Conflicting values - everyday ethical and leadership challenges related to care in combat zones within a military organization

Kristina Lundberg
Misce stultitiam consiliis brevem: dulce est desipere in loco.

Scribendi recte sapere est et principium et fons.

(Horatius 65-8 B.C.)

To Louise, Karl Johan and Rikard

διοτι αγαπητοι μοι γεγενεσθε
Abstract

Introduction: Licensed medical personnel (henceforth LMP) experience ethical problems related to undertaking care duties in combat zones. When employed in the Armed Forces they are always under the command of tactical officers (henceforth TOs).

Aim: The overall aim was to explore everyday ethical problems experienced by military medical personnel, focusing on licensed medical personnel in combat zones from a descriptive and normative perspective. A further aim was to explore leadership challenges in leading licensed medical personnel.

Methods: For the research descriptive, explorative (inductive and abductive) and normative designs were used. Data collection was undertaken by using different methods. Altogether 12 physicians, 15 registered nurses, seven combat lifesavers and 15 tactical officers were individually interviewed. The participants were selected by strategic (I), purposive (II) and theoretical sampling (III). The interviews were analyzed by using qualitative content analysis. Study III used classic grounded theory and study IV was a normative analysis of an ethical problem based on the idea of a wide reflective equilibrium.

Results: We found that LMP experience ethical problems related to dual loyalty when serving in combat zones. They give reasons for undertaking, or not, military duties that can be seen as combat duties. Sometimes they have restricted reasons for undertaking these military duties. Furthermore, LMP are under the command of TOs who found it challenging when leading LMP, since TOs have to unify LMP in the unit. The unifying makes it difficult since LMP experience dual loyalty.

Conclusions: LMP experience dual loyalty in combat zones. The reason may be that humanitarian law and the medical ethical codes are not clear-cut or explicit about how to be interpreted around these everyday ethical problems in internal military operations. In order to fit in todays context humanitarian law needs to be revised. Furthermore, LMP need further training in parallel with reflections on ethical problems in order to adapt to the combat zones of today.
Keywords: combat zones, ethical problems, everyday ethical problems, health care, licensed medical personnel, medical ethics, military ethics, military medical personnel, military personnel
Original papers

The thesis is based on the following papers, which are referred to by their Roman numerals and as Papers I, II. III and IV in the text:

Paper I

Paper II
Lundberg, Kristina; Kjellström, Sofia; Sandman, Lars (2017). Dual Loyalties: Everyday ethical problems of registered nurses and physicians in combat zones. *Nursing Ethics X(XX)*

Paper III
Lundberg, Kristina; Kjellström, Sofia; Sandgren, Anna (20XX). Unifying loyalty: a grounded theory about tactical officers’ (TOs) challenge when leading licensed medical personnel (LMP) in combat zones. On plan: *Military Medicine*

Paper IV

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Preface

Some years ago I served as a Battalion Chaplain to the Swedish Armed Forces, based in Kosovo and Afghanistan. During these operations I worked quite closely with the licensed medical personnel (LMP) and I realized that their work was extremely important, since we could not rely on the local healthcare in the event of injuries or diseases. Many soldiers and officers have died on duty during the military operations, but there were also many among the severely injured who survived due to the professional highly qualified medical skills of LMP.

On these military operations I was subordinated to rules and laws that also to some extent applied for LMP, such as the Geneva Conventions (GC) and other parts of humanitarian law. Sometimes I was asked to undertake duties that collided with these laws, e.g. to guard at the main gate. I then noticed that LMP also had the same “problem”. It was not easy to stand up against an officer and say: “I cannot undertake duties that are combat duties due to professional ethical codes and the role as chaplain”. Furthermore, since we partook in internal conflicts in Kosovo and Afghanistan and the fact that the laws applied in international armed conflicts, it was not obvious how to interpret them. Before I rotated to Afghanistan I had become very interested, from an ethical point of view, in how the healthcare personnel coped with being in a combat zone. I began my PhD-project in healthcare science with a focus on ethics in combat zones just before I went to Afghanistan.
Introduction

In this thesis there is a focus on the licensed medical personnel (LMP) and the ethical problems they experience in the context of combat zones. The Swedish LMP participate with healthcare in the context of combat zones. Being LMP in this context creates a range of ethical problems (Agazio et al., 2016; Foley et al., 2000; Kelly, 2011; Scannell-Desch & Doherty, 2010), problems where they have to weigh their values to save lives against the values of the Armed forces, e.g. prioritizing the military operational goals.

It is important to explore and describe the ethical problems LMP experience since these problems put great demands on LMP in the context of combat zones and LMP’s experiences affect the patients as well as themselves (Dahlberg et al., 2010). In ethically difficult contexts, such as combat zones, the personnel’s experiences and their own well-being must be problematized and it is essential to highlight how these ethical situations appear to healthcare personnel (Dahlberg et al., 2010), since ethical problems are intensified abroad in combat zones (Nilsson et al., 2010).

A large number of ethical problems described in previous research were severe such as LMP participating in torture or torture-like situations (Balfé, 2016; Boseley, 2013; Miles, 2008). Most of the research on severe ethical problems has been undertaken after 9/11 and has carried out in combat zones among other countries’ LMP.

The Swedish LMP are employed in their primary role as physicians or registered nurses and are expected to follow their ethical codes and have an obligation to follow Swedish health care legislation as well as humanitarian law when in combat zones.

However, being under the command of TOs, LMP have to weigh their dedication to healthcare duties against military duties. Among these duties there are duties that the LMPs are expected to do or that they do them by own willing, and it could be questioned whether LMP at all should do these duties at all, i.e. duties that could lead to ethical problems. This can create dual loyalties, which sometimes occur in military and healthcare organizations which is seen in previous research as well (Benatar & Upshur, 2008; Physicians for Human Rights, 2002).

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Concerning these everyday ethical problems related to dual loyalties experienced by LMP not much research was found, hence the need for this study.
Background

Context of combat zones

Swedish Armed Forces have participated in peacekeeping or peace enforcing military operations abroad since 1948 (Rehman, 2011). From 1956, Sweden has contributed with units in e.g. Lebanon, former Yugoslavia, Afghanistan, (Rehman, 2011) and now recently in Mali (Swedish Armed Forces, 2015).

The contexts of combat zones in this thesis are Afghanistan, Mali and Aden (Somalias coastline) and these places are all examples of non-international armed conflicts. The majority of all armed conflicts now occur within the borders of states, which means they are non-international armed conflicts (Henckaerts, 2012) and only a minority of all military armed conflicts are international armed conflicts (Harbom et al., 2005).

The counterpart, or enemy, is often part of a non-governmental force and dressed in a uniform, which can be a mixture of various clothing and therefore hard to recognize.

The assignment Sweden had in Afghanistan between the years 2006-2014, through the International Security Assistance Force (ISAF), was a United Nations (UN) mandate operation led by North Atlantic Treaty Organization (NATO), and the duties were to participate in creating security and support the reconstruction of the provinces in the German-led Regional Command North (Swedish Armed Forces, 2009)\(^1\). Sweden also supported the training of the Afghan army. The overall purpose of the operation was to achieve independence for the Afghan people. Some of the tasks were solved by patrolling both in vehicles and on foot where units were frequently exposed to danger (Andersson, 2014; Gellerfors & Linde, 2014). From September 2014,

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\(^1\) There were five Regional Commands in Afghanistan, and Sweden led from Spring 2006 Provincial Reconstruction Team (PRT) Mazar-e-Sharif, in the German-led RC North. The provinces Sweden had responsibility for were Balkh, Jowzjan, Samangan and Sar-e-Pol (Swedish Armed Forces, 2009).
a smaller unit is supporting the Afghan government in providing security for
the civilian population.
The assignment for Sweden in Mali from 2014\(^2\), The United Nations
Multidimensional Integrated Stabilization Mission in Mali (Minusma), is a
UN led operation in Mali (Swedish Armed Forces, 2015). Some of the duties
are to stabilize larger populated areas, help the state to take control of the entire
country, protect civilians and other UN personnel, to promote the protection
of human rights and support humanitarian aid. In addition, Sweden contributes
with duties such as supporting the authorities and creating safe environments
for projects aimed at stabilizing northern Mali disarming mines and other non-
detonated ammunition, and protecting some historical cultural buildings in
Mali. The Security Council calls on Minusma to act more proactively and in
accordance with the mandate (The Swedish Armed Forces).
Sweden has, since May 2009, sent four contributions to Operation Atalanta,
the European Union (EU) Marine Initiative in Aden, outside the coast of
Somalia. The EU force protects ships against pirate attacks and allows
emergency transport to vulnerable people in the region.
Operation Atalanta protects ships transporting food to emergency workers in
Somalia. Other tasks included in the operation are to protect the African
Union's maritime transport to Somalia, monitoring the fishing outside the
coast of Somalia and to ward off and fight the pirates and armed robbery
against ships. The basis for the action in Aden is a UN Security Council
resolution, resolution 1816. With the support of the UN resolution, EU Navfor
can help Somalia's transitional government to seize and apprehend suspected
pirates (Swedish Armed Forces, 2017b).
Generally, the modern military combat zones are in many ways extreme and
different from the military home context. The context is fragmented, blurred
and complex (de Graaff, 2017), lacking dividing lines between own and
enemy forces, with high mobility and high tempo, isolated small units
composed ad hoc which affects not only the units but also the healthcare
provided by LMP in combat zones (Andersson, 2014; Blaz et al., 2013;

\(^2\) The first officers arrived in Mali Spring 2013.
Dalenius, 2000). The units are exposed to different obvious threats, such as homemade bombs triggered by a mobile phone or by accidentally walking on a pressure plate on roads or various places and different kinds of weapons (Andersson, 2014) but the units are also exposed to diseases, such as vector-borne diseases, spread through mosquitoes of different kinds, e.g. leishmaniasis and malaria, different infections, e.g. ebola and HIV (Swedish Armed Forces, 2015). Furthermore, LMP have to be prepared for healthcare under fire or in darkness, lacking necessary medical equipment or having to wait for transporting the patient to safe spot (MEDEVAC). Furthermore, combat zones have miscellaneous climates, e.g. extreme heats, dry climate in deserts, sand storms, rain forests and cold (Swedish Armed Forces, 2009, 2015).

A military organization appears to be different from other organizations, and seems to be homogenous, since everyone appears with the same characteristics such as: 1/The uniform, referring to Latin uniformis, i.e. having one form. The uniform expresses the uniting, dividing and military operating objective; 2/The hierarchy: all are under a command, soldiers as well as officers. The rights and duties depend on where in the organization soldiers and officers are; 3/The military has a coercive power, which is based on the duties towards the military service. The military has sometimes the mandate to use force on on the community or part of the community; 4/Even now, the Armed Forces are dominated by men although some changes have occurred; 5/The military has symbols: the flag, the uniform, how to salute, parades and certain patterns for movement; 6/The military camps are restricted areas (Lunde et al., 2009). However, there are similarities with other organizations in several ways e.g. uniformsed dress, hierarchy, dominated by either men or women, having symbols and having restricted areas.

Within this organization there are variations, depending on weaponry (air forces, marines and army) and in level (ranks) (Lunde et al., 2009). When the Swedish Armed Forces participate on a military operation abroad, it implies that a Swedish military organization moves abroad. The training and preparation before rotation takes place in Sweden and the reality the unit meets in combat zones differs significantly from the training environment (Andersson, 2014). Within the last years, the Swedish Armed Forces have changed training focus, from preparedness to defend Swedish borders to a focus on peacekeeping or peace enforcement operations abroad in a combat zone (Regeringens proposition, 2008/09:140). Since soldiers are voluntarily
employed for rotating to combat zones, it is no longer the closed organization that it used to be, but a more transparent organization (Swedish Armed Forces, 2017a).

Healthcare in combat zones

In combat zones LMP are responsible for providing healthcare in the Swedish unit. The primary medical education of the Swedish LMP is from civilian settings. Besides LMP undertaking healthcare duties, Sweden also contributes with combat lifesavers, i.e. combat soldiers who are medically trained within the unit.

As being exclusively assigned to healthcare duties Swedish LMP are employed by the Armed Forces and are a part of the military unit but their duties are to provide care for the injured in their own unit, among allied and for those injured by Swedish soldiers in combat. The Swedish military context has temporarily moved to a combat zone.

In the event of heavily injured and death casualties in the Swedish unit, LMP have a responsibility in undertaking care and making sure that patients are prepared as well as possible for transportations home to Sweden. LMP’s healthcare contexts vary depending on where they are stationed and the context is in many ways a challenge for LMP.

Mostly, the healthcare skills of LMP are not acutely needed since soldiers normally are very healthy. Consequently, LMP, like most of the personnel in a military camp, undertake other duties than healthcare, for example duties they may be unprepared for, filling in for other colleagues, the soldiers, and other duties that have to be done, e.g. guard duties in the tactical operation center (TOC), taking care of the gym and undertaking massage among the soldiers and officers.

