

Dual Loyalties and Shifting (Bio)ethical Principles. An Analysis of the Defense Health Board's Ethical Guidelines and Practices¹

Abstract: Since the Nuremberg Military Tribunals and the Belmont Report, the military environment has been a testing ground for scientific research and for increasingly urgent ethical debates regarding the multifaceted legal status of various military and non-military physicians and patients. In particular, military medical physicians, who work in complicated situations and environments - ranging from combat to humanitarian zones - could be called upon to make life-changing and potentially controversial decisions with significant bioethical implications. Because this category of health professionals pertains to military institutions, it is positioned along the blurred line between the Hippocratic aspirations and safeguarding of medical practice and the requirements of military culture. From a linguistic perspective, these professionals adhere to military communication and its specific language, genres and means of knowledge dissemination, thus calling discourses of power into play. Therefore, to investigate how the military community defines and disseminates information on the activity of its medical professionals, as well as face possible bioethical conflicts and challenges, the Defense Health Board's 2015 *Ethical Guidelines and Practices for US Military Medical Professionals* will be analyzed based on a Critical Discourse Analysis approach sustained by qualitative data, thus underlining the clear contrast between civilian and military communicative patterns, medical practices and founding principles, which reflect military and non-military cultural differences.

Keywords: *bioethics, critical discourse analysis, medical ethical guidelines, military discourse, military medical ethics*

1. Introduction: The Military and Bioethics

Since the end of the Nuremberg Military Tribunals in 1947, which led to the founding principles of modern bioethics,² the 1974 Federal framework governing human subjects research, and the introduction of the *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (known as the *Belmont Report*) in 1978, the military environment has always represented a starting point and a testing ground for scientific and medical research on ethics and bioethics. In addition, it contributed to important debates in 1991, the year of the 'Common Rule' for the protection of research subjects through means such as informed consent, reviews by the Institutional Review Board and institutional assurances of compliance with federal policies and the beginning of consideration for 'vulnerable populations' like pregnant women, children, fetuses, neonates and prisoners.

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² Mark A. Rothstein, "The Role of Law in the Development of American Bioethics", *J. Int'l de Bioéthique*, 20 (2010), 73-84.

There is, however, a blurred line between the aspirations of medical research and the issues and limits of medical practice in the military context (e.g. physical and cognitive enhancements, off-label and non FDA-approved uses of medication). While DoD (Department of Defense) directives attempt to provide additional safeguards, other institutions provide exceptions for these forms of protection in relation to operational tests and evaluation, off-label use of medication and informed consent waivers.³ In truth, soldiers have limited rights when it comes to certain decisions regarding collective treatment and disclosure of information, as well as the possibility of seeking legal redressal for medical conditions resulting from their adherence to orders from superiors (e.g. the Feres Doctrine, the case of the ‘Gulf War Illness’ in the 1990s and the 1998 DoD vaccine anthrax immunization program).⁴ This is probably due to the fact that there is no framework “to guide the military in how it should treat its own personnel”⁵ due to military justice’s “commander-centric”⁶ approach, which leaves discretionary decision-making power to higher ranking figures in the chain of command.

The legal standing of military health care has become even more of an international concern as a result of the war on terrorism and the involvement of new, unforeseen legal subjects like terrorist prisoners of war who do not abide to traditional rules of engagement.⁷ The foundational importance of the military in the field of bioethics is further confirmed by discussions on the necessity of revising the principles of bioethics in relation to “the use of military personnel as research subjects; the deployment use of biomedical agents; and the obligations of military physicians towards their own troops”.⁸ For instance, instead of beneficence, autonomy, justice, and nonmaleficence, Mehlman and Corley advocate proportionality, paternalism and fairness, which are more in line with military values but still uphold standards for service members’ and civilians’ well-being. Moreover, the military values that are advocated in the literature, the DoD, and the individual military branches, foresee that

³ Efthimios Parasidis, “Emerging Military Technologies: Balancing Medical Ethics and National Security”, *Case Western Reserve Journal of International Law*, 47.1 (2015), 167-183, 172-173.

