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Care and the Ethics of Care in Civilian and Military Triage

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Article Info

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Abstract

One of the emotionally most difficult experiences for care providers is to not be able to treat patients that are before them face-to-face. This occurs for many civilian providers treating patients during natural disasters and military providers treating their own and enemy soldiers injured in large numbers during combat. The Care Perspective most captures both their felt obligations in these contexts and the angst these providers may feel when they can't fulfill these obligations. This perspective, though common in both women and men, is particularly predominant in women. This piece will examine and compare and contrast the ethical conflicts providers experience in both of these contexts. Finally, recommendations will be offered for those making policy for both groups of providers serving in these settings.

Keywords: Ethics of Care; Civilian; Military Triage.

Care and the Ethics of Care in Civilian and Military Triage

A most emotionally painful circumstance care providers can encounter is their knowing that they could save patients' lives, but that they are not able to because of a shortage of resources. This can occur, for example, in civilian settings after natural disasters and in the military when mass casualties occur during combat. This pain was expressed by two civilian doctors, for example, when they treated patients after an earthquake in Haiti. The standard of treatment they could offer became lower and lower. They worried then that they were on "a slippery slope toward inhumane medicine" [1].

These circumstances may not only cause them these painful feelings. This may violate their moral beliefs regarding what they believe is right for them to do. This may, in addition, then, cause them moral distress. The moral framework this is most likely to violate is the so-called Ethics of Care or Care Perspective. This perspective grew out of Carol Gilligan's book *In A Different Voice*, which she wrote in 1982. She suggested in this work that, in general, women relied more than men on their feelings and relationships with others when making moral decisions [2]. Gilligan has continued to build upon the insights that led to her earlier book [3]. Joan Tronto, an eminent theorist on the Care Perspective, like Gilligan, also sees women as having in these same ways a greater moral sensitivity. She sees it as unclear, however, whether this is merely because they are female, because they are mothers or potential mothers, or because of their place in their societies' cultures [4].

Since this time, Gilligan's view, here, has been subject to different interpretations [5] and to controversy. Some, for example, have seen it as inextricably relating to feminist politics and philosophies**.** Tronto asserts, here, that feminist theory, inextricably connected to Gilligan's insights, grows out of the attempt to end women's marginal state in society [4]. Others have seen it as needing along with it, to be credible, and/or practical, traditional principles such as autonomy and equity [6-8].

Still, notwithstanding these challenges, this framework continues to be most relevant and important in enabling providers to care for patients optimally [9]. It gives providers, for instance, quintessential, additional medical goals and then a check on whether they have achieved these goals – effecting positive feelings and a trusting relationship between themselves and their patients [10,11]. These two factors may in some cases be as critical as any to both their patients and to how their patients fare. If, then, in triage situations, providers have insufficient resources, in addition to hurting from this emotionally, they may feel also profound moral distress.

In this piece, I shall discuss in greater detail what care providers may experience in both the above contexts. I shall also discuss then how they, the institutions in which each serves, and other care providers less affected by these situations may best provide care under these circumstances. I shall do this in three main sections. First, I shall say more about the care perspective. I shall include here why it remains important today. Second, I shall discuss how providers in both these contexts, civilian and military, may be affected. Here, both may have to abandon their usual priority of treating first the worst off patients before them so as to save the greatest number of patients' lives. In other ways, however, their sources of angst differ. Thus this comparison, hopefully, should deepen our understanding of the complex emotions these providers are likely to feel. Third, I shall discuss finally the implications of this analysis. These implications will apply to both institutional policies and providers and will apply both before this conflict arises and after providers have become engaged.

The Ethics of Care

The Ethics of Care, alternatively referred to as the Care Perspective, is defined in term of emphases of concern and discernment. Providers, for example, would focus more on avoiding the dangers of patients perceiving them as abandoning them than on providers, inadvertently or otherwise, committing harms as a result of their medical treatments. The Care Perspective reads the moral questions presented by a situation more in terms of responsibilities rather than rights. It attends more to skills that enhance patient care provider bonding than to how providers should best apply abstract principles [9].

Carol Gilligan who initiated this perspective, now almost four decades ago, emphasized the importance of feelings and of the relationships between people. She discussed then how women may respond more than men on the basis of how they feel for others as I've said. Men, in contrast, may decide what they believe is right to do more on the basis of their reasoning. That women may differ from men generally in this way has, I believe, generally been accepted. Beyond this, however, the role the Care Perspective should have, if any, in clinical practice has been subject to differing views. Gilligan's work continues, however, to be relevant [7,8,10,11].