The quality of the premises, i.e. healthcare centers and hospitals, varies between the different operations abroad. The field hospital in Afghanistan in the taskforce where Swedish LMP were based was German-led and became in time well-functioning, sophisticated and technically advanced and a fully equipped hospital. In the early stages of the operation in Mali, where Swedish personnel relied on the newly set up Nigerian field hospital, they could initially not offer similar advanced healthcare. The context for the operation in Aden was on a ship. LMP often provide healthcare in situations where
access to medical care facilities usually are limited (Stendt, 2006; Sullivan, 2006).
In order to function in the context of combat zones, Swedish LMP are trained in Battlefield Advanced Trauma Life Support (BATLS), to deal with care situations in combat zones, outside hospital areas (Andersson et al., 2007; Andersson et al., 2013, 2017; Lundberg, 2010; Lundberg et al., 2009). They are also trained in specific operations with adapted training such as care under fire, tactical care and evacuation of injured persons, i.e. the education concept Tactical Combat Casualty Care (TC3) (Andersson, 2014; Butler Jr et al., 2007; Lundberg et al., 2009). The Centre for Defence Medicine in Gothenburg is responsible for the training of LMP before rotating to combat zones (Andersson, 2014). Despite this training it is known that there are discrepancies between the training and the context of combat zones (Andersson, 2014).
In the Swedish battalion LMP are uniformed, armed and equipped with assault rifles and pistols and appear to be part of the fighting squad (Hague Regulations, 1907) and they are trained to protect themselves and their patients (Bring & Körlof-Askhult, 2010). Some of the LMP have previous experiences of being in a military setting and others lack this experience (Andersson, 2014). When employed as permanent healthcare personnel LMP have, according to humanitarian law, non-combatant status (Henckaerts et al., 2007).
Besides LMP, the units also consist of combat lifesavers (Cloonan, 2003; FömedC, 2014; Studer et al., 2013). Combat lifesavers are primarily combat soldiers (Hague Regulations, 1907; Henckaerts et al., 2005a), with basic military medical trauma training, based on the concept Tactical Combat Casualty Care (TC3) (Butler Jr et al., 2007). The combat lifesavers can give first aid according to <C> ABCDE (Andersson, 2014; Andersson et al., 2015; BATLS, 2000; Lundberg, 2010; Lundberg et al., 2009) with a special focus on hemorrhage control. Their training consists of five weeks’ basic combat lifesaver training and two weeks’ pre-hospital training (Andersson, 2014; Andersson et al., 2013). The goal of their medical training is to be able to undertake acute trauma care in the combat zone context in order to increase the survival of the injured soldiers and also to perform self-care and health protection (FömedC, 2014). However, they undertake care when needed in their care duties but they are primarily combatant soldiers.
The LMP as well as the combat lifesavers are subordinated to a military commanding officer in the unit when undertaking duties in combat zone, a tactical officer (TO). The TOs are chiefs in the unit and rank from non-commissioned officers, i.e. ranking below warrant officers, to officers. The TOs are ultimately responsible for healthcare duties meaning the TOs lead the LMP and they are responsible for securing the environment in the event that LMP need to care for an injured person (Andersson et al., 2015).

LMP and TOs have different goals with the operation. The TOs are obliged to focus on the military duties, such as maintaining security, where shootings and killings are necessary in implementing the military duties whereas the duty for LMP is to save lives. Caring for the injured in their own unit can be challenging for LMP, especially if they have to leave the injured in case the area is not adequately secured (Waldman et al., 2012).

Laws and rules guiding LMP

LMP are governed by a number of rules and laws, both referring to being a part of a military unit in combat zones but also laws referring to their professions as LMP. The provenance of these respective laws and rules can sometimes be contradictory. In the throes of combat zones judgments are more difficult to make because LMP have to juggle two spheres of accountability.

In the context of combat zones humanitarian law applies which is a large branch of laws where the most significant are the four Geneva Conventions, the Additional Protocols and laws that all aim to protect and alleviate human suffering among persons not partaking in hostile actions, for example the LMP (Convention Against Torture CAT, 1984; International Committee of the Red Cross (ICRC), 1949; International Law in Armed Conflicts, 2010:72; Melzer, 2010). Today this branch of law relies on customary law (Henckaerts et al., 2005a, 2005b; Newalsing et al., 2008). Humanitarian law governs how states shall act against each other and since the end of World War II, human rights have become a central part of humanitarian law, due to unethical experiences from times when severe transgressions occurred (Howe, 2003; Miles, 2004, 2008). Humanitarian law is introduced as either customary law, i.e. rules developed over time and which states themselves consider to be followed, or as treaties, i.e. bilateral or multilateral agreements, such as UN conventions. Since most of all armed conflicts today are non-international, the laws that apply are laid down in Article Three (Gandhi, 2001), which is common to all
four Geneva Conventions as well as in Additional Protocol II (International Committee of the Red Cross, 1977). However, when Sweden participates in non-international armed conflicts, e.g. the assignments in Afghanistan, Mali and Aden, the Swedish supreme commander has executed an order where the Swedish units are bound to follow humanitarian law even in today’s non-international conflicts (Swedish Armed Forces, 2001).

According to customary law, LMP who are exclusively assigned as medical personnel are non-combatants (Hague Regulations, 1907; Henckaerts et al., 2005a; International Law in Armed Conflicts, 2010:72) and are obliged to wear a Red Cross Identification card and an armbelt with the distinct emblem, the Red Cross (ICRC, 2014; International Committee of the Red Cross, 1977; Lavoyer, 1996; Quéguiener, 2007; Slim, 1989). The emblem shows LMP’s duty to care for people that are not participating in the combats. When helping sick and injured, LMP should be protected from attack and always be respected (Henckaerts et al., 2007; International Committee of the Red Cross, 8 June 1977; WMA, 2012). Having a non-combatant status is, according to Bring & Körlof-Askhult (2010), to use proportionate force in self-defense, to be equipped with a lightweight personal armament only for LMP’s own safety and protection of the patient.

The Universal Declaration of Human Rights complements humanitarian law and states worldwide what all human beings are inherently entitled to (ICCPR, 1966; UDHR, 1948), such as respect for all individuals without distinctions of religion, politics, nationality etc. Humanitarian law is exclusively applicable during armed conflicts, but the Universal Declaration of Human Rights shall always be respected, in peace as well as in armed conflicts.

Documents complying with military operational and policy considerations, such as Rules of Engagement (International Institute of Humanitarian Law, 2009), based on the general and overriding international rules (Lunde et al., 2009) are applied. The Rules of Engagement are rules or directives which define the circumstances, conditions, degrees, and manners in which the use of force, or actions which might be construed as provocative, can be applied (Cole et al., 2001). The Standard Operations Procedures (SOP) are a set of rules that regulates the personnel in the whole unit (SOP Standard Operations Procedures), and can differ depending on mandate of operation, peacekeeping or peace enforcement, or where Swedish units are based.

Furthermore, Swedish LMP have a duty to follow Swedish healthcare legislations which apply for LMP even in combat zones (Hälso- och
These laws are connected with LMP’s duties as healthcare providers both in the Swedish civilian healthcare but also in combat zones and the legislation deals with undertaking care based on their professional obligations.

Professional ethical codes and medical ethical principles

Swedish healthcare personnel generally encounter and experience ethical problems. Ethical problems can be defined as problems where different values collide which require a moral solution (Aitamaa et al., 2010). The ethical problems encountered by healthcare personnel in their civilian work range from severe ethical problems dealing with life and death to more everyday ethical problems like how to deal with patient autonomy, integrity, equality on a daily basis etc. In a similar way LMP encounter ethical problems in the military setting, however, when in combat zones, these can be expected to differ from the ones experienced in civilian care.

LMP are governed, beside laws and rules, by ethical values, norms and professional ethical guidelines, which also apply for LMP when being in the military context. Physicians and registered nurses have their respective ethical guidelines. Physicians worldwide are guided by World Medical Association and registered nurses are governed by international and European nurses’ organizations. Both professions are also governed by their “codices ethicus” (Codex Ethicus Medicorum Svecorum; European Council of Nursing Regulators, 2008; International Council of Nurses ICN, 2012; Swedish Society of Nursing, 2011; Sveriges läkarförbund, 2017; WMA, 2006). Since combat lifesavers are combat soldiers and not wear the Red Cross ID, they are not governed by these ethical codes, principles and norms.

Furthermore, everybody involved in healthcare, LMP and other healthcare personnel including combat lifesavers, should be guided by general ethical principles. One formulation of these basic ethical principles is found in the four basic principles of medical ethics from Beauchamp and Childress (2013). In this thesis the interpretation of the four principles by Beam, in his influential foundational work on military medical ethics (2003) is used. The four basic
principles are: 1/beneficence \(^3\); to do the best for the patient from the patient’s own perspective; 2/non maleficence \(^4\); not to hurt others; 3/respect for everybody’s autonomy \(^5\); the patient’s right to decide over her/his own life; and 4/justice \(^6\); the equal distribution of scarce health resources and equality when deciding who gets what treatment (Beam & Sparacino, 2003). Additional widely accepted norms also found in military contexts guiding healthcare professionals are norms related to dignity and integrity, (Enemark, 2008; Gross, 2006) which are of importance in healthcare, but also the more general norm of loyalty (Robinson, 2008). Dignity refers to everybody having the same value, meaning every human life in all its forms is worthy of respect and should be preserved (International Committee of the Red Cross, 1949, Practise Relationg to Rule 154). Integrity is to act with honor, to perform duties with impartiality and avoid conflicts of interest (Powers, 2015).

Privacy is another accepted norm in healthcare even if not explicitly found within military ethical discussions. Privacy is about securing a safe space and control over this space for a person, regardless of whether it concerns a person’s physical body or physical space or information (Fjellström et al., 2005). Privacy is a relevant norm for patients, but in the military the norm might have somewhat less relevance due to space for privacy being limited when in combat zones. Still, it is important to consider given the professional background of LMP.

Loyalty is a central value to uphold in the military (Coleman, 2009; Robinson, 2008), but is rarely defined within the military setting (Olsthoorn, 2011). However, in the current context loyalty means to show loyalty to a military unit in order to unite the platoon or group.

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\(^3\) Beneficence, Lat., *Benefactum*, good deed.

\(^4\) Non maleficence, Lat., *non maleficentia*, not to harm.

\(^5\) Autonomy, Greek, *autos*, self, and *nomos*, rule or law.

\(^6\) Justice, Lat., *Justitia*, fair or juste.
Ethical problems in combat zones

The ethical problems LMP experience in combat zones range from severe ethical problems, or rather transgressions, to everyday ethical problems which occur more or less every day. When encountering everyday ethical problems some of the LMP experience these ethical problems as related to dual loyalties.

Ethical transgressions in combat zones

After 9/11, a considerable amount of research describing LMP involved in severe ethical problems was done, e.g. in the Iraqi prison Abu Ghraib and at the Cuban base in Guantanamo Bay (Bloche, 2016; Boseley, 2013; Grohol, 2014; Howe, 2003; Miles, 2004, 2008; Singh, 2003). In these severe ethical problems it is clear that LMP were breaking the ethical rules and principles that should have guided their actions when they participated in torture or interrogations including dubious methods (Kottow, 2006; Lifton, 2004), both in developing methods of torture as well as actually participating in the torture process (Balfe, 2016; Lifton, 2004). Participating in torture and undertaking duties related to torture are against ethical principles (Beam & Sparacino, 2003; Convention Against Torture CAT, 1984; Physicians for Human Rights, 2015).

LMP, as exclusively employed for their medical skills, sometimes seemed to put the medical ethics of commitment aside, and acted both as assisting interrogators and “facilitating interrogations” with combatant duties. In these cases medical ethics almost risked being undermined and the purpose was non-medical (Kottow, 2006). In some cases, the physicians seemed to justify these duties by referring to a separation of two roles, being LMP and military (Bloche & Marks, 2005). That is, the physicians claimed they did not act against their ethics when they used their skills for military duties since they were not acting as physicians at the time and the medical ethic therefore did not apply (Bloche & Marks, 2005).

LMP have also been recruited for intelligence gathering, or spying, purposes but then they had non-therapeutic roles (Enemark, 2008). Sometimes LMP have violated military interest in favor of what is ethically best for an individual. If ethical priorities are to remain unchanged, it would seem that values related to the treatment of terrorists or prisoners of war...
should remain unchanged. Some of these values must be maintained even if it means that LMP are violating military interests, and, indeed, the optimal interests of the communities, which the military is serving and protecting. If not, it is a sign that we have regressed (Howe, 2003).

However, in the US it is stated that medical professionals must not involve themselves in coercive interrogations or hostile actions in any way, since the American Medical Association (AMA), as well as the American Psychiatric Association (APA), have deemed such conduct as unethical (AMA American Medical Association, 2016; Grohol, 2014).