⁴ The Feres doctrine, which was overturned in 2019 after almost seven decades, prohibited military service members from suing the government over medical malpractice. The ‘Gulf War Illness’, also known as the ‘Gulf War Syndrome’, is a chronic and multi-symptomatic disorder that affected many returning military veterans who took part in the Persian Gulf War in the 1990’s and was due to their exposure to pyridostigmine bromide, a substance used as a pretreatment to protect against nerve agent effects. Finally, the ‘anthrax vaccine immunization program’ was enacted and made mandatory by the Clinton administration to immunize military personnel and affiliated civilians who were deployed in combat zones against the anthrax threat even though the vaccine had not completely undergone the standard FDA approval procedure. This led to petitions and injunctions that resulted in a 2004 ruling that required the DoD to allow service members to choose whether to be vaccinated under an informed policy unless the president decided to bypass this requirement by means of an executive order.

⁵ Maxwell J. Mehlman and Stephanie O. Corley, “A Framework for Military Bioethics”, *Journal of Military Ethics*, 13.331 (2015), 2, *ssrn.com*.

⁶ Eugene R. Fidell, *Military Justice: A Very Short Introduction* (Oxford: Oxford U.P., 2016), 9.

⁷ Jonathan D. Moreno, ed., *In the Wake of Terror: Medicine and Morality in a Time of Crisis* (Cambridge, Massachusetts: The MIT Press, 2003); Jonathan D. Moreno, “Embracing Military Medical Ethics”, *The American Journal of Bioethics*, 8.2 (2008), 1-2; George J. Annas, “Military Medical Ethics: Physician First, Last, Always”, *New England Journal of Medicine*, 359 (2008), 1087-1090; Jed Adam Gross, “Caring for and about Enemy Injured”, *The American Journal of Bioethics*, 8.2 (2008), 23-27; George J. Annas and Sondra S. Crosby, “Post-9/11 Torture at CIA ‘Black Sites’ – Physicians and Lawyers Working Together”, *New England Journal of Medicine*, 372.24 (2015), 2279-2281.

⁸ Mehlman and Corley, “A Framework for Military Bioethics”, 3.

the core military values relevant to bioethics are selflessness, the duty to obey orders, accountability, and the obligation to look out for the welfare of one's subordinates. The contrast between these values and the values that hold sway in civilian life of individualism, equality, self-rule, and freedom of action ... shows how the principles that govern civilian bioethics are not suited to the military.⁹

This distinction in principles and values is especially relevant when considering situations and discourses in which military and civilian values clash and, as will be expounded in the present study, even more so for military medical practitioners who are ruled by both. From a linguistic perspective, the military context is relevant within the discourse of bioethics, especially as far as power is concerned,¹⁰ in that “in determining the nature of professional obligations, both the CIA and Department of Defense reframed the duty of non-maleficence into a duty only to obey the law”.¹¹ This arbitral determination is addressed and contested in the *Ethical Guidelines and Practices for U.S. Military Medical Professionals*,¹² requested by the Assistant Secretary of Defense for Health Affairs ASD(HA) in 2011 and presented by the Defense Health Board (DHB) in January 2013. The aim of the pre-decisional draft of the guidelines, which will constitute the data set for the present study, is to clearly reframe and review the challenges stemming from military health professionals' dual roles as military officers and medical providers in problematic (bio)ethical matters, starting from the following two questions:

- 1) How can military medical professionals most appropriately balance their obligations to their patients against their obligations as military officers to help commanders maintain military readiness?
- 2) How much latitude should military medical professionals be given to refuse participation in medical procedures or request excusal from military operations with which they have ethical reservations or disagreement? (EGP: 2)

In light of this, the most urgent matters concern military health care professionals' role and protocol of reference for circumstances concerning problematic bioethical issues, rather than the outlining of the circumstances themselves or the discussion of the principles of bioethics in military medicine. Such a focus on people underlies the predominance of agency in discursive and linguistic terms, and the present study demonstrates that this occurs in different ways and to different degrees based on the institutional perspective.