Joan Tronto, another key theoretical thinker in this area, contends that the care perspective alone is incomplete and what she calls Kantian thinking is additionally necessary to insure to a greater extent that equity and justice adequately prevail in healthcare. She asserts that this Kantian thinking is a necessary check on "unrestrained, unevidenced and unanalyzed 'moral knowing' [4]. Rationality, she states, provides skepticism, equity, and evidence, and no reasonable ethics can exist which does not satisfy all three of these requirements [4].

The View of Nel Noddings

Providers may or may not, then, add to a care perspective what Tronto calls Kantian thinking. This Kantian addition may as we shall see offer these providers a way to reduce their emotional pain. To best appreciate how morally and emotionally these situations may so affect providers, however, it may be at this point most helpful to consider also the view of another eminent thinker on the Care Perspective, namely, Nel Noddings. To illustrate what it means to her to adhere to this perspective, Noddings gives the following example involving her son. Should she, she asks, ever lie for him? She answers that she believes that she should. She would, for example, if his school called, asking if he was sick, say he wasn't there. She would, that is, lie for him. She would say that he was sick, even when he wasn't. If necessary, she would continue to do this, even many times. She would do this to save him from being punished by the school. "I may choose to lie," she says, "*regularly* in order to meet my son as one-caring rather than as one conforming to principle" [12].

The Care Perspective that she is seeking to illustrate here transcends moral principles. It appeals to a still higher principle. This transcendence is necessary, she asserts "to give proper-place value to human love, loyalty, and the relief of suffering" [12]. This different moral commitment requires, she says, a rearranging of the usual hierarchy of traditional moral principles. This and only this, she maintains, will enable us to turn *to*, not from, real people.

This rationale explains why this particular perspective may be so dearly held particularly by some providers. They enter medicine and then serve patients whether as civilians or military personnel in the hope of healing them. It is this prior commitment and quest that some providers may find first challenged and then broken in the rigors of disasters and war. A paradigmatic example in which then the Care Perspective and traditional ethics may conflict is the following: Two children need the same, single organ via transplant to survive. Parents adhering to the Care Perspective, as Noddings does, might, here, do all they can to try to help *their* child be the one who gets this lone organ. Others may, though, here, favor equity. This might involve, theoretically instead, these "competing parents" flipping a coin.

Noddings recognizes also, however, how, at this same time, people's giving priority to the Care Perspective may become a double-edged sword. It may be that those who hold to it most dearly may inadvertently do more harm than good. People's feelings may, she says, dictate their beliefs, and they may not know that this is occurring. These beliefs

may, then in some way or other, differ from and distort what these person's initial feeling reflected. Then, "in arguing from principles," she says, "one often suppresses the basic feeling that prompts the justification" [12]. One's feelings in this sense may, then betray them. We shall consider how this may occur in both types of providers practicing in triage situations shortly. This may be, as we shall see, what may happen to civilians having to leave patients untreated during disasters. They may rationalize that this is best for them when it is not. It is possible by pushing the envelopes of their rules, however, as we shall see, to do better. Similarly, providers on the battlefield may feel enmity for enemy soldiers they must treat. This enmity may result in their rationalizing away feelings they had that moved them initially to care for all patients when they first chose to enter medicine.

The View of James Sabin

This bring us to the more concrete ethical question as to what providers should generally do when their duties to just one patient and their duties to many conflict. As I indicated previously, there are some measures they may take to reduce the emotional angst that they may feel.

Here, James Sabin provides one. He asserts that these two approaches, treating just one and treating the many may not be mutually exclusive. He believes that patients in such situations know that their providers must make triage-like decisions in many contexts and, moreover, that they both need and want this. Further, he asserts, providers shouldn't share with their patients that in these situations they are making the compromises they must make. He asserts that providers sharing this information explicitly or even implicitly would only add unnecessary, additional burdens to their care [13]. Adopting Sabin's belief is one way providers can better resolve this conflict. They can consider that on the basis he asserts a conflict doesn't exist and then, if they find this argument valid, make this conclusion.

They can also remind themselves that in net effect they can do the best for large numbers of patients if they "follow the rules". I shall have more to say about this also later.

Still, however, some providers' torn feelings and/or their moral distress may remain. The remainder of this discussion will focus on how providers' emotions in these two situations may come about and then, in this piece's last section, how institutions and providers may each reduce the anguish of the providers who most feel it in these situations.

Civilian and Military Triage

Resources may become low in disaster and combat settings. Then care providers may have little-to-nothing to offer the patients before them. They may then only be able to bear witness to their suffering, though they are accustomed to being able to treat every patient before them optimally and on the basis of each of these patients' individual needs. Thus, to "let" some people go without treatment may seem to them emotionally close to unconscionable.