**Everyday ethical problems in combat zones related to dual loyalty**

When LMP serve in combat zones they are expected to follow their medical and nursing ethical principles, such as not doing harm, preserving human life and undertaking a role as healer (Allhoff, 2008). But, from a more general perspective, LMP seem to be challenged by dual loyalties towards their own ethics and the military when in the context of combat zones, i.e. balancing healthcare duties with the military duties. Dual loyalties are particularly difficult in combat zones since the military, or state, put pressure on LMP (Clark, 2006). The healthcare professionals are the ones that should guarantee that human rights, or ethical norms are respected and act with impartiality towards their patients and people in their care. When LMP override these principles and standards in favor of military duties, dual loyalties may arise, especially in combat zones (Clark, 2006).

LMP are also educated in triage, a process for sorting and prioritizing patients. Triage is used in emergency care, primary care and in combat zones. In combat zones triage can imply prioritizing to put soldiers back in service, rather than prioritizing to care for the most severely injured, as is generally the case in civilian healthcare (Agazio et al., 2016). This can be interpreted as triage in a combat zone context not aiming to save all lives, but rather to save lives in order to put them back in combat again, implying an instrumentalized view of humans (Kelly, 2010). That is, by referring to the principle of beneficence (Beauchamp & Childress, 2013), the duty may be to use battlefield triage where the scenario may be that the number of patients and severity of injuries exceed the capability and thus duty may be not to try to save the more severely injured but the ones with a reasonable chance to survive and continue the combat (Kelly, 2010; Repine et al., 2005), due to the
The fact that military needs were more urgent than saving a patient. The consent to medical treatment and refusal of treatment is an ethical issue that is not taken into account in combat zones since the TOs decide when and where LMP should care for a patient or not (Kelly, 2011). The individual ethics often taken for granted in civilian healthcare imply putting the individual above all, whereas the combat zone context, the unit comes before the individual (Mehlman & Corley, 2014). That the unit comes before can be illustrated in following agonizing example: an injured soldier can perhaps not receive any treatment at all from his own unit since it may be too risky for the unit to even stop, due to improvised explosive devices or mines in the ground. The worst case the unit has to leave the individual soldier on the ground in a combat zone. The principles of preserving human life and beneficence (Beauchamp & Childress, 2013) are then overruled by the military demands (Kelly, 2010). The obligation to save patients can also require a registered nurse to undertake a medical duty which a physician should do, such as amputating a limb, since there is perhaps no physician available (Gross, 2006; Kelly, 2011). In this case the armed conflicts in combat zones put an emphasis on doing duties a LMP would not normally do.

In the context of combat zones there are also the dimension that a single patient can be an enemy who has been in combat with the LMP’s unit and due to injuries is treated by LMP (Ross et al., 2008). According to ethical principles and human rights LMP nevertheless have to provide care for the single patient despite being an enemy.

When in context of combat zones, ethical problems related to dual loyalties occur. This means that LMP experience conflicting loyalties between following healthcare values or objectives and military values and objectives. This has been shown to be difficult and even dangerous when it comes to group dynamics (Zimbardo, 2008) and the fear of being ostracized (Balliet & Ferris, 2013).

Swedish armed forces with LMP and coalition forces are still serving in combat zones and they experience the everyday ethical problems described above. There is a lack of research about these everyday ethical problems and especially these everyday ethical problems related to dual loyalties as experienced by LMP, although we know these problems occur.
Research concerning the ethical problems experienced by combat lifesavers is lacking completely. Moreover, military leaders can be expected to be an important factor in resolving problems of dual loyalties, but no research on this problem has been found.
Rationale

When Swedish armed forces participate in military operations in combat zones personnel with medical competence are part of the organization, i.e. LMP and combat lifesavers.

In the military unit LMP’s primary duties are to provide care for their injured in their own unit, the allies and even enemies the LMP’s own forces have injured. During military operations LMP are expected to follow humanitarian law, Swedish healthcare legislation, military operation rules, their own professional ethical codes and the medical-ethical principles. They are in an organization where lives are constantly threatened. In the context of combat zones LMP encounter and experience ethical problems, which is confirmed by earlier research.

Besides LMP, combat lifesavers have a certain responsibility for undertaking medical duties, even if they are not primarily healthcare personnel. Little is known about to what extent combat lifesavers experience ethical problems in relation to their medical duties.

Previous research on ethical conflicts and problems for LMP in the context of combat zones has primarily focused on severe transgressions of ethical values and norms that should govern LMP’s actions, such as participation in interrogation techniques and even in torture. Research on ethical problems experienced by LMP has observed that LMP might also experience other ethical problems where some are related to dual loyalties.

However, there is general lack of research about these potential everyday ethical problems experienced by LMP and combat lifesavers. Moreover, there is also a lack of research on how dual loyalties affect LMP in these everyday situations.

Likewise, more normative in-depth analyzes are lacking as to how to deal with situations of dual loyalties in everyday ethical problems.

Furthermore, since military organizations are hierarchical and those involved in military operations are expected to act based on orders, it becomes important to clarify how TOs argue about the ethical situations that LMP face. There is no previous research on how TOs reason in these ethical situations.
Aims

The overall aim was to explore everyday ethical problems experienced by military medical personnel, focusing on licensed medical personnel (LMP), in combat zones from a descriptive and normative perspective. A further aim was to explore TOs’ main leadership concerns in leading LMP given their experiences of dual loyalties.

The aim of study I was to explore the Swedish military medical personnel’s subjective experience of what it means to engage in a healthcare role in a combat zone.

The aim of study II was to describe how Swedish LMP reason about everyday ethical problems stemming from dual loyalties when providing healthcare in combat zones.

The aim of study III was to explore the TOs’ main concern when leading LMP and how they resolved it.

The aim of study IV was to normatively analyze how LMP’s intelligence gathering while providing care for civilians in the host nation relates to humanitarian law and the established professional codes and principles of medical ethics.
Theoretical stance

An important theoretical assumption in this thesis is that ethical values and norms have a special standing in guiding the interaction between people. This implies that ethical values and norms are not simply the result of people’s opinions or subjective preferences but have a more objective or inter-subjective ontological standing (Daniels, 2016). Hence an ethical value or norm can be valid for a specific context, implying that it should be respected and followed. Moreover, in line with such a more objective or inter-subjective view on ethical values and norms, different ethical values and norms, and the standpoints following from them should be consistent with each other. Another way to express this is to say that when taking a specific stand in a situation, that will give rise to a more principled standpoint of how to act in that and similar situation, and any digression from such a standpoint in another situation needs to be argued for by pointing to relevant differences. Following this, our set of ethical values and principles, and the concrete standpoints in specific situations implied by these values and norms, should ideally form a consistent whole, what is often called a reflective equilibrium (Daniels, 2016; Rawls, 1999b).

In relation to this thesis this theoretical stance implies: Firstly, that ethical values and norms have an important standing that makes it central to explore how the ethical problems related to or implied by them are experienced; secondly, that exploring how ethical values and norms and the resulting ethical problems are experienced is not enough, but the results have to be assessed against the above meta-ethical assumptions. Hence, some experiences and attitudes of ethical values, norms and problems, can be assessed as more well-founded or acceptable given the larger set of established ethical values and norms (in healthcare), thirdly, that normative analysis can, to some extent, arrive at a more well-founded judgment as to what should be recommended the ethically problematic situations experienced, given this established set of ethical values of norms within healthcare (Daniels, 1979; Sandman et al., 2017).
Methods

Designs

For the four included studies different designs were used, i.e. explorative and descriptive, abductive, conceptual and normative design.

For study I inductive, explorative and descriptive design was used, since the intention is to explore the research problem rather than build on a previous theory (Chalmers, 2013).

For study II an abductive design was provided in order to elucidate the arguments related to dual loyalties as given by LMP in study I. An abductive design implies a move between theory and empirical evidence where the understanding gradually emerges. Interpretivism was involved where it was assumed that the emerging ideas were understood, or interpreted, dependent upon how they were observed and apprehended (Carson, 2009).

Study III was undertaken by using an inductive conceptual theory generating design. Grounded theory is discovered and not explored and is a suitable design when the area studied had limited prior knowledge (Grbich, 2013), which was the case in this study.

Study IV had an inductive normative design, where an ethical problem explored in study I was reasoned around using ethical principles and assumptions in terms of coherence, in order to reach reflective equilibrium.

An overview of each study is presented in Table 1.
Table 1. Overview of studies I-IV.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Data collection</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Explorative and descriptive</td>
<td>20 physicians, registered nurses and combat lifesavers</td>
<td>Individual interviews</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>II</td>
<td>Abductive</td>
<td>14 physicians and registered nurses</td>
<td>Individual interviews</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>III</td>
<td>Inductive, conceptual, theory-generating</td>
<td>10 tactical officers (TOs)</td>
<td>Individual interviews, conversations and literature</td>
<td>Grounded theory</td>
</tr>
<tr>
<td>IV</td>
<td>Normative</td>
<td>Based on study I</td>
<td>Seeking coherence in arguments used in study I</td>
<td>Wide Reflective equilibrium</td>
</tr>
</tbody>
</table>

Study I

Method

The method provided was a qualitative content analysis which was suitable since knowledge dealing with the phenomenon was fragmented (Elo & Kyngäs, 2008).

Participants

It was decided that the inclusion criteria required participants to be Swedish citizens and having served on at least one military operation abroad, within the years 2009-2012. The year for start, 2009, was important in order to recruit participants with the same presumptions, i.e. having served after the Swedish Armed Forces had undergone the change from invasion defense to the peacekeeping and peace enforcing operations abroad of today (Regeringens proposition, 2008/09:140). Some of the participants have experience of
several operations and have had positions as physicians, registered nurses or combat lifesavers, which are shown in Table 2. The selection was a strategic sample (Polit & Beck, 2012). Twenty participants volunteered to participate in the study. There were five physicians, eight registered nurses and seven combat lifesavers. The ones who wanted to participate were chosen.

Table 2. Demographic data of participants in study I.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sex</th>
<th>Age</th>
<th>Places of assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>21-30</td>
<td>31-40</td>
</tr>
<tr>
<td>Physicians</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>RNs</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Combat lifesavers</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

**Data Collection**

Information about the project and for collecting data was given on two occasions, first in Afghanistan and later by contact with Swedish Centre for Defence Medicine (FömedC). Information about the project was initiated by the thesis author at staff meetings where medical personnel (physicians, registered nurses and combat lifesavers) partook, at the Swedish military camp Northern Lights in Afghanistan, during fall 2011 by thesis author. After one of the meetings four volunteer from the medical personnel wanted to partake during the time when they still were in Afghanistan. A time was set for doing four of the individual interviews. No personal outreach took place during the operation.

Later, in the spring 2012, information about the project was sent to FömedC. At FömedC the medical personnel are train and are educated before rotating to combat zones. Information was also put on Facebook and Twitter and spread from person to person. Six of the participants volunteered through FömedC and 10 through Facebook and Twitter. The 10 who volunteered through Facebook and Twitter were known to the thesis author since the time in combat zones. All 16 interviews took place in Sweden in a variety of places.
according to the participants’ wishes, such as their homes, working places and at cafés.

All the data for the study was collected by individual open-ended interviews by the thesis author. All the interviews started with small talk and presentations of the project. The interviews were digitally recorded and the participants were initially asked the question “how they experienced to serving in a combat zone” and then the starting question was followed by more in-depth open questions, i.e. questions dealing with their experiences of being medical personnel in the context of a combat zone. The interviews lasted for 40 to 120 minutes and then they were transcribed verbatim and translated. The quotations in the article were translated then by thesis author.

**Analysis**

The data was analyzed using qualitative content analysis with an inductive approach and mainly followed the main phases according to Elo & Kyngäs (2008).

Units of the data were selected during the preparation phase. During this phase the research team read the data units through several times in order to become familiar with and make sense of the data. Meaning units, i.e. phrases or sentences that described or expressed different aspects of the interviewees’ experiences and feelings, were identified. During the following phase the data was organized, and the open coding began. The thesis author and the fourth author (LS) then read the meaning units again to ensure that they corresponded to the purpose of the study, and headings were written in the margins to ensure that the whole content was described. These headings were then gathered from the margins to coding sheets, and the subcategories started to emerge. The subcategories were classified as being a part of or belonging to a specific group, and the thesis author and fourth author (LS) compared the groups, changed and finally decided which group the subcategories belonged to. The purpose of this stage was to describe and generate new knowledge, and in the last phase, the subcategories were condensed and became mutually exclusive, i.e. data that did not correspond with the aim was excluded. The data was compiled to constitute eight subcategories and four categories (Table 3. below) about the medical personnel’s lived experiences in the combat zone (Elo & Kyngäs, 2008). Instead of the term generic category (used by Elo & Kyngäs), the term category was used (Patton, 1990).
Study II

Method

A qualitative content analysis was provided as method for analyzing the arguments related to dual loyalties given by LMP (Polit & Beck, 2012).

Participants

The inclusion criteria required participants to be registered nurses and physicians and to have been stationed with the Swedish Armed Forces in a combat zone, with a peace keeping- or peace enforcement UN operation (Chapter VII-mandate), within the last three years (for the same reasons as for study I). Therefore, LMP were selected by purposive sampling, i.e. LMP that were most familiar with the topic (Polit & Beck, 2012).

Seven registered nurses (two women and five men) and seven physicians (two women and five men) were recruited from FömedC by the thesis author and one of the supervisors (AJ).