The presentation of the pre-decisional draft of the *Guidelines* analyzed here took place in February 2015, but there have been no announcements or steps to implement the document's proposals since then due to the change in presidential administration. Because this document presents preliminary

⁹ Mehlman and Corley, “A Framework for Military Bioethics”, 7.

¹⁰ Norman Fairclough, *Analysing Discourse: Textual Research for Social Research* (New York: Routledge, 2003); Jeffrey P. Bishop and Fabrice Jotterland, “Bioethics as Biopolitics”, *Journal of Medicine and Philosophy*, 31 (2006), 205-212.

¹¹ Leonard S. Rubenstein, Scott A. Allen and Phyllis A. Guze, “Advancing Medical Professionalism in US Military Detainee Treatment”, *PLoS Med*, 13.1 (2016), 1-7, 2-3.

¹² The document may be found at: apps.dtic.mil. From this point on, all references to the document will be indicated as *Guidelines* within the text and as EGP in the quoted excerpts.

proposals for matters with vital consequences from procedural and bioethical perspectives, its disregard represents a missed opportunity to address such unsolved issues. Moreover, to the author's knowledge, there has been no further research on the document. However, as the present study argues, another implicit reason for this may lie in the inherent linguistic and discursive ambiguities and divergences between the two fields of ethics, i.e. medical and military, that are juxtaposed in the document with the supposed intent of negotiating a common ground to regulate medical professionals' actions and practices when ethical and bioethical principles are at stake. For this reason, the document will be explored in its entirety on a macro-structural level to highlight the innovativeness of its proposed aim (RQ1), and then on micro-structural level to investigate into the peculiar role and challenges of military health care professionals (RQ2), and to verify whether there is a true discursive and argumentative balance between civilian and military medical ethics (RQ3).

2. Data Set and Methodology

The starting point of the data set from which the present inquiry stems consists in the document by the Defense Health Board (DHB) entitled *Ethical Guidelines and Practices for U.S. Military Medical Professionals* (word tokens: 40244; word types: 3772), which was reduced by excluding non-discursive sections like the Table of Contents, list of Board Members, Reference sections and Appendixes (thus amounting to word tokens: 29643; word types: 3089).

The present study will analyze the *Guidelines* by considering three research questions that range from conceptual to linguistic. In order to highlight the relevance of the document for discussions on bioethical issues and cultures, the first research question is framed as follows:

RQ1: What is innovative about these guidelines in the discussion on medical ethics and bioethics in civilian and military cultures?

From a conceptual perspective, the *Guidelines* point out that the “DoD does not have an enterprise-wide, formal, integrated infrastructure to systematically build, support, sustain, and promote an evolving ethical culture within the military health care environment” (EGP: 58). There is therefore a gap due to the complexity of the military health care environment and its implications for professionals and procedures. The document outlines and addresses the latter in an attempt to better blend civilian and military medical cultures and approaches in view of the problematic situations that increasingly arise in current and ongoing international military missions.

From a macro-level perspective, the *Guidelines* are divided into the following macro-sections which, at a first glance, convey a sense of balance between military ethics and civilian (medical) ethics:

Executive Summary

1. Introduction
 2. Principles and Practice of Medical Ethics
 3. Principles and Practice of Military Ethics
 4. Ethical Issues in Military Medical Settings
 5. Ethics Education and Training
 6. Conclusion: The Need for a Systems Approach to Military Medical Ethics Preparation and Practice
- Appendixes

Upon observing the document in its entirety, it is possible to notice that the text displays a significant degree of interdiscursivity, given by the presence of a variety of genres and formats¹³ including records of historical events, narrative descriptions of current military medical ethics, definitions and summaries of theories and regulations, case studies and examples, argumentative considerations that are repeated in the findings/recommendations pairings of each section, as well as references and the appendixes (consisting in the letter of request of the ASD(HA) for the Guidelines to the DHB (A), the Guidelines' Terms of Reference (B), the minutes of the Meetings and Briefings that were organized to discuss and decide on the content of the Guidelines (C), Fundamental Ethical Theories and Excerpts from Selected Codes of Ethics (D), a list of acronyms (E), and Names and titles of the members of the support staff (F)). The appendixes make the document easier for non-experts to understand its content but were excluded from the micro-level analysis in sections 3 and 4 in order to focus the data set on the discursive and argumentative parts that actively discuss bioethical principles and procedures.