This may mean in situations such as natural disasters or war that care providers must knowingly not treat some patients before them whom they know they could save. Providers may be expected, however, in these mass casualty settings to switch from their usual patient-centered practice of treating worst off patients first to a practice fostering the greatest good for the greatest number without this disturbing them greatly. Such factors as the sheer number of patients needing treatment and their ever more shrinking resources may then cause providers to have painful feelings and even violate their moral tenets, especially those of an Ethics of Care. This may come about in response to any degree to which they violate these tenets.

In this second section, I shall discuss two contexts in which these conflicts occur - natural disasters and combat or war. These contexts differ of course in many respects, but emotionally and morally, for providers serving, they may be emotionally alike.

Civilian Providers treating Patients in Natural Disasters

Civilian providers may hurt and face moral angst during disasters. During Hurricane Katrina, for example, care providers at a private hospital were isolated and surrounded by a flood. They, then, had to wait for rescue efforts but did not know when these would arrive. These providers had to decide such agonizing questions as which patients among many should be the first ones rescued when rescue boats or helicopters came [14]. One of the most agonizing aspects of this particular, paradigmatic question that these providers faced and had to answer was whether family members should be allowed to stay together. The providers there had to decide whether to separate family members on the basis of other criteria they applied to others, such as age, or whether they should allow families to stay together.

Another kind of example in which providers felt they had to abandon their usual practice occurred in Haiti after an earthquake there. Care providers had, due to limited resources, to go well outside the usual standards of their practice. After they had applied a solution they had available to treat a patient's parasitic rash, for example, they ran out. Then, they would, sometimes, have to use *sewer water* subsequently to continue to bathe these patients [15]. Civilian providers in these contexts also may do procedures they otherwise never would do under normal circumstances. Some did surgery, for instance, that they had only seen but had never done. They did this, of course, because if they didn't, these patients would be much worse off.

A nurse describes this. She says that physicians "provided us with instruction on how to do procedures we had only previously seen performed…we performed nerve blocks, hematoma blocks, reductions and splinting without x-rays, needle decompressions, thoracentesis, paracentesis, and even procedural sedation without having access to oxygen, suction, or advanced airway supplies…we used sheets and

gallon containers with dirt, water, or anything else we could find" for traction, and pins were placed with "manual drills, as there were no electric ones, and in fact…no electricity." The focus, she explains, was on "saving as many people as possible" [16].

Another such example occurring in Haiti involved a boy with a badly infected leg. He needed an amputation to survive. His mother, however, refused to give her consent. This surgeon chose then to do something he would never do in the states. He took this mother to her son's bedside and removed then his leg's bandage. His infected wound looked and smelled bad. She then consented. Her son had the amputation, lived, and did well.

In civilian disasters then, as after this one in Haiti, care providers may have to decide to give patients sub-optimal treatments or even in some cases, none. Providers may believe in this latter instance that it is better to give a patient *no* treatment because in the other host country in which they are providing treatment, local hospitals and providers would not be able to give this patient adequate, necessary, follow-up care. A paradigmatic example of this occurred in Haiti. A 46-year old Haitian woman had had a femur fractured. It had not been treated, but had partially healed in a way that left her leg crooked. Her leg had healed in a way that caused her upper leg to angle out "in an awkward V." As a result, she was unable to walk. The doctors who had come there from the U.S. to help treat these patients could have re-broken her leg and, then, "pinned it back in place". Medically, there was no reason that they couldn't do this. This would have, though, required that these providers take her back to the states so that they could, then, give her there the follow-up care that she would need. Resources, though, wouldn't allow this. Expending the extra efforts that could have enabled her to walk, it was believed, were too extensive to carry out. Her care providers could not, then, treat her as they wanted to, and as the Care Perspective might more suggest that they should. They, instead, pursued the only action that they felt they could do, namely, leave her untreated. This patient was, therefore, discharged and a friend, then, carried her home [1].

Military Providers treating Patients during Combat

Military care providers may feel great loyalty to their own service members. They may, as a result, feel highly conflicted when they are tasked with having to treat captured enemy soldiers equally. They know that, as a result of their doing this, they may have to give some of their own soldiers' needs less priority and thus less timely medical care. To them, their doing this may be like Noddings has described. This may, referring to her example, be like a provider's having to treat another patient with the unavoidable result of having to treat her own children only later. These providers' ambivalence may be still more pronounced if they know or suspect that the enemy soldiers they are treating have previously killed or wounded their own soldiers. Here, the more apt Ethics of Care analogy might be that of a provider's having to treat a patient who had just killed or injured her child.