In study I it was found that combat lifesavers did not experience dual loyalties and therefore they were excluded from study II.

Table 3. Demographic data on participants in study II.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Sex</th>
<th>Age</th>
<th>Years in Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>Female</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Physicians</td>
<td>Male</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Data collection

During the fall 2014 the thesis author contacted a tactical officer at FömedC responsible for the training and preparation of LMP rotating with the first Swedish military unit to Mali in January 2015. The reason for the contact was that the research team wanted to pilot the interview guide. We were invited to a course in ethics for LMP at FömedC before their rotation to combat zones. In all, 18 physicians and registered nurses participated. During the course the
thesis author and the third author (LS) presented eight ethical problems, based on study I. The participants discussed and reasoned around these ethical problems. Based on the LMP’s answers, an interview topic guide (Crabtree & Miller, 1999; Polit & Beck, 2012) was developed by thesis author and third author (LS). This interview guide was developed containing four vignettes presenting the four of the eight situations, which were associated with dual loyalties when LMP undertake care in combat zones.

In June 2015 the thesis author contacted a tactical officer at FömedC responsible for training and preparation of LMP for operations in combat zones and asked for permission to meet the following team of LMP recruited for a new Mali operation. The thesis author was invited and visited LMP at FömedC and informed them about the study. Of these, 14 LMP volunteered to participate in individual interviews. These LMP were presented with the ethical problems, and were told that they could read them through before the interviews. The purpose for using vignettes was to encourage the LMP in ethical reasoning (Lindblad, 2013). Each of the vignettes started with an open-ended question and continued with follow-up questions (Crabtree & Miller, 1999).

Time for interviewing LMP was settled. The interviews were carried out by the thesis author at various cities and places in middle Sweden chosen by LMP. Most of them were done at their work place, and some in the homes of LMP. The interviews started with “small talk” (Polit & Beck, 2012). Then the LMP were presented the ethical problems which they were to reason around during the interview. The interviews lasted between 35 and 90 minutes and were audio taped and transcribed verbatim, including breaks, doubts and laughter.

Analysis

The analysis process comprised distinctive stages and began with the research team reading the data over and over again. The thesis author and the third author (LS) organized the data in manageable meaning units i.e. phrases or sentences that described or expressed different aspects of the LMP’s experiences and feelings. The meaning units were read again to ensure that they corresponded to the purpose of the study and notes were made in the margins about the studies (Patton, 1990) and then all data was cut and pasted and finally organized and classified (Patton, 1990). A scheme of the classified
meaning units was developed and the units were coded. After reading the codes again until everyone agreed, the codes were classified into three categories and eleven sub-categories (Table 4. below). The team intended to let categories and sub-categories be on a descriptive level in order to see the general patterns in how LMP reasoned and related to being both caregivers and soldiers (Polit & Beck, 2012). The analysis was done by the thesis author and two of the supervisors (LS, SK).

In the article quotations were used in order to elucidate what the LMP told in the interviews. The quotations in the article were translated by the thesis author.

Study III

Method

A classic grounded theory was the method used here in order to develop a theory that is grounded in systematically collected data which explained and conceptualized the main concern (Glaser, 1998, 2002). Classic grounded theory is a general inductive method possessed by no particular discipline, data source or theoretical perspective and there is no need to position the ontology or the epistemology to justify the method (Holton, 2008), even if there have been disagreements and other researchers view it differently (Crotty, 2012; Reiter, 2017).

Grounded theory stands alone as being a conceptualization method (Holton, 2008). It is the participants’ behavior which is generalized and conceptualized, and the behavior transcends the borders of units (Christiansen, 2007). Questions dealt with in grounded theory are: What happens in the data? What is the data a study of?

A grounded theory is abstract in time as well as in places and participants (Glaser, 2016). No previous research is reviewed and the any preconceptions have to be carefully put aside (Glaser, 2016).

The area of interest

A classic grounded theory starts with an area of interest (Glaser, 1998, 2002). The area of interest in this study was TOs’ leadership of LMP in the military units given the experience of dual loyalties found in previous studies.
Participants

In total, ten TOs were recruited by the thesis author to participate in the study (seven male, three female) with various ranks from non-commissioned officers, i.e. ranking below warrant officers, to officers (two sergeants, one captain, two majors, one lieutenant-colonel, two colonels and two lieutenant-commanders), aged between 38 and 60. All of the TOs were from various Swedish regiments. The first three TOs were included through purposive sampling (Polit & Beck, 2012) before it was decided that the study was going to be a classic grounded theory design. Thesis author wrote emails to the three TOs, known from previous operations in Afghanistan. After the interviews, the thesis author asked the three TOs if they knew presumptive TOs that fitted the inclusions criteria, i.e. TOs that have been leading LMP on a military operation abroad in Afghanistan, Mali (Army) and/or Aden/outside the coast of Somalia (Navy), and also if they knew TOs that would want to participate in the study. Through emails the thesis author received answers from seven TOs who agreed to participate.

Data collection and analysis

In grounded theory data collection and analysis of data occur simultaneously. However, to explain these two processes, they are presented separately. Data collection was done through individual interviews, conducted by the thesis author. The first three TOs recruited received an interview guide before the interview which consisted of questions based on the topic guide with the four vignettes used for study II, where LMP were interviewed about undertaking military tasks in combat zones. Although the first three interviews were conducted using an interview guide and the study had another focus from the beginning, these interviews were also analyzed according to a classic grounded theory when the study changed design. These following seven interviews were more like open-ended informal conversations than interviews and the analysis of the following interviews occurred simultaneously with data collection. Theoretical sampling guided the interviews which implicated that new ideas emerged during the conversations.
and guided which questions could be asked further on in additional conversations. The interviews lasted from 45 to 90 minutes and were undertaken at various places in the mid-Sweden such as the participants’ work places and also in their homes.
The main questions provided for the TOs were how they experienced to lead LMP, and how they viewed medical ethical codes and the humanitarian law when it comes to leading LMP.

In grounded theory it is not necessary to record the interviews, since a grounded theory does not describe but conceptualizes and explains patterns of behavior. Hence, important information from the interviews will emerge anyway (Glaser, 1998). However, the first three interviews were digitally recorded and transcribed verbatim including breaks, doubts and laughter. The following five interviews were digitally recorded and transcribed, but only what the TOs actually said. The two final interviews were not taped.

During the interviews field notes were written. While listening to the first three taped interviews field notes were written as well. After each of the ten interviews and when analyzing each interview, memos were written, in order to conceptualize data (Glaser, 2002). The field notes and the memos, which are essential in grounded theory, were used as data. Memos are the theorizing write-up (Glaser, 1998). Finally memos on memos were written and in due course a rich bank of memos was established about the emerging theory.

The analysis started with coding the data and to find out what was going on in the data (Holton, 2010). During the open coding process, questions were constantly asked: “What happens in the data?” “What are these data a study of?” The purpose of these questions was to maintain theoretical sensitivity when conceptualizing the data. The purpose with these questions was to maintain theoretical sensitivity when conceptualizing the data. The codes that emerged were then compared with each other which generated new concepts. During this process the core concept emerged. The core concept is essential and explained how the main concern was resolved.

After the core concept had emerged, the selective coding process started. The theoretical sampling of new data was done having the core concept in mind and only concepts that had relationship with the core concept were included. In order to deepen the understanding in the interviews additional conversations were conducted by phone. These conversations took place with five of the 10 TOs already interviewed. Through recommendations from the interviewed TOs, five additional TOs participated on phone (i.e. 10 interviews
and 10 additional conversations in all). There were in all 20 participations including the interviews and conversations. This was done with the purpose of saturating the emerged core concept and the concepts that were related to the core concept. These conversations were carried out and were subsequently included, since everything in grounded theory counts as data (Glaser & Strauss, 1967).

All 10 additional conversations field notes were taken. These additional conversations and field notes did not contribute to new data but saturated the emerging theory. Therefore the decision was made to cease the data collection since data was considered to be theoretically saturated.

In the theoretical coding phase more memos were written where the memos explained the relationships between the concepts and the core concept. The memos were sorted and it was during this phase that the theory emerged (Glaser, 2002; Glaser & Holton, 2007), the theory unifying loyalty.

Quotations from the interviews were used for elucidating the behavior of the participants and they were translated by the first author. A classic grounded theory is always presented in present tense (Glaser, 1978).

Study IV

Method

Wide reflective equilibrium⁷, is the provided method and the meta-ethical perspective where different ethical principles should be in coherence with other ethical assumptions (Daniels, 1979; Daniels, 2016). The frame is based on the theoretical assumption that in order to be ethically acceptable, a specific standpoint or action should be consistent with other ethical standpoints that are made, and above all what may be considered as more basic or well-established ethical values and norms. The underlying key is justifying various ethical assumptions against other principles and searching

⁷ Equilibrium, Lat., aequus, equal, and libra, balanced
for ways in which some of these assumptions support others, seeking coherence among the widest set of assumptions and revising them at all levels. In wide reflective equilibrium different ethical values and norms should be consistent with each other and the positions in individual situations should be justified (Rawls, 1999a, 1999b) by basic and established values and norms and also by adjusting them to a pre-systematic practice (Hahn, 2016). Wide reflective equilibrium is reached when there is an acceptable coherence among these ethical principles and assumptions.

**Methodology**

An assumption was made that there are more universally accepted ethical values and norms that are valid within the field of military medical and nursing ethics as well as within the field of medical ethics in general. These ethical values and norms should also preferably harmonize with military ethics. The norms and values chosen were the general, international professional codes and medical-ethical principles. The professional codes that guide LMP are, for physicians, International Code of Medical Ethics (WMA) (2006) and, for registered nurses, International Council of Nurses (ICN) (2012). Furthermore, the four medical ethical principles originally from Beauchamp and Childress as interpreted by Beam (2003) were used for the military medical situation: beneficence, doing the best for the patient from the patient’s own perspective; non maleficence, not to hurt others; respect for her or his autonomy, the patient’s right to decide over the own life; and justice, distribution of scarce health resources and fairness and equality in decisions about who gets what treatment. Apart from the four principles interpreted by Beam (2003) other medical norms were used, i.e. everyone’s right to human dignity (International Committee of the Red Cross, 12 August 1949, Practise Relating to Rule 154; 1949), implying that everybody has the same value, because “we all are humans”; integrity (Powers, 2015), motivating attitudes and actions; and privacy (Fjellström et al., 2005), securing a safe space for each person.

In order to attain reflective equilibrium, or wide reflective equilibrium, several criteria had required to be met. These criteria had to be explained in terms of coherence and should have leastwise a little epistemic standing of initial credibility since the coherence per se could not generate justification ex nihilo.

In the selected ethical problem which concerned LMP gathering information
claimed to be intelligence, different possible scenarios were analyzed in the light of humanitarian law, professional ethical codes and general medical ethics principles in order to see if they could be justified. The analysis was undertaken in three steps, i.e. first, an analysis in relation to humanitarian law, then an analysis in relation to the professional codes of LMP, and last, an analysis in relation to medical-ethical principles. Finally, an overall analysis and conclusions based on this were completed.

Ethical considerations

When undertaking research involving humans a mindset of ethical reflection had to be maintained during the whole process, such as taking into account the demands in research involving information about the project, informed consent and confidentiality (Gustafsson et al., 2011). The four ethical principles, i.e. autonomy, beneficence, non-maleficence and justice, were taken into consideration (Beauchamp & Childress, 2013). Since the research involved humans the Regional Ethics Review Board in Gothenburg approved the research even if it was not required by law (D Nr 2012/1029-11) for study I (D Nr 2014/816-14) and for studies II and III (Act on Ethical Review of Research Involving Humans 460, 2003; Gustafsson et al., 2011; Swedish Privacy Law, 1998:204).

Several measures were taken to inform possible participants about this project. The participants actively volunteered to take part in the project. When they contacted the thesis author, they were given further oral and written information about the project, its methods and that the research was to be published in peer reviewed journals (Kalman et al., 2012). Since they all signed up voluntarily for studies I, II and III, and were told that they could at any time discontinue participation if they so wished, without having to explain why, it was concluded that the requirements for informed consent and the principle of autonomy were met (Declaration of Helsinki, 2013). It was difficult to find participants who wanted to participate and therefore it became even more delicate and essential to ensure informed consent and to uphold the principle of autonomy.

Data collected was treated with confidentiality, i.e. the link between the person and the data will only be possible to track by means of a code listing that will be kept separate from the data (Declaration of Helsinki, 2013). All data is stored so no unauthorized person will have access to it. It will not be possible
to identify the specific individuals among the participants in the presented results, since the participants were questioned about their personal experiences and should be treated with respect according to ethics even if it might not be sensitive information according to Swedish law (Swedish Privacy Law, 1998:204, § 13).

The participants declared in interviews the importance of undertaking research in these matters, and that they wanted to participate since they trusted the thesis author. The research team was therefore assured that the research would benefit these groups according to the principle of beneficence. The principle of beneficence would promptly be linked to the training session, study II.