In order to inquire into the cultural background and discourse of military and civilian medical ethics, and therefore into their relation in terms of power, the present study adopted the methodological framework of Critical Discourse Analysis with the support of data that leads it to tend towards the CADS methodology.¹⁴ Such an approach united a qualitative analysis of the document, based on the discursive and linguistic tools provided by Critical Discourse Analysis¹⁵ and its observation of cultural and linguistic displays of power,¹⁶ with a quantitative and empirical analysis by means of the AntConc 3.5.6. software.¹⁷ This enabled the retrieval and observation of relevant occurrences and collocations in relation to three important issues: the position of military medical

¹³ Fairclough, *Analysing Discourse: Textual Research for Social Research*.

¹⁴ Alan Partington, "Corpora and Discourse, a Most Congruous Beast", in Alan Partington et al., eds., *Corpora and Discourse* (Bern: Peter Lang, 2004), 11-20; Giuliana Garzone and Francesca Santulli, "What Can Corpus Linguistics Do for Critical Discourse Analysis?", in Alan Partington et al., eds., *Corpora and Discourse*, 352-368.

¹⁵ Lia Chouliaraki and Norman Fairclough, eds., *Discourse in Late Modernity: Rethinking Critical Discourse Analysis* (Edinburgh: Edinburgh U.P., 1999); Teun A. van Dijk, "The Discourse-knowledge Interface", in Gilbert Weiss and Ruth Wodak, eds., *Multidisciplinary CDA* (London: Longman, 2003), 85-109.

¹⁶ Norman Fairclough, *Critical Discourse Analysis: The Critical Study of Language* (London: Longman, 1995); Norman Fairclough, *Language and Power, 2nd edition* (Harlow: Pearson, 2001).

¹⁷ Anthony, Laurence, *AntConc*, Version 3.5.6 [Computer Software] (Tokyo, Japan: Waseda University, 2018), www.laurenceanthony.net.

physicians, balance – or lack thereof – in the military and civilian medical ethics sections of the *Guidelines*, and possible linguistic and discursive strategies that could improve the overall communicative efficacy of the document. Although the document is short, the quantitative analysis was necessary to gain clarity in face of a marked repetition of expressions indicating obligation, values and more or less technical terms. Furthermore, it confirmed and complemented the in-depth discursive analysis with empirical data and further information on patterns, thus permitting a more complete and objective pragmatic interpretation of the findings.

After having investigated the overall structure of the *Guidelines*, the following paragraph will focus on the “Executive Summary” and “Introduction” chapters to face the second research question:

RQ2: How is the position of military medical professionals framed in the Guidelines?

Such a definition is essential due to the *Guidelines*’ intent to present the anomalous professional position of military medical practitioners who are divided between two jurisdictions and roles, i.e. military and medical, but are more strongly bound to the rules and regulations of the former. In the ongoing development of warfare and consequent management of medical situations with ethical and bioethical implications, however, change or greater flexibility may be necessary. Section 3 will analyze the parts of the document outlining duties and responsibilities and how this could impact on their ethically significant decisions.

After examining the professionals’ hybrid roles, section 4 will focus on answering the third and final research question:

RQ3: Are the sections of the Guidelines on civilian and military medical ethics presented in a quantitatively and qualitatively balanced manner and using the same discursive and linguistic strategies?

This question verifies the discursive and argumentative balance – or lack thereof – in the presentation of military and civilian medical practices and protocols in relation to emergency circumstances requiring ethical and bioethical attention. Such analyses focus on topics and perspectives, as well as the linguistic choices and strategies in the sections of the *Guidelines* dedicated to and seen from military and civilian points of view. More specifically, it will inquire into references to concepts that are fundamental in ethically and bioethically relevant decisions such as morality, conscience, discretion, obligation, as well as distinctive metaphors, markers of indexicality, and the use of technical terms in the sections of the documents related to military and civilian medical ethics.