Here, the sources of military soldiers acquiring exceptionally strong, negative feelings toward enemy prisoners may be profoundly distressing and unique. One soldier, for example, was wounded and "bleeding out" from a leg injury. A medic then went to this soldier's aid, applied a tourniquet and saved this soldier's life. Seconds later, an enemy soldier shot this medic, and killed him. The soldier saved felt grateful but guilty that he had survived, and he hated this enemy soldier. Another soldier came to aid a pregnant woman who came into the clinic. When he came to help her, a bomb she had strapped on underneath her clothing exploded and killed them both. This evoked fear and distrust of civilians. Still another soldier went to help others after a bomb went off, harming some of them. This first bomb was a trap. After others went to help, a second bomb exploded, killing those who came to help. Military providers are, of course, also deeply aware and concerned about the feelings of service members who have experienced incidents such as these.

Military providers, under International Law, are required during triage to treat enemy soldiers as they would their own. They are not required to treat civilians, equally, also, except under specified circumstances. This is because the U.S. has not agreed to the provision within the Geneva Convention that would require military providers to treat civilians as they would and on a par with their own service members. This was based on its view that it could not, in good faith, deliver this degree of extensive care to all these three groups - its own service members, enemy soldiers, and civilians - as their agreeing to this additional provision would have explicitly promised.

Since the Geneva Convention requires U.S. military providers to treat enemy soldiers equally, military law requires this, as well. Also, practically, if military care providers treat enemy prisoners "equally", this models a highest standard of care. In addition then to this equal treatment being, most feel, right in itself, some hope that if they treat enemy soldiers equally, other countries would be more likely to follow suit. Individual enemy soldiers who are patients and treated "as equals" may, too, be personally moved by this. Some hope too that as a result of this, these enemy patients may then even switch their allegiance so that they turn to supporting the U.S.

Military care providers can and do, of course, often go beyond merely treating enemy patients equally to doing all for them that they can. These providers treating these patients on a military hospital ship, for example, went to the ship's commander to request that they constrain enemy prisoners ill and on board with less confining physical restraints so that these "ship-hospital prisoners" could be more comfortable and to a greater extent care for themselves. Without permanent arm restraints, for example, they could go on their own inside rest rooms. These military providers succeeded.

Military providers, often, as in this example, seek to help every patient they can, including civilians, even when they aren't required to do this under either the Geneva Convention

or military regulations. Another example here is that of a pregnant woman who ideally needed specialized care. This was not available in her local hospital. The military providers to whom she had gone found a way to fly her by helicopter to a military hospital that could provide the care to her that she and her baby needed. She and her baby both then did well.

Their treating enemy soldiers equally may be more difficult in practice than in theory. Providers may, of course, feel much more love for their own soldiers. They may see their own soldiers much as Noddings sees her son - as if they are members of their families. This sense of loyalty and commitment is often profound. For some soldiers, their loyalty and commitment to each other may be the main or even sole reason that they are willing to continue to fight. This commitment may be no less strong for military providers,

Thus, with this loyalty, they face a conflict between on one hand treating first all their fellow soldiers and on the other hand their treating enemy soldiers equally. This conflict gets worse if and as resources become more limited. It may then become agonizing. The argument in favor of equality is however morally supported also by other factors. Enemy patients once stricken are, for example, no longer combatants. They no longer pose the same degree of a threat. As Noddings might say in regard to these soldiers, then, they are now only real persons.

These enemy patients may, then, in addition to evoking some providers' enmity, also evoke their compassion. A U.S. military surgeon expressed this. When he was doing surgery on an enemy soldier, he held this patient's heart in his hands. He felt, then, "at the deepest level," he said, that this person was "no more or less than a human like me."

Providers with this enmity and compassion may then feel emotionally-wracking ambivalence. Military providers' emotional angst due to their ambivalence may then compare in its painful intensity with the pain civilian providers may feel when they are not able to treat fully all the patients before them. Military providers' pain, finally, may be additionally exacerbated in this situation by their feeling, perhaps rightly, that when they treat enemy soldiers ahead of their own service members, at least some of their fellow soldiers, also stricken, may see them then as betraying them.

This surgeon's view of such patients as fellow humans like himself, as opposed to enemies at this time, would seem to epitomize what Zhang Longxi refers to as the "new humanism". He speaks of this concept as seeing all people as "truly human" with" universally found feelings and ideas shared by people in all parts of the world" [17]. He elaborates this concept, citing Oliver Kozlarek – one of the authors of a book Longxi has edited [11]. Kizlarek argues "for humanism as a praxis," as a "caring effort" for the neglected, marginalized, underprivileged people in our world [17].