There were, according to the principle of non-maleficence, no risks to participating in the project they were told, both in writing and orally.

Four of the interviews for study I were conducted in Afghanistan. There it was thoroughly discussed from both ethical and legal aspects to not end up in a conflict between the two roles, the researcher and the priest, in the interviews, in order to prevent the roles being mixed. An additional legal aspect was the fact that the interviewees were part of a Swedish contingent in ISAF and that the analysis of the interviews took place in Sweden and it was assumed after thorough discussions in the research team that the Swedish ethical laws and principles were applicable in this case (Act on Ethical Review of Research Involving Humans 460, 2003, § 5).

The principle of justice is applicable here since the data collected in combat zones was done under the pressure of the unanticipated conditions associated with being in this context. It was difficult to find time and space for the interviews, and the interviews were interrupted many times, due to emergencies. Although, this may be legally accepted, it is sometimes difficult to talk about one’s own experiences in a stressful environment (Michel, 2005), e.g. a combat zone, which may stir up emotions and memories the interviewees not were aware that they had (Dahlberg et al., 2008). If the interviews carried out in Afghanistan had been perceived as difficult for the interviewees, contact could have been established with either Human Resource Center, at Swedish Armed Forces headquarter or with another battalion priest, e.g. the Finnish priest who was stationed at the Swedish camp Northern Lights, in Mazar-e-Sharif.
Summary of the studies

The results are presented in this section under the titles of the studies I, II, III and IV.

Experiences of Swedish Medical Personnel in combat zones: Adapting to competing loyalties (study I)

Table 4. Categories and subcategories describing experiences of Swedish medical personnel in combat zones.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being in a primarily non care-giving organization</td>
<td>Adapting to military objectives before following caring norms</td>
</tr>
<tr>
<td></td>
<td>Suffering consequences when prioritizing care-giving norms</td>
</tr>
<tr>
<td></td>
<td>Finding that care has a low position in the military hierarchy</td>
</tr>
<tr>
<td>Caring in emotionally charged relationships</td>
<td>Caring for “one of us”</td>
</tr>
<tr>
<td></td>
<td>Forced to care for the enemy</td>
</tr>
<tr>
<td>Lacking an open dialogue about expectations of killing</td>
<td>Saving essential materials for their own unit</td>
</tr>
<tr>
<td>Having to prioritize scarce resources</td>
<td>Wishing to give even a limited help to the host nation</td>
</tr>
<tr>
<td></td>
<td>Having to act in isolation</td>
</tr>
</tbody>
</table>

The medical personnel easily adapted to military objectives and undertook duties that were not purely care-giving when they were in combat zones. An example of duty they undertook was that they gathered information while they cared for people from the host nation. Some of the medical personnel experienced that they undertook healthcare more or less in order to acquire information and they emphasized that is a problem from both ethical as well as legal aspects when being for permanent medical personnel. However, when medical personnel prioritized healthcare, at the expense of military units, they suffered consequences from the military chief/tactical officer, and they received a lower grade.

Being in a military unit, medical personnel felt they had low status and even experienced that they were not as good soldiers as the rest of the unit. As a consequence, medical personnel volunteered to do more military duties, e.g.
volunteered at the shooting range, implying they did more of the dangerous military duties, which in turn could lead to their suffering own injuries or even worse.

The patients for the medical personnel were either from their own unit or belonged to the enemy side. Caring for a familiar person or having to care for an injured enemy can stir up different kinds of emotions, and put more pressure on the medical personnel, but in combat zones there are no alternatives. However, in combat zones medical personnel most likely have to act alone as well as professionally towards both close friends and also individuals who have recently fought against their unit.

The medical personnel are employed in an organization where one of the goals is to kill other human beings in order to fulfill assignments. Since the medical personnel basically are lifesavers, the killings are expected to be discussed but they rarely are. Some of the medical personnel, the combat lifesavers, claimed however that their primary role was as combat soldiers, and for them the killing was a part of ordinary duties. Therefore, the permanent medical personnel and the temporary medical personnel did not have the same ultimate goal in the combat zones.

LMP had the resources they could carry in a crash bag, which might have been the only available medical equipment. Before rotation to combat zones they were trained in triage, to prioritize among injured. However, in the combat zones they prioritized the own unit regardless of whether the host nation had more urgent need of treatment.

Before the operations discussions occurred about whether the medical personnel should provide care for the people in the host nation or not. If they have to follow up the care they are told not to provide care, but when they arrive at combat zones and see the needs, they feel they want to help people but they use materiel that might have expired or materiel they do not need themselves.

Having a care-giving role in combat zones can also mean having to act in isolation. A registered nurse, or a combat lifesaver, could then be the highest medically educated person there. Sometimes they were not informed in advance how they would be organized and this could cause stress among medical personnel and these situations were very vulnerable.
Dual loyalties: Everyday ethical problems of registered nurses and physicians in combat zones (study II)

Table 5. Categories and subcategories around dual loyalties of registered nurses and physicians.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for not undertaking combat duties</td>
<td>Lacking military competence</td>
</tr>
<tr>
<td></td>
<td>Against the ethos of the care-giving role</td>
</tr>
<tr>
<td></td>
<td>Following the letter and intention of humanitarian law</td>
</tr>
<tr>
<td></td>
<td>Should prioritize healthcare and not military duties</td>
</tr>
<tr>
<td>Reasons for undertaking combat duties</td>
<td>Humanitarian law is not relevant</td>
</tr>
<tr>
<td></td>
<td>Having a military role and a military competence</td>
</tr>
<tr>
<td></td>
<td>Doing one’s share</td>
</tr>
<tr>
<td></td>
<td>Contribute to force protection</td>
</tr>
<tr>
<td>Restricted loyalty to military duties</td>
<td>Undertaking combat duties when under threat</td>
</tr>
<tr>
<td></td>
<td>Undertaking combat duties if unseen</td>
</tr>
<tr>
<td></td>
<td>Undertaking combat duties if not needed for healthcare duties</td>
</tr>
</tbody>
</table>

Physicians and registered nurses (LMP) reasoned around every-day ethical problems stemming from dual loyalties, whether they found reasons for undertaking combat duties or not and if they would undertake combat duties under certain circumstances. The ethical problems concerned situations when the LMP undertake military duties that can collide with being healthcare personnel.

Reasons for not undertaking some military duties were the fact that LMP lacked the military competence. Competence was merely referred to as having the education or being trained. LMP also referred to that undertaking some military duties was against the ethos of their care-giving role. Referring to the ethical code to do no harm, LMP claimed they would not undertake military duties that in some circumstances were against that code. Furthermore, according to humanitarian law, LMP claimed, they should not be involved in combat duties. If they had undertaken combat duties, they claimed that the trust for them as being Swedish LMP would have been damaged. They did refer to their duty to prioritize healthcare duties as well as the breach towards patients as being no reasons for not undertaking combat duties.
When LMP claimed they would undertake military duties such as combat duties they referred to humanitarian law as being irrelevant, implicating that humanitarian law is not valid since most of the armed conflicts Sweden participates in are non-international and therefore parts of humanitarian law do not apply. But LMP also referred to humanitarian law as if LMP could choose to follow the law or not. If the enemy did not follow humanitarian law why should LMP follow it, they reasoned.

If LMP had been employed as temporary medical personnel and had the military competence and knew how to undertake military duties, they would not hesitate in undertaking these duties. If they had been temporary medical personnel it would not have been a problem according to humanitarian law to participate in military duties, since they then would already have been part of the fighting squad. LMP also claimed it was important to be united in the unit and therefore they wanted to show that they, like everybody else, should contribute with undertaking different military tasks.

Sometimes there is a shortage of personnel and LMP referred to justice and claimed they felt obliged to contribute by doing different tasks, even military tasks they normally should not do. Undertaking combat duties may be also be seen as contributing to force protection, they reasoned almost in terms of justifying their decision to undertake duties that they are not primarily employed for.

Then there were conditions or occasions where they would undertake military duties that were not in their role. When under threat, they would undertake combat duties. They claimed it is awkward and unethical if they as LMP did guard duties, but under threat they would not hesitate to do it. If they did other tasks when not needed in healthcare duties they found it natural since everybody has to contribute by undertaking different tasks when on operative duty.
Unifying loyalty: a grounded theory about tactical officers’ challenges when leading licensed medical personnel in combat zones (study III)

The TOs find it challenging to lead LMP. The emerged theory, Unifying loyalty, offers an explanation to why TOs are challenged when leading LMP and how this is handled. The essence of the theory is to create loyalty towards the unit, since the goal for TOs is to unify LMP with the other soldiers in order to become a team. This has to be done before rotating to combat zones. Loyalty is an important value within the military. That the unit becomes unified is essential since it has to do with security for the whole unit. If the unit were not united there would be a risk that military duties would not be carried out. Consequently, not being united endangers security for the whole Swedish unit which in the end would be a matter of life and death.

In order to be unified and create loyalty the TOs use four different strategies. These strategies are executing orders, clarifying rules and laws, clearing out roles and marking limits.

Executing orders refer to that TOs giving orders to LMP about what to do, when to do it and who will do what. Clarifying rules and laws refers to making LMP obey certain rules and laws. Clearing out roles refers to which duties LMP should undertake. Marking limits refer to explaining who has responsibility for what. These strategies are done through TOs and they use two different leadership archetypes, either a hierarchical leadership or a democratic leadership. Basically, the hierarchical leadership archetype is built on one-way communication and not open to discussions and the democratic leadership archetype is built on consensus and open to discussions.

Furthermore, there are also some conditions that impact whether the TOs use the hierarchical or democratic leadership archetype. These conditions could be having a shortage of LMP, the training of LMP, TOs’ experiences of being TOs’ and TOs’ knowledge, the kinds of duties and the ages of TOs’ and LMP. Besides the conditions, if TOs’ have previous experiences of leading LMP on military operations this may also affect the result, likewise if LMP has previous experiences of participating in military operation affect whether LMP are united fully in the unit. Sometimes LMP do not partake in the training and education before rotating to combat zones, which may also affect whether TOs can unite LMP into the unit. The main goal for TOs’ is to unify LMP in the unit in order to ensure stability and security.
Gathering intelligence or providing medical care on military operations: an ethical problem for Swedish LMP in combat zones (study IV)

The everyday ethical problem when LMP are gathering intelligence was chosen for a normative analysis. Reasons for choosing this everyday ethical problem was that when LMP are gathering intelligence during caregiving or simultaneously it might be an example of when medical ethical norms collide with undertaking military duties.

The ethical problem was analyzed in relation to humanitarian law, the professional codes of LMP and general medical-ethical norms.

According to humanitarian law LMP should not undertake duties that can be referred to as acts of hostility. However, acts of hostility are not defined in customary law. Whether gathering information means participating in hostile acts is not clear.

In the professional codes for physicians and registered nurses it is stated that LMP should provide care to anyone in need, but the military regulations can contradict these codes, especially in times of armed conflicts and other violent situations. Medical confidentiality is essential undertaken through an interpreter and can be seen as not sensitive information. Gathering information is therefore not explicitly forbidden and there can be room for interpretation.

In relation to the ethical codes a number of questions were considered, whether LMP gathered intelligence voluntarily or by order, under which conditions LMP gathered intelligence, whether it was before, concurrently or after caregiving, whether LMP gathered intelligence transparently or covertly, if there were any short or long term risks and if intelligence gathering violated privacy and integrity.

It was considered that during some situations it could be acceptable for LMP to gather intelligence, i.e. if intelligence gathering does not condition care, is voluntary and transparent. However from a systemic perspective it is problematic to compromise with LMP’s non-combatant status. It was also considered problematic from an ethical point of view, especially in the long run, since LMP then risk not being able to fulfill the principles of medical ethics referring to beneficence, doing good for the patient, and non-maleficence, not harming the patient. There are risks if LMP undertake duties they are not trained for in the long run. The risks for becoming mission creep, i.e. an incompetent expansion of military objectives at the expense of care
objectives, can increase if LMP do things that are not part of their role. The question will be where they then draw the line? Where is the limit for not being acceptable to undertake military duties? Here is a possible slippery slope.

Furthermore, since the humanitarian law does not fully apply in non-international armed conflict contexts of today revisions would be desirable. A concrete suggestion is that a humanitarian law should discuss not only the severe ethical problems that have occurred in history, but also the everyday ethical problems and how to act in these situations. Through education and reflection it could be possible to prepare both the LMP and the tactical officers as well as the whole military unit for the problem of dual loyalties, preferably before the rotation to a combat zone. The education and reflection could contain teaching about humanitarian law and human rights in order to ensure that human dignity and privacy should remain core values for LMP.
Discussions

The main findings from the results of studies I-IV discussed in this section are how LMP reason around humanitarian law, that LMP sometimes experience dual loyalties when stationed in combat zones and the education and preparation before rotating to combat zones.

