a time and place at your convenience unless conducting the interview remotely.

Will my taking part or not taking part affect my Service career?

No. Your decision to take part in, not take part in or withdraw from the study at any time will not affect your military or professional career in any way. This also applies to what you say during your interviews – the content of your interview will in no way adversely affect your military or professional careers.

Who do I contact if I have any questions?

If you have a question about any aspect of this study, you should contact the researcher who will do his best to answer your questions. Alan Brockie can be contacted on , or at .

Who do I contact if I have a complaint?

If you cannot resolve your complaint or issue informally with Alan, please feel free to contact his military sponsor at any time if you have any concerns or complaints about his study. Group Captain Di Lamb can be contacted on , or at .

What happens if I suffer any harm?

Given the nature of the study, you are not expected to suffer any kind of harm. However, if you suffer any harm as a direct result of taking part in this study, you can apply for compensation under the MoD's 'No-Fault' Compensation Scheme; details of which are attached. However, if during the course of an interview it becomes clear that you are at serious or ongoing risk of harm, or become distressed, the PI has an obligation to immediately terminate your involvement in the study. The researcher is a qualified TRiM practitioner and Team Leader, so can signpost you to the relevant support network should you become distressed during the course of an interview, depending on the nature of your distress (e.g. Chaplain, medical centre, DPHC CPN walk-in clinics etc.).

Will my records be kept confidential?

Yes. Your records will be kept confidential at all times and all interview data will be anonymised. Written data will be stored securely in a locked cabinet, in a locked

room on University of Birmingham campus for up to 7 years after the study has ended in accordance with MOD policy, including consent forms. Any digital data will be kept on a password-protected University or MOD server for a minimum period of 10 years. Thereafter, all data, including the audio recordings and transcripts will be destroyed per MOD policy.

Who is organising and funding the research?

This study is organised by the Principal Investigator, Alan Brockie, as part of his educational programme with the University of Birmingham. It is funded entirely by the Ministry of Defence.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by the RAF Scientific Assessment Committee, the Ministry of Defence Research Ethics Committee (MoDREC) and University of Birmingham Research Ethics Committee.

Further information and contact details

Name: Alan Brockie

Address: c/o Birmingham Medical School, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT..

Tel No: E-mail:

Compliance with the Declaration of Helsinki

This study complies, and at all times will comply, with the Declaration of Helsinki as adopted at the 64th WMA General Assembly at Fortaleza, Brazil in October 2013.

Appendix 5: Arrangements for the payment of no-fault compensation to participants in studies reviewed by MODREC (Taken from JSP 536 Pt 1, Ch. 6 (V3.1, Mar 20))

MOD No-Fault Compensation Arrangements:

1. MOD maintains an arrangement for the payment of no-fault compensation to a person who suffers illness and / or personal injury as a direct result of participating in research conducted on behalf of MOD. The no-fault compensation arrangements only apply to research participants (military, civilian, or non-MOD) who take part in a Trial that has been given a favourable opinion by the MODREC.

2. A research participant wishing to seek no-fault compensation under these arrangements should contact the Directorate of Judicial Engagement Policy, Common Law Claims and Policy (DJEP-CLCP), Ministry of Defence, Level 1, Spine 3, Zone J, Whitehall, London, SW1A 2HB who may need to ask the Claimant to be seen by a MOD medical adviser.

3. CLCP will consider reasonable requests for reimbursement of legal or other expenses incurred by research participants in relation to pursuing their claim (e.g. private medical advice, clinical tests, legal advice on the level of compensation offered) provided that they have been notified of the Claimant's intention to make such a claim.

4. If an injury is sufficiently serious to warrant an internal MOD inquiry, any settlement may be delayed at the request of the research participant until the outcome is known and made available to the participant in order to inform his or her decision about whether to accept no-fault compensation or proceed with a common law claim. An interim payment pending any inquiry outcome may be made in cases of special need. It is the Claimant's responsibility to do all that they reasonably can to mitigate their loss.

5. In order to claim compensation under these no-fault arrangements, a research participant must have sustained an illness and / or personal injury as a direct result of participation in a Trial / Study given a favourable opinion by MODREC. A claim must be submitted within 3 years of when the incident giving rise to the claim occurred, or, if symptoms develop at a later stage, within 3 years of such symptoms being medically documented.

6. The fact that a research participant has been formally warned of possible injurious effects of the trial upon which a claim is subsequently based does not

remove MOD's responsibility for payment of no-fault compensation. The level of compensation offered shall be determined by taking account of the level of compensation that a court would have awarded for the same injury, illness or death had it resulted from the Department's negligence.

7. In assessing the level of compensation, CLCP, in line with common law principles, will take into account the degree to which the Claimant may have been responsible for his or her injury or illness and a deduction may be made for contributory negligence accordingly.

8. In the event of CLCP and the injured party being unable to reach a mutually acceptable decision about compensation, the claim will be presented for arbitration to a nominated Queen's Counsel. CLCP will undertake to accept the outcome of any such arbitration. This does not affect in any way the rights of the injured party to withdraw from the negotiation and pursue his or her case as a common law claim through the Courts.