The Care Perspective adds to this new humanism perspective by similarly highlighting our need to feel caring and committed toward those with whom we are closest. As Noddings expresses this, "The ethics of caring is a rapidly developing normative moral theory. It is concerned with how, in general, we should meet and treat one another–with how to establish, maintain, and enhance caring relations" [18]. This surgeon's feeling of caring when holding the enemy's heart, as he seeks to save his life would, at this moment, represent both this universal caring and commitment.

Implications

How, then, might providers in both contexts fare better?

First, it may be that in both these contexts, providers may gain some relief from their distress by following prescribed triage rules, as I have noted already above. One reason they may want to do this is that they can then use these rules to help justify, validly, what they do. If, instead, all providers followed only or mostly their own moral principles, sometimes these would be unavoidably idiosyncratic feelings and ethical preferences. This would possibly or probably result overall in less acceptable outcomes. Large numbers of patients might do much worse.

Second, the institution that "sponsors" them – as well as other care providers not so stressed - should afford these providers utmost respect if and when providers who feel distressed by what they must do in these disaster contexts make this known. Tronto, for example, sees the ethics of caring as being an institutional as well as an individual responsibility [4].

Third, *if* these care providers can anticipate that they might have these feelings, they should disclose this to their sponsoring institutions in advance. Then these institutions can accordingly plan better. They may, for instance, not place these providers in situations that are as likely to violate either what they feel or what they believe.

Fourth, if providers can recognize that they have these dysphoric feelings or must violate their moral convictions only *later*, their sponsoring institutions should treat them again with the same utmost respect. In this instance, this may be harder. This may be the case at least in part because it is here more plausible that under these circumstances, providers may report these feelings and or value conflicts falsely to be relieved from these assignments. They could say, for instance, that they found them exceedingly distressful when, in reality, they did not. There then may be no way that others, making these assignments, can determine here the truth. Providers making this claim and being relieved of these assignments may also, of course, leave other providers with decreased numbers and, thus, increased work.

Civilian and military providers may though feel this way only suddenly. Some care providers serving in Haiti, for example, found more emotionally difficult than anything their walking to the clinic at which they would treat patients there. As they walked to the clinic, people starving begged them for food. They, of course, themselves needed food to be able to continue to treat patients in their clinic.

A care provider made the decision to share her food and water in New Orleans after Hurricane Katrina. At the same private hospital I previously mentioned, hospital staff were supplied with small amounts of water and food which they

were expected to use bit by bit over days as the hospital at which they worked remained isolated due to flooding outside it, because it wasn't known how long it would be before all would be rescued. A teenager who was pregnant and visibly dehydrated asked one of the staff members for water and food. If, of course, this staff member gave her some of her water and food, her doing this could have resulted in this provider, later, not having enough for herself. She might then not have been able to continue to care for patients. As a result, some patients might have even died. This staff member, regardless, gave this girl water and food. All were rescued, as it turned out, before, due to lack of water or food, anyone died. This example epitomizes, of course, this provider's applying an Ethics of Care, much as Nodding describes with her son.

This provider's angst and decision may though have harmed many. Still, if providers anticipate or later find out that this kind of experience violates their feelings for such patients unbearably, other care providers not feeling this and the institutions sponsoring these disaster medical interventions should support them. They should explicitly encourage them to express this both in advance and later. Then they should continue to value them afterwards as much as they have beforehand.

Conclusion

Care providers in both civilian and military contexts may feel conflicted when practicing in triage and triage-like situations in disaster and combat contexts. This may be because they so value giving their patients the optimal individual care that they usually can give. Civilian care providers may be able to stretch this care as in the case of the patient who couldn't walk. They could, perhaps, have somehow "squeezed her in" aboard their ship to take her back with them to the U.S. for treatment. This would have enabled her to walk for the rest of her life. They may also go outside the usual rules in other ways. This may occur in the military as well. Military providers may, for example, treat civilians whom they don't have to by law or military regulations, such as the pregnant woman as I related above.

These examples are and will be, though, rare exceptions. Mostly, both kinds of providers will have no way to relieve their distress, and it may be emotional, moral, or both. Some providers may feel this distress more deeply and painfully than others. They, themselves, should seek to reduce this if they can once they feel it, but if they can't identify these feelings beforehand, they should not value themselves any less and should report that they feel this way as soon as they find what they must do emotionally ungluing and beyond their control. Sponsoring institutions and fellow care providers not feeling this same degree of distress should value and support those who do then as fully. They should offer this validation explicitly and support them even though they know that these providers' reports *may be* untruthful and even though unwanted, adverse outcomes causing harm may as a result come about.

Disclaimer

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