Humanitarian law

The core of humanitarian law, i.e. the four Geneva Conventions from 1949 and the three Additional Protocols, regulate the conduct of armed conflicts and aim to limit its effects and reduce the sufferings. They specifically protect civilians and healthcare personnel who are not taking part in the combat, and those who are no longer participating in the fighting squad, such as wounded, sick and shipwrecked soldiers and prisoners of war (ICRC, 1949a, 1949b). The worldwide humanitarian organization, the International Committee of the Red Cross (ICRC), founded by Henri Dunant 1863, is the origin of the Geneva Conventions (International Committee of the Red Cross, 12 August 1949). At the battle of Solferino in 1859 Dunant experienced the sufferings of thousands of wounded soldiers which made him write A Memory of Solferino (Dunant, 1862) and this book proved decisive in the founding of the ICRC. Humanitarian law is today included in customary law (Henckaerts et al., 2005a; International Law in Armed Conflicts, 2010:72; Melzer, 2010) all these laws are in accordance with the Human Rights (Physicians for Human Rights, 2002).

In our studies we have found that LMP reason around the applicability of humanitarian law in combat zones. When employed as permanent LMP, they sometimes find it warranted to see humanitarian law as something they can choose to obey or not and humanitarian law does not always seem to be important to LMP, since they often say that they do not take humanitarian law seriously (study II). Occasionally they seem to treat humanitarian law pragmatically, meaning for example that LMP undertake duties that are non-medical when personnel resources are limited (Study II). Sometimes LMP even claim humanitarian law does not apply in combat zones, which they show by undertaking military duties such as guarding (study I) and intelligence gathering (study IV) which normally are done by soldiers
especially trained in doing these duties. Furthermore, they do not always wear the ID card and the armlet with the distinctive emblem, the Red Cross, which they are provided with when rotating to combat zones (Study II). Since enemies ignore humanitarian law LMP claim that humanitarian law has lost its value (Study II).

Nowadays, when the majority of contemporary armed conflicts are non-international (Harbom et al., 2005), such as Afghanistan and Mali (Swedish Armed Forces, 2009, 2015), there is strictly speaking a lack of applicable rules, but more essentially, there is a disrespect for the most well-known parts of humanitarian law, the Geneva Conventions (ICRC, 2007). Article Three which is common to the four Geneva Conventions, (Henckaerts, 2012) has become a baseline from which no departure is allowed (ICRC, 2007), and this is applicable for the Additional Protocol II as well (ICRC, 1977), which supplements Article Three. However, these rules do not provide detailed regulation of the non-international armed conflicts, since these conflicts are subjected to a smaller amount of treaty rules than before when most armed conflicts were international (Henckaerts, 2005). Therefore, this lack of detailed laws opens possibilities for interpreting the few applicable laws and rules, as seen in our studies.

In customary law it is stated that LMP are not allowed to participate in acts of hostility (Henckaerts et al., 2007), since then they will lose their protection (International Committee of the Red Cross, 12 August 1949). However, which duties lead to acts of hostility are not precisely defined in customary law (Henckaerts et al., 2005a), but a possible explanation might be whether LMP undertake those particular duties actively or defensively (Melzer, 2010). But, an uncertainty in both international and non-international armed conflicts is what is meant by “direct participation in hostilities” (Henckaerts, 2005). LMP are allowed to use their weapons for self-protection and for the protection of their patients. To stand guard, meaning to prevent enemies from entering the camp, can lead to LMP having to use their weapons actively, meaning that LMP as permanent healthcare personnel would then act as combatants (Sandoz et al., 1987), with the addition that “act as combatants” is not clearly defined in non-international conflicts (Henckaerts, 2005). It is however clear that LMP lose their protection if they are involved in acts “outside their humanitarian function that are harmful to the enemy or acts that are hostile acts” whether the armed conflicts are international or non-international (de Waard & Tarrant, 2010). Gathering intelligence can be seen as indirect or
more passive and in the end even save lives, which could refer to the fact that the information they receive deals with enemies’ whereabouts and therefore could involve e.g. a distract from the care-giving and hindrance of an assault. However, if the intelligence gathering is done more actively, it can distract from the care-giving and medical treatment undertaken by LMP since they are not trained in doing these duties. Thus, perhaps LMP should refrain from intelligence gathering, but it is neither clear that intelligence gathering is forbidden according to customary law, nor is it clear that it can be seen as acts of hostility. Humanitarian law can therefore seem unclear and one possible interpretation is that LMP are not obliged to follow humanitarian law 8.

However, Sweden’s Supreme Commander has executed an order in 2001 in which he declared that Swedish Armed Forces, including LMP, shall comply with humanitarian law when participating in military operations abroad (Swedish Armed Forces, 2001), meaning that the spirit of humanitarian law still applies, even if the conflicts are non-international. The order has not expired and must thus be obeyed.

Here it might well be relevant to ask which parts of humanitarian law the Supreme Commander is referring to and whether these parts are known to LMP, since humanitarian law is complex and consists of a huge branch of laws and treaties. To some extent LMP seem to be familiar with humanitarian law, since some claim reasons for obeying humanitarian law or not, and also have restricted loyalty towards humanitarian law (Study II). If, as has been found, humanitarian law is not clear-cut, there may be a resistance to obeying the law. LMP may then make their own interpretation. Generally, there is an increasing disrespect for basic legal norms in humanitarian law which may result from the Geneva Conventions of 1949 being seen as old fashioned in the light of the dynamics of armed conflicts today (Wilkinson, 2017) and this is a well-known problem even in states that have ratified humanitarian law, additional protocols and treaties (Bangerter, 2011). It is far from automatic to make a decision to follow humanitarian law or not, regardless the decision is

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made by an armed unit or a state (Bangerter, 2011), or a Supreme commander it seems. Irrespective of armed conflicts, the core of humanitarian law, the Geneva Conventions of 1949 and their 1977 Additional Protocols remain as pertinent to today’s combat zones as ever (ICRC, 2007). There are still prohibitions on direct attacks against civilians and other transgressions such as using torture-like interrogation techniques in armed conflicts. Thus, when healthcare personnel participated in severe transgressions such as torture-like interrogation techniques and waterboarding during armed conflicts humanitarian law is clear (Miles, 2004, 2008, 2013) and this should be repudiated. If humanitarian law had been respected in severe situations, it would perhaps change the face of many armed conflicts worldwide (Bangerter, 2011). Humanitarian law sets out in clear terms the values and the standards relating to these severe transgressions to which, among many countries, Sweden has agreed to adhere (ICRC, 2007).

The existence of humanitarian law seems not to be enough for people to obey it (Bangerter, 2011; Slim & Mancini-Griffoli, 2007). If the goal is that the Swedish units, including LMP, should always obey humanitarian law, they must have good reasons and rationales for following the law (Bangerter, 2011), otherwise an order might not be obeyed. When there are no consequences for ”bad behavior”, or when states and non-state actors benefit from violations, there is an even less incentive to comply. As seen in our studies, LMP question orders (Study III), and they want reasons for why they should obey an order. A respect for humanitarian law can only be encouraged, and hence improved, if the reasons that are used by the military to justify the respect or lack of respect are relevant for LMP, and if the arguments in favor of respect take these reasons into account (Bangerter, 2011). If the Swedish Commander’s order is to apply, it is crucial to clarify exactly which parts of humanitarian law are to be followed and how they should be interpreted since humanitarian law is not clear-cut in internal conflicts, but also why these parts should be followed, since we have found that motivation seems important (Bangerter, 2011), especially in these everyday ethical situations.

Slim & Mancini-Griffoli (2007) claim that it is not enough to repeat the circular reasoning over and over again that “undertaking duties that are pure military is wrong because it is against the law and it is against the law because it is wrong”.

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If personnel do not respect humanitarian law, the problem is not necessarily the law itself, but rather their education in humanitarian law before rotation to combat zones.

Dual loyalties

Dual loyalties is a complex conflict implying the existence of simultaneous obligations that conflict with each other (Allhoff, 2008). This conflict occurs frequently in different organizations but military healthcare personnel are faced with an ethically difficult dual loyalty conflict, especially during armed conflicts, of healthcare duties on the one hand and possible military duties on the other (Clark, 2006; Griffiths & Jasper, 2008; Physicians for Human Rights, 2002). Some extreme examples of dual loyalty were shown at the Iraqi prison Abu Ghraib and at Guantanamo Bay where Iraqi prisoners of war were tortured and healthcare personnel were involved in torturous interrogations (Clark, 2006; Miles, 2004, 2008). Furthermore, in Afghanistan Dutch healthcare personnel thought they had communicated the problem of dual loyalties in a thorough way providing healthcare for people of the host nation with medication reserved for their own Dutch unit, but in actual situations it differed from person to person how they viewed helping the host nation or not (Olsthoorn et al., 2013). Loyalty is a common concept in the military context, but at the same time there is not much research in the military context about this concept (Coleman, 2009).

It has been found that LMP sometimes experience a fundamental dual loyalty between healthcare norms and military norms (Study I). They are put in situations with conflicting loyalties demands meaning that they feel loyalty towards their healthcare duties but are expected also to be loyal towards the military organization. This is seen in combat zones when LMP undertake duties that are not primarily care-giving, such as performing body search, providing care in order to acquire information and undertaking guard duties (Study I). LMP saw the information gathering as force protection and they volunteered to do military duties, such as practicing on the shooting range.
The duties undertaken by LMP might not be unlawful per se (study IV)\(^9\), but are still not duties that normally are in the healthcare role. LMP experience dual loyalties, but we also find that they feel primarily loyal towards their healthcare duties, in which case they do not experience dual loyalties (Study III).

The TOs are responsible for healthcare (Andersson, 2014) and have to be prepared to handle difficult situations when participating with a unit in combat zones. It is therefore of importance that they are familiar with LMP and their duties. The TOs are challenged when leading LMP, which affects their leadership since the TOs want to create loyalty in the unit and unify LMP in the unit and this can often exacerbate the dual loyalties that LMP experience. Leading a military unit today is complex and the contexts that shape military leadership are the military core duties, which are to maintain security (Kark et al., 2016). An example of this complexity is when military units end up in situations where no solutions are given in advance and where the only judgment they have to rely on is that of the tactical officer (Victor Tillberg & Tillberg, 2012).

It can be argued that dual loyalties may not be a major issue in peacekeeping or peace enforcement operations, but a risk that is discussed is mission creep. Mission creep (Allhoff, 2008; Davis et al., 1996; Enemark, 2008; Sullivan, 2006) is a term that is often related to military operations (Hoagl, 1993) and it is an expansion that goes beyond its original aim and involves undertaking duties that were not part of the original plan (Choi & Berger, 2010), but creep in insidiously (Enemark, 2008; Sullivan, 2006). That LMP gather intelligence while providing care can be advantageous for the unit, but there is a risk that a mistake could occur which could cause severe problems not only for LMP but for the whole Swedish unit, since LMP were not originally employed for these duties. LMP undertake these duties voluntarily. The risk for going beyond the limits for what is ethically acceptable becomes greater for each time which also risks the confidence Sweden has from other countries. Thus,

\(^9\) Accepted article: Gathering intelligence or providing medical care on military operations: an ethical problem for Swedish licensed medical personnel (LMP) in combat zones. Military Ethics, 2017-18, X(XX).
where is the line to be drawn? In the end LMP risk starting do unacceptable things as seen for example in recent research about severe ethical problems in the Iraqi prison Abu Ghraib and Guantanamo Bay (Clark, 2006; Miles, 2004; Zimbardo, 2008). There may be a slippery slope here (Saliger, 2007) meaning when a relatively negligible duty culminates in a significant, often negative, effect. An example is if LMP were to undertake a specific duty that led to unexpected, negative results. This could happen to Swedish LMP just as it has happened to other nationalities’ healthcare personnel.

There are several reasons for undertaking these military duties at the expense of care duties. In combat zones, LMP live closely with their units in the camp and they share barracks, dining-hall and leave their laundry at the same place as the other soldiers and officers. The camp becomes an small, isolated community. Due to these circumstances it is difficult to stand up and claim ones rights against an officer if disagreements with someone in the unit occur without feeling disloyal. It is a question of how LMP would cope with being, or at least feeling, disloyal towards the military. Interpersonal relationships, such as the feeling of belonging (Bryan & Heron, 2015; Umphress et al., 2010) and being a part of the military unit and being a good friend are therefore essential especially on the military operations abroad and a reason for LMP to show that they are as good soldiers as anybody else, which is seen in our studies (Lundberg et al., 2014). They fear exclusion from the unit and that they will be ostracized (Balliet & Ferris, 2013; Thau et al., 2015). LMP live in this context seven days a week, 24 hours per day and cannot go home after work. Their basic moral compass may therefore risk being overcome and it can become more important for them to be loved or popular in their unit than to stand up for humanitarian law and their own ethical codes. If LMP are not accepted in the group, the time on the operation in combat zones will be unbearable for them.