Additional / Alternative Compensation Arrangements

9. **Compensation for Service Personnel (SP).** SP who took part in studies before 6 April 2005 and who consider that they may have suffered later harm or disability due to that study should contact MOD Defence Business Services– Veterans (DBS- Vets) Service Personnel and Veterans Agency (SPVA) for consideration of a war disablement pension. The personnel who are entitled to make claims under the war disablement pension scheme are laid out on the SPVA website, as are details of the claim's process.

10. In the event of service personnel suffering injury or disability as a result of their participation in work given a favourable opinion by MODREC on or after 6 April 2005 then they may be entitled to compensation under the Armed Forces Compensations Scheme (AFCS). The details of the AFCS are promulgated on the MOD Intranet and are also available on the DBS-Vets website. Claims should be made to DBS-Vets following the instructions available on the MOD Intranet and DBS-Vets website.

11. In the event of service personnel suffering injury or disability as a result of their participation in research having gained a favourable opinion from MODREC which is sufficiently serious for subsequent medical discharge from the services, their medical records will automatically be forwarded to DBS-Vets for consideration of compensation and pension enhancements in addition to whatever MOD pension / gratuity they are already entitled to by virtue of their service. Similarly, in the event of death as a result of their

participation in MODREC endorsed MOD research, their dependants may be entitled to receive a supplemented pension.

12. However, if either a SP or their dependants receive payment under the MOD 'no fault compensation' arrangements (or as the result of a common law compensation claim) for the same condition as that for which a pension is received, any pension entitlement may be reduced since compensation should not be paid twice for the same injury, disability or death.

13. **Civilian Pensions.** In the event of a civilian research participant suffering injury or disability as a result of their participation in MODREC endorsed MOD research sufficiently serious for them to subsequently suffer a loss in earnings capacity; they may be eligible for benefits under Section 11 of the Principal Civil Service Pension Scheme (PCSPS). Further details are available in the PCSPS booklet Injury at Work. Similarly, in the event of death as a result of participation in MODREC endorsed research, their dependants may be entitled to receive benefits.

14. **Common Law Compensation.** If a research participant or their representative believes that injury, disability or death was caused by the negligence of MOD or its staff, and do not wish to pursue the possibility of a 'no-fault' compensation payment, a common law claim for compensation should be submitted to Directorate of Judicial Engagement Policy, Common Law Claims & Policy (DJEP-CLCP) (at the address in Para 2 above) detailing the full facts of the claim and stating that common law compensation is being sought.

Multinational / Multicentre Research And Research Involving Other Government Departments

15. When MODREC is involved in studies which involve Departments other than MOD there may be a requirement for specific Compensation Arrangements on a study by study basis.

Appendix 6: Study topic guide

Interviews will be semi-structured. Responses will be elicited to the following, or similar, questions. However, the researcher will be free to adapt the sequencing and exact phrasing of questions to the circumstances of each interview.

ENSURE CONSENT FORM IS SIGNED, A COPY GIVEN TO THE PARTICIPANT. Then turn audio recorder on.

Use neutral language throughout to avoid perception or suggestion of good / bad; right / wrong actions of participant.

Warm-up questions and interviewee background:

What brought you into nursing, and then the Armed Forces, as careers?

Tell me about the jobs you've had in your career to date.

Which one have you enjoyed the most? Why?

What operational tours have you deployed on?

Ethical decision-making in military nursing:

1. In this study, I am interested in your experience of ethical or moral decisions made, observed or witnessed in your nursing practice during your service; particularly on operational tour. Can you tell me about this? (Allow participant to respond, they may need some prompting as to what they interpret as being an ethical / moral decision).
2. Can you give me any examples of what you mean?
3. What did you learn in your pre-deployment ethical training? (MOST course etc., if applicable)
4. Do you think that ethical decision-making is important in nursing in general? Why do you say that?
5. What about military nursing, in operational practice in particular?
6. Are frameworks that we have for ensuring ethical conduct (e.g. NMC guidelines and DONC / SOPs) helpful for nurses to make ethical decisions? Why/why not?

Prompts (only as a loose guide for the PI – will not be addressed as 'test'-type questions):

Tell me about any times where an ethical decision you may have observed, or been a

part of when deployed, has left you pleased, proud and *in your opinion* a 'right' or 'good' decision was made.

Tell me about any times where an ethical decision you may have observed, or been a part of when deployed, has left you feeling uncomfortable, upset, or that it was somehow 'wrong', 'not right' or 'bad'?

Do you still think back on any of these experiences now? Why do you think that is?

Using your experience, or thinking about it now, can we discuss the thought process that you, personally, might go through to make a difficult ethical decision?

What resources or experience do you think that you, personally, might draw on to make an ethical decision?

Do you try to help your colleagues to make ethical or moral decisions at work, or can you remember doing so on tour? How do / did you do that?

Warm-down questions:

> Now that we have discussed your thoughts on ethical decision-making in operational clinical practice, is there anything else relevant that you wish to talk about or tell me?

THANK PARTICIPANT, AND SWITCH OFF AUDIO RECORDER