The fifth and final section will summarize the most relevant findings with a twofold purpose: attempting to explain why the document was not ultimately implemented, and considering possible changes that could lead to the document’s enhanced dialogical power.

3. Role of Military Medical Health Care Providers

The second research question was phrased as follows: *RQ2: How is the position of military medical professionals framed in the Guidelines?* and entails the close reading of the “Executive summary” and first chapter (“Introduction”) of the document by specifying that:

There are unique challenges faced by military medical professionals in their dual hatted positions as a military officer and a medical provider. Such positions require them to balance and prioritize their role as an officer in the military, and their role as a medical professional with ethical responsibilities to their patients. (EGP: 2)¹⁸

Military medical physicians are distinguished by their “dual loyalty”¹⁹ in issues such as confidentiality, informed consent, and autonomy, which may become problematic when they clash with national security or organizational well-being.²⁰ These highly specialized medical practitioners find themselves in a singular situation because they must face a series of challenges that stem from the military context and its values. Such challenges may be divided into:

clinical (patient rights in the military, experimentation, investigational drugs, medically engineered enhancement drugs, machine-brain interface, neural prostheses, genetic engineering, mechanical cybernetic improvements) and non-clinical (employment of medical workers in weapons development using advances in pharmacology, neurophysiology and genetics).²¹

For instance, decisions on whether to send an injured service member back into combat or not may be based more on the order: “to conserve the fighting force”²² during critical situations or on the principles of military necessity and salvage²³ than on the injured soldier’s individual medical needs. Moreover, the emergency contexts that have emerged in recent times encompass issues such as resource allocation, triage and detainee treatment (interrogation, torture, treatment, triage), as well as medical humanism. This is especially important considering the ongoing war on terrorism, which raises further complicated questions such as whether these new situations and subjects fall– or should fall– under the 1949 Geneva Convention or other international human rights agreements. Such debate

¹⁸ All of the underlining in the quoted excerpts is the author’s.

¹⁹ Laura L. Sessums et al., “Ethical Practice under Fire: Deployed Physicians in the War on Terrorism”, *Military Medicine*, 174 (2009), 441-447.

²⁰ Michael L. Gross, “Military Medical Ethics: A Review of the Literature and a Call to Arms”, *Cambridge Quarterly of Healthcare Ethics*, 22 (2013), 92-109.

²¹ Gross, “Military Medical Ethics: A Review of the Literature and a Call to Arms”, 92.

²² Parasidis, “Emerging Military Technologies: Balancing Medical Ethics and National Security”, 168.

²³ Gina D. Bien, Lisa M. Kinoshita, and Allyson C. Rosen, “Need Versus Salvage: A Healthcare Professional’s Perspective”, *The American Journal of Bioethics*, 8.2 (2008), 21-23; Jason Gatliff, “Principle of Salvage: A Mischaracterization of Military Medicine”, *The American Journal of Bioethics*, 8.2 (2008), 17-18; Michael L. Gross, “Why Treat the Wounded? Warrior Care, Military Salvage and National Health”, *The American Journal of Bioethics*, 8.2 (2008), 3-12; Michael L. Gross, “Response to Open Peer Commentaries on ‘Why Treat the Wounded?’”, *The American Journal of Bioethics*, 8.2 (2008), W1-W3.

on consolidated military protocol has led to a mistrustful intellectual climate in recent times²⁴ and the resulting need, addressed by the *Guidelines*, to provide a framework of reference for this category of physicians. They are, in fact, in a position— or better yet, in a conceptual, professional, and discursive ‘juxtaposition’— between medical and military ethics:

As a health care provider, the professional is obligated to preserve life, attend the sick and wounded, and minimize suffering, even on behalf of the enemy. On the other hand, the health care professional, as a Service member, is obligated to support the mission, maintain military readiness, and support military operations. (EGP: 2-3)

When considering common classifications of cultural dimensions such as Hofstede’s, the military community and its communication and interaction patterns, as opposed to civilians, rank high in ‘collectivism’ and ‘high power distance’.²⁵ Rank disparity and peer pressure therefore have a significant impact on a service member’s and a military medical professional’s obedience to orders and accountability. This is clear upon analyzing the “double oath” that military medical professionals have to take before officially entering the profession, i.e. an oath to the branch of military services they have decided to serve, and the Hippocratic Oath that all physicians must swear by. Significantly, both texts are explicitly cited in the *Guidelines*:

- (1) I, _____, having been appointed an officer in the Army of the United States, as indicated above in the grade of _____ do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office upon which I am about to enter; So help me God. (Department of the Army Form 71, July 1999, for officers; EGP: 1).
- (2) I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism. I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug. ... I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind as well as the infirm. (Modern Hippocratic Oath, in part.; EGP: 1)

²⁴ Kendra L. Scroggs, *Identification of Bioethical Dilemmas, Ethical Reasoning, and Decision-making in Military Emergency Medicine Departments* (unpublished dissertation, 2000), available at www.dtic.mil; Edmund G. Howe, “Dilemmas in Military Medical Ethics since 9/11”, *Kenneth Institute of Ethics Journal*, 13.2 (2003), 175-188; Gross, “Military Medical Ethics: A Review of the Literature and a Call to Arms”.

²⁵ Robert L. Ivie, “Foreword: Telling the Stories of the War State”, in Erin Sahlstein Parcell, ed., *A Communication Perspective on the Military: Interactions, Messages and Discourses* (New York: Peter Lang Publishing, 2015), xi-xiii; Takim Ajom Okongor, “A Lexico-Semantic Analysis of Military Language”, *International Journal of Humanities and Cultural Studies*, 2.3 (2015), 652-664; Roxanne Barbara Doerr, “The Scholarly Soldier: Distinguishing Features of Online Military Academic Journals”, in Stefania M. Maci and Michele Sala, eds., *Representing and Redefining Specialised Knowledge: Variety in LSP*, Cerlis Series, Vol. 8 (Bergamo: University of Bergamo, 2019).

A qualitative, Critical Discourse Analysis of these excerpts of the oaths sheds light on a relevant difference in the force of such obligations based on disparity of power: the underlined lexical choices in (1) highlight the connotative and semantic strength of the previously mentioned military core values of selflessness, duty to obey, and accountability. On the other hand, (2) appeals to the aspiring professional's discretion and core values as an individual human being as much as, or even more than, a professional. The military physician's decision making process must therefore go beyond profession and country and consider all "fellow human beings", including soldiers, allies, injured enemies (prisoners of war and others), freedom fighters, and civilians,²⁶ as patients regardless of the commander's orders.

4. (Un)balance between Medical and Military Spheres

To address *RQ3: Are the sections of the Guidelines on civilian and military medical ethics presented in a quantitatively and qualitatively balanced manner and using the same discursive and linguistic strategies?*, the present study, in analyzing the document in its entirety, will verify whether there is any divergence in the representations and arguments of civilian and military medical ethics.

A starting point may consist in observing the juxtaposition and implicit evaluation²⁷ of the semantic fields of medical ethics—advocating flexibility, discretion, morality, and conscience— and military ethics, based on rigidity, directions, and law. The military and civilian sections' lexis reflect the resources on which professionals may rely to make life-changing decisions in unclear situations, thus confirming the more open discretion and individualism of civilian medical ethics in (3) and (4), and the more restricted precision for many decisions in the military context in (5):

- (1) If a medical procedure is immoral or unethical according to the standards of the health care professional's belief system, then the senior medical officer should seek another similarly qualified professional to replace the individual who objects to the procedure. (EGP: 5)
- (2) Health care professionals can invoke conscience clauses if they refuse to perform a legal role or responsibility based on moral or other personal objections. (EGP: 15)
- (3) As described in this report, military health care professionals can rely on ethics guidance and standards developed by their professional societies to guide difficult ethical decisions. These codes provide a solid foundation on which to base ethical decision making, and the elements described in the codes are remarkably consistent across the professions. In addition, DoD and Military Department policies, instructions, manuals, and standard operating procedures provide comprehensive and often detailed procedural guidance that implicitly operationalize many of the ethical principles expressed in professional codes. (EGP: 4)

²⁶ Gross, "Caring for and about Enemy Injured", 23-27.

²⁷