Thus, it is about surviving mentally, from pre-deployment preparations through deployment and post deployment adjustment, (Bryan & Heron, 2015). This is a socialization process from the organizational level (Olsthoorn et al., 2013) to the individual level, through which individuals who are living in the unit transform the norms or culture of the environment in order to strengthen the unit’s cohesion and survival opportunities. This is often achieved indirectly through contact with the members of the unit and it is done unconsiously to a large extent (Sheffield et al., 2017). Sometimes they work alone as LMP in distant places together with a small unit of soldiers and
officers (study I) and then it may be even more important to fit in, since they are exposed and it is obvious who they are.
Furthermore, being on a military operation for a long time can cause boredom, a “hurry up and wait” aspect of many military operations (Hancock & Krueger, 2010). Examples of boredom can be repetitive work for periods and not having a variety of duties can result in powerlessness (Hancock & Krueger, 2010). This is especially often seen in the navy, such as when LMP participated in Aden outside the coast of Somalia, where the units spent a long time together in tight housing. On one hand there are moments that are acutely overloaded and stressful in many ways due to danger and on the other hand periods of being under-occupied and experiencing a fatigue over just about everything and everyone and they can lose the mood (Hancock & Krueger, 2010). This can be a reason for undertaking new military operations.
However, this phenomenon is not only psychological with the importance of blending into the units, but can also be experienced as an ethical demand in these situations. When LMP become aware that soldiers are working hard, such as each day with the same schedule, rough weather from very cold to extreme heat, dusty or rainy etc, dual loyalties can occur where an ethical demand (Lögstrup, 1992) arises which claims that it is difficult to see how soldiers are hardworking while LMP are inactive. LMP see that there are more important values to highlight than keeping the law and find it fairer if they work hard as well (Nathanson, 2013). In social situations, such as in the military where everyone depends on everyone else, an ethical demand arises. No one requires necessarily that the ethical demand is fulfilled, neither the soldiers nor the officers, but it might be experienced as a silent or unspoken demand (Fink & MacIntyre, 1997). It is a silent or unspoken demand (Bengtsson, 1989). It is up to each individual to decide how to respond to the demand and whether they will help or simply ignore the demand. The demand in itself implies that a person will do the best for the other part, but it is up to everyone's judgment to decide what the best thing to do is.
It is understandable that LMP end up with dual loyalties and want to be fair towards the unit (study II) and group pressure or group identification and loyalty rather than formal requirements seem to constitute the explanation for their behavior (Hildreth et al., 2016). According to Bangerter (2011) LMP must have reasons for obeying the law but if their loyalty towards the unit is stronger than the loyalty to the law they are loyal to the unit. It may not be the case that LMP do not know the rules, the laws, and the ethics, but they want
to stand up for the unit and simply be humans and show humanity. Although this reaction may be lessened, LMP are in a context with different norm systems, which are not always easy to harmonize with one another.

**Education: reflection and military training**

In view of LMP’s problem of dual loyalty with regard to humanitarian and military law respectively, and when ethics are at stake, is it likely that these problems can be managed through education (Lederman et al., 2016) and if so, what kind of education would then be required? Sometimes, the questions to ask when ethical problems are in focus are: ”How could this happen?” and “How can we prevent these issues arising?” (Seiler et al., 2010). These questions lead us to wonder about the preparation before rotation to combat zones, the education LMP are giving in humanitarian law and whether they have any reflections concerning their experiences of dual loyalty, but also about the military training. In our studies we have found that humanitarian law is sometimes not clear-cut and that LMP therefore are not necessarily breaking the law (Study IV), as can be seen when LMP question the applicability of humanitarian law, believing that following it is simply a matter of choice and pragmatism (Study II). LMP reason and act in different ways on dual loyalty (Study II). Consensus seems to be lacking about how to view humanitarian law and how to deal with the problem of dual loyalty and how to unify LMP in the unit. Therefore reflection around humanitarian law and dual loyalty seems essential for LMP as well as for the TOs, who lead LMP in combat zones. Furthermore, LMP sometimes have demands such as rotating on their “own rotation” (Study III), meaning that they require a minimum of education and preparation before rotating to combat zones. The TOs claim that LMP lack sufficient training and education with the unit and that LMP therefore have their “own rotation”. This makes it hard for the TOs not only to unify them in the unit, but also risky since LMP might not function in fully in combat zones. However, since the TOs want to create loyalty and LMP experience dual loyalties and sometimes undertake duties that are not pure healthcare, then the effect of dual loyalty can be even stronger. Therefore, not only reflection but also military training seems to be necessary for LMP. Thus, one can question whether there is a possible conflict here, meaning if additional military training would rather make them more likely to choose
military tasks in terms of the dual loyalty conflict or rather that military training would better equip them for where the line should be drawn for duties they may undertake. Perhaps a combination and interaction of education and military training may be the best solution, and that they should also discuss how to handle and evaluate the conflict of dual loyalty situations.

Earlier researchers claim the importance of balancing military necessity and military ethics with adequate preparation, discussions and reasoning on the ethical problems and how to relate to them (Beam & Sparacino, 2003; Clark, 2006; Gross, 2006; Kottow, 2006; Lifton, 2004) and also how to prevent healthcare personnel from committing unethical actions (Lucas, 2009). If healthcare personnel are not prepared or have not reflected around ethical questions there are risks of ending up in severe difficulties (Nathanson, 2013), and it is particularly important to have the knowledge to apply the correct tools when in the combat zone (Nathanson, 2013). Examples of severe transgressions involving healthcare personnel have end up in are when United Kingdom (UK) was engaged in Iraq and the US involvement in Guantanamo Bay and Abu Ghraib (Clark, 2006; Miles, 2004; Nathanson, 2013). The main focus in their education was on earlier research when healthcare personnel were not following humanitarian law and human rights (Tripodi, 2006), and even if critical reflection as well as analysis can lead to knowledge, very little analysis has been done (Chamberlin, 2013).

However, our studies have not focused on severe transgressions outside the medical role but show that there are circumstances when it is ethically acceptable to undertake duties, such as gathering intelligence (Study IV). We have seen that the context of combat zones give rise to complex and often unique situations, exceptional circumstances. In spite of this, there may remain reasons for not undertaking such tasks, which fall outside of the medical role. To provide simple answers to difficult questions is counterproductive, since decisions in combat zones are always subject to review and must be able to be justified after the fact. Hence the need for in-depth education as well as training, in order to give the best grounding and preparation for the ethical problems that can and do occur in combat zones. In order to make decisions which can be both justified and defended, a thorough preparatory course of reflection on these issues is necessary.

The education and training, i.e. the ethical reflection but also the military exercise, can be integrated from the beginning.
In the reflection the ethical situation is recognized, implying to understand which values are at stake (Wortel & Bosch, 2011). The reflection may include knowledge in medical ethics not only in the context of combat zones, but also in peacetime, for obtaining a proper preparation when facing the ethical problems (Nathanson, 2013) and thus being able to prevent ethical misuses (Lederman et al., 2016). The ethical problems in focus should not be the extreme situations, such as when LMP participate in torturous situations, since these situations are not typical, but focus should rather be fixed on actions that are lawful and beneficial (Gross, 2010).

For the education to have a positive effect, it is important to discuss real problems occurring in combat zones (Seiler et al., 2010; Tripodi, 2006; Warner & Appenzeller, 2011). However, there is no evaluation from this education so it is hard to tell what effect if any it had on the participants’ reasoning or behavior.

In order to argue successfully for choosing to follow humanitarian law it is important to be familiar with the context of the combat zone in question including the setting and the unit involved in the operation. The mandate of the operation may also be essential, since this is regulated in humanitarian law. Therefore, it is essential to have a strategy for each education session in humanitarian law as well as in ethical problems with the aim of contextualizing the sessions.

This education in humanitarian law should include not only LMP but also the tactical officers, since they lead LMP in their healthcare duties. The commanding officer (CO) has the final responsibility for seeing that LMP are properly employed.

Furthermore, these ethical problems should preferable be included in rotation education before they occur, so as to avoid the risk of being unable to evaluate an ethical situation quickly and then respond appropriately in a real crisis (Baker, 2012; Kahneman, 2011).

However, military exercise is important as well and should be integrated into ethical reflection. The goal of military education today is to be prepared to serve as soon as the unit arrives in combat zones, which requires training before rotation to be adapted. Previous research has shown that there may be a discrepancy between the preparatory education and the reality in combat zones (Andersson, 2014). The education should preferably include realistic training, which is described in the US as “train as you fight” (Andersson, 2014). The unit has to be prepared for working in the combat zone as soon as
they arrive and therefore they need to be unified in the unit, which is a challenge for TOs (Study III), since LMP do not have sufficient training. However, LMP experience dual loyalties and therefore it is a matter of debate whether they need more military exercise. Their military preparation is limited when they travel to combat zones on their own rotation. The military duties they do are voluntarily and not something that the TOs ordered them to do. If they receive military exercise together with the rest of the unit, then they become unified in the unit and train in the duties they should undertake. That is, train in healthcare under fire and care-giving in that particular combat zone. When undertaking own rotation they will maybe not be unified in the unit.

The education can consist of training in different “train as you fight” scenarios can be set up. In order to show how to reason around different issues, Study II can be used as a discussion paper. From there, general ethical norms described in Study IV can be linked and be an example how one can reason from a normative perspective in these issues. Furthermore, with TOs being challenged when leading LMP Study III can be used in terms of how to communicate and training.

Methodological considerations

Throughout, the studies included a combination of evaluation criteria to ensure the trustworthiness of the research findings. Credibility, dependability and confirmability were discussed concerning studies I and II (Creswell, 2007). Four criteria (fit, relevance, workability and modifiability) (Glaser, 1998) apply for evaluating the grounded theory study (III). For ensuring trustworthiness in study IV coherence was important. Generally, it has been important to highlight the voice of the thesis author (reflexivity) (Creswell & Miller, 2010).

Reflexivity refers to the background, position and preconceptions brought into this research by the thesis author and are essential to elucidate in order to avoid subjectivity (Malterud, 2001; Palaganas et al., 2017). Reflexivity can be used as a concept for ensuring trustworthiness (Palaganas et al., 2017). The thesis author is an ordained priest in the Lutheran Church of Sweden as well as being a researcher. Having dual roles, priest and researcher, requires careful considerations as is confirmed by The Swedish Research Council (2002). The dual roles are complicated since ordained priests have an absolute
duty of confidentiality meaning that priests are not allowed to reveal what emerges during confessions or in individual counseling, or even mention that these have taken place in order to always protect the confidant (Biskopsbrevet, 2008). It is strictly prohibited to use information from a confession in another context (Kyrkoordningen, 2000). Priests cannot be absolved from the duty of confidentiality and can never be called as witnesses in court concerning information obtained during a confession or an individual counseling, and the vow of secrecy is lifelong (Rättegångsbalken 1942:740). At the time for data collection for study I, the thesis author served as battalion chaplain in Afghanistan, and four of the interviews were done in Afghanistan. This had to be carefully considered, in order to always protect the confidant. On military operations priests regularly have, more or less, sensitive conversations with soldiers and officers. From an ethical point of view, as well as from a professional, it was important to clearly distinguish the different roles from one another and maintain an ethical state of mind for protecting the participants throughout the research process (Silverman, 2006). The subsequent interviews, after the first four, were undertaken in Sweden. It was clearly established that the interviews were not confessions in a pastoral sense. If necessary, due to circumstances, for further support, the interviews would have been interrupted and not included in the research. In case the situation so demanded, any interview could have been canceled. This did not occur. When familiar with the context of the research it is important to reflect on possibly bias. Knowing the context can be valuable when undertaking interviews. However, it was important to be observant during the whole process so that the participant’s voices were heard in the interviews and not that of the thesis author (Malterud, 2001). To sustain a balance during the interview process was essential (Denzin et al., 2011; Padgett, 2009) and not to fall into either of the ditches: being too distant or going native. The balance was upheld through keeping close to the text when reporting the result, i.e. being manifest when the result was presented.

Studies I and II

Credibility refers to what extent the data, the interviews, capture the intended focus (Silverman, 2006). During the analysis, the categories were developed from the data and in study I the thesis author used member checking, in order
to let the participants confirm the credibility (Creswell & Miller, 2010), and strengthen the credibility.
The research team was involved when analyzing the data and when reporting the findings. Quotation from participants were used to ensure that the analyzed data represented empirical findings (Creswell, 2007) thus strengthening the credibility.
Possibly weaknesses are that it was hard to find participants and that we therefore selected the ones who wanted to participate, that were the most articulate, that had a positive attitude towards the project and therefore wanted to be interviewed. The ones that did not participate would perhaps have had different views. The participants were not representatives of the Swedish Armed Forces, since the majority of them had not been on a military operation abroad. However, new employees in the Swedish Armed forces are obliged to participate in military operations abroad. Furthermore, there are contextual variations implying that not all participants had the same views and experiences from the operations.
Another weakness is also that only the results in study I, but not study II, did underwent member checking.
Sometimes it is difficult to talk about experiences in tough environments, referring especially to the four interviews conducted in Afghanistan, or after having been exposed to tough environments, the rest of the interviews, and that could have affected the results. Furthermore, the interviews were of different lengths due some having more information to give than others, or due to memory being selective. Some of the participants were known to the interviewer, which may have affected how they answered and consequently the credibility. However, careful reasoning around these issues in the research team vouches for data really capturing the focus.

*Dependability* refers to replicability and avoidance of risk for inconsistency (Lincoln & Guba, 1985). Consequently it was of importance to describe and to thoroughly report inclusion criteria. The interviews were carried out by the thesis author. Dependability during the data collection was supported by using the same introductory question to all the participants. The introductory question was followed up by some more in-depth open questions. As for study II, the same topic guide with the four vignettes was used for all participants, including the same interview questions with all of the participants.
A strength was that the multifaceted background in the research team (caring science, theology, ethics and military experience) vouched for interdisciplinary triangulation (Creswell & Miller, 2010; Padgett, 2009). However, weaknesses were that the participants were selected by purposive sampling (I) and strategic sampling (II) but only three were interviewed from that session, and instead eleven new participants were recruited. The participants who finally wanted to participate and were interviewed had both interest in and knowledge of the research topic. Some of the participants were known to the thesis author, from operations abroad. This may be claimed to have influenced the results, implicating that the participants would have answered an unknown interviewer differently. However, some of the participants said that they would undertake military duties and they would therefore most likely not have answered differently even if the interviewer had been unknown to them.

Regarding the question about stability of data over time and conditions that is if the results would be the same if data were repeated, the question is likely to be answered with a no. The context, trust in the first author and existential situation when further away from the actual time spent on a military operation, would maybe give another answers.

**Confirmability** refers to the findings reflecting the participants and not the interviewer (Lincoln & Guba, 1985). The context was known to two (KL & AJ) in the research project and therefore it was of importance to constantly be aware of eventual preconceptions (Malterud, 2001). Being familiar with the context may be a positive effect for a better understanding of the interviewees’ answers. Possible preconceptions were under careful consideration during data analysis. The researcher tried to remain impartial that the result has been questioned to ensure it derived from the data and that the interpretation of the findings derived from the data.

It was, on one hand, more important to consider the confirmability since the participants explicitly stated, on several occasions, that they would not have agreed to participate if the interviewer had not been familiar with the context. On the other hand, the preconceptions were of importance when asking relevant questions (Morse, 1992) since the participants already had confidence in the first author and also could be more precise in their answers.

The research team and respective authors were all involved in analyzing processes in studies I and II and ensured that all interpretations derived from
the data. All read the condensed codes and contributed to naming the categories, a continuing process until all agreed (Elo et al., 2014). By using quotations from the interviews when presenting the results the interpretation was further elucidated. Two members of the research team had no preconceptions (LS and SK).

**Study III**

Before it was decided that grounded theory would be the provided method, three of the interviews were already completed by the thesis author. It was difficult to find participants and therefore the research team (KL, SK and AS) decided that these interviews should be included. However the analysis of these interviews were done with classic grounded theory, with memo writings, field notes and memos on field notes. It was of importance to be open-minded to what emerged from the data and to avoid any preconceived idea. Thesis author had from start an idea about TOs leading LMP in combat zones, but what emerged was a different main concern for TOs. However, the TOs discussed how LMP should view humanitarian law and undertake duties which might be interpreted as combat duties as well. Being open to what emerged turned out to be very essential for the emerging theory.

The analysis-process was carried out according to a classic grounded theory, with memo writings, field notes and memos on field notes. But, nonetheless, the results might have been different if the first three interviews had also been carried out according to grounded theory from the start.

By using grounded theory the thesis author started with an area of interest, after the first three interviews.

Thesis author had from start an idea about TOs leading LMP in combat zones, but what emerged was a different main concern for TOs. When undertaking a grounded theory study there are four ways of evaluating the emerging theory: fit, relevance, workability and modifiability (Glaser, 1978, 1998). The suitability of grounded theory refers to how well the concepts represent the pattern of behavior described. During the analysis process, the codes and the concepts were constantly compared, and new codes and concepts were generated in order to fit the data until data was saturated. The theory Unifying loyalty fits as it emerged from the data and was drawn from the explanations of TOs.
It would have been possible to force the data, but it would have been difficult to find additionally data that corresponded with existing data, since it was already difficult to find TOs who wanted to participate.

Being of relevance refers to what extent the concepts are dealing with as well as being relevant for the main concern. The concepts have to be relevant for the main concern which they were, since they solved the main concern.

The workability means that the theory can explain how the main concern is to be resolved, in this study why it is challenging for TOs to lead LMP. Throughout the analysis follow-up conversations were used as a way to saturate the data. However, the theory may also be modified, and is never complete, which is in line with classic grounded theory. When new data comes up, it can be compared with existing data and may lead to a modification of the theory, and this is called modifiability.

Grounded theory is abstract and its concepts last forever and can be expanded to other areas as well, meaning that the theory Unifying loyalty can apply in other settings.

The emerged theory Unifying loyalty does not explain every pattern of behavior. The participants were occupied with other things as well which can be explored in future research.

The process was based on observations of the data and the grounded theory emerged from data (Crotty, 2012). The theoretical perspective could be seen as influenced by symbolic interactionism and that it developed a theory which was grounded in data (Crotty, 2012; Sbaraini et al., 2011). However, it is debatable whether grounded theory is an aspect of interactionism (Reiter, 2017). According to how classic grounded theory is viewed it is a general method and therefore possessed by no particular discipline, data source or theoretical perspective and is always presented in the present tense (Glaser, 1998; Holton, 2008).

**Study IV**

The chosen ethical problem was when LMP provide care for the people of the host nation they also gather intelligence. The reason for choosing that particular problem was that it is an example of undertaking care and military duties simultaneously/the duties collide. Using reflective equilibrium is a way to systematically reason around a problem, and to be consistent in the reasoning.
The main criticism towards using reflective equilibrium (wide or narrow) concerns whether the method really shows consistency or coherence in the justification of ethical principles and assumptions (Harman & Kulkarni, 2006). In moral epistemology the method of reflective equilibrium is often accused of being intuitive, or rather assumed to be a method for justifying these intuitions (Brun, 2014).

A counter-argument against that criticism would be that if “ordinary reasoning” was used instead of reflective equilibrium, there would be a risk that the reasoning could be affected by “heuristics and biases” (Kahneman, 2011; Tversky & Kahneman, 1974), which is comparable with using arbitrary intuitions in the reasoning. The normative perspective used here focused on explaining and to some extent predicting why we have the intuitions we have and how we should think and act when reasoning and justifying our ethical values and principles.

Coherence, or consistency, in reflective equilibrium refers to the reliability of inductive reasoning and also to the importance of weighing the arguments equally. However, when weighing the ethical principles and assumptions it was of concern that these ethical principles should have similar levels of relationship (Polit & Beck, 2012). This is shown when using universal ethical values and norms that are valid in similar situations, i.e. in military medical ethics and medical ethics generally.

One might argue that there is no assurance, or maybe not even a need for assurance, that reflective equilibrium is stable or coherent. The equilibrium can very well be modified as new ethical principles or assumptions arise in our thinking.

Notwithstanding the criticism we argue for broader understanding when it comes to using reflective equilibrium as a method in practical ethics. There is a claim that ethical theories cannot be separated from practical ethics, and that theories must be tested and revised in the light of the assumptions under consideration about moral practice (Daniels, 2016).

By all means, reaching equilibrium may never be achieved, but still can very well be an ideal good enough to strive for and return to and apply over again, rather than just be set aside (Cath, 2016).
Conclusions and implications

Humanitarian law is not clear-cut how to be interpreted in internal military operations Sweden participates in today when it comes to the issues described in the studies. Nor is the law explicit about the everyday ethical problems discussed in the studies. In order to fit in today’s context of combat zones humanitarian law needs to be updated to the conditions that occur today in the armed conflicts. Furthermore, it is of importance to give LMP a rationale why humanitarian law still applies, and also clarify humanitarian law to Swedish context of combat zones.

LMP experience dual loyalty when being in combat zones. Some of the LMP weigh their loyalty between their healthcare duties and military duties, and give explanations for undertaking certain military duties or refrain. Since humanitarian law seems to be unclear for LMP, LMP are experiencing dual loyalty and that the tactical officers seem to be challenged when leading LMP the preparation before rotating to combat zones. The preparation is of importance. The education should include ethical reflections and more military training in order to adapt to the combat zones of today.

Future research

When the Swedish LMP claim that the law do not apply, even though the commander has claimed it applies, the question is whether the problem is with the law itself, or if LMP do not understand or are familiar with humanitarian law, or if it has to do with the implementation and enforcement of humanitarian law. This is an unexplored area, and since Sweden contributes with units abroad this is a topic to do research in. As LMP seem not to be trained in identifying dual loyalties during the deployment in Armed Forces, or at least they seem not aware about dual loyalties, should we expect that LMP are having the ethical mind only due to the fact that they are LMP? That needs to be explored further.
Summary in Swedish

Svensk sammanfattning

Introduktion


En stor del av tidigare forskning kring etiska problem är från amerikansk kontext, och gäller mer allvarliga etiska problem.

Den svenska sjukvårdspersonalen ska följa lagar (folkrätten, svensk hälso- och sjukvårdslagstiftning) och professionsetiska och medicinsk etiska koder när de verkar i insatsområdet. Sjukvårdspersonalen utför inte endast sjukvårdsuppgifter utan också militära uppgifter. Det finns tveksamheter huruvida sjukvårdspersonalen alls skall utföra vissa av de här militära uppgifterna, eftersom de kan leda till etiska problem. I den här kontexten kan sjukvårdspersonalen uppleva dubbla lojaliteter, vilket man även har sett i tidigare forskning när det gäller inom organisationer som t.ex. Försvarsmakten och sjukvårdsorganisationer.

Det övergripande syftet med denna avhandling var att utforska och beskriva de etiska problem som legitimerad sjukvårdspersonal upplever när de verkar i stridsmiljön och hur man normativt kan se på att de gör uppgifter som leder till dessa etiska problem. Ett vidare syfte var att utforska de taktiska officerarnas huvudangelägenhet när de leder sjukvårdspersonalen, eftersom sjukvårdspersonalen upplever konflikten med dubbla lojaliteter.

Metoder

Induktiv, explorativ, deskriptiv och abduktiv design samt teorigenererande och normativ design användes. Kvalitativ innehållsanalys användes för att beskriva vad legitimerad sjukvårdspersonal upplever när de är på militära

Resultat

Resultaten från delstudie I visade att den legitimerade sjukvårdspersonalen lätt anpassar sig till den militära organisationen och utför uppgifter som inte endast är sjukvårdsuppgifter. De vårdade i situationer som kan upplevas känslomässiga, t.ex. vård av de egna eller fienden. Vidare diskuterades aldrig sjukvårdspersonalens tankar om att behöva döda någon.

I delstudie II resonerade sjukvårdspersonalen hur de skulle agera i olika etiska situationer. De argumenterade för och mot att utföra militära uppgifter som enligt folkrätten skulle kunna beskrivas som kombattantuppgifter. Vidare, resonerade de kring att de under visa omständigheter skulle kunna tänka sig att genomföra militära uppgifter, t.ex. om de befinner sig under ett hot. Idag är de flesta väpnade konflikter icke-internationella och där är folkrätten otydligare när det gäller vad som är kombattantuppgifter. Kombattant definieras inte i den typen av insatser.

I delstudie III visade resultatet att de taktiska officerarna upplever en utmaning med att vara chef över sjukvårdspersonal, vilket berodde på olika omständigheter. Dessa omständigheter är t.ex. huruvida sjukvårdspersonalen hade genomgått en fullständig rotationsutbildning eller inte men också om de, både TOs och LMP, hade deltagit i tidigare insatser. Ibland rekryteras sjukvårdspersonal på vakanser och då får de en s.k. egen utbildning. Under de omständigheterna är det en större utmaning att leda dem. Målet för de taktiska officerarna är att ena sjukvårdspersonalen och få in dem i förbandet som en hel enhet. En försvårande omständighet för de taktiska officerarna när det gäller att få in sjukvårdspersonalen i förbandet och bli en enhet, är att sjukvårdspersonalen upplever dubbla lojaliteter.


Slutsatser och rekommendationer

Avhandlingen visar att sjukvårdspersonalen upplever dubbla lojaliteter när de befinner sig i insatsområdet. Det kan bero på att folkrätten och de professionsetiska koderna inte är tydliga när det gäller de vardagsetiska problemen som identifierats. Kanske skulle folkrätten förnyas och förtydligas för att anpassas i högre utsträckning till dagens väpnade konflikter som oftast är inomstatliga. Vidare behöver sjukvårdspersonalen utbildas i att reflektera kring etiska frågor innan de roterar till insatsområdet. Den här reflektonen skulle kunna ske parallellt med att sjukvårdspersonalen får mer av militär träning för att utbildas i vilka av de militära uppgifterna de kan utföra.
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I never thought I could do such a thing as writing a thesis. Words from the most distinguished book in Novum Testamentum, finally convinced me, namely the letter:

ΠΡΟΣ ΦΙΛΙΠΠΗΣΙΟΥΣ. 4:13: "πάντα ἰσχύω ἐν τῷ ἐνδυναμοῦντί με ἐν χριστῶ".
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The Vicarage in Karlskoga in October anno 2017,

Kristina Lundberg
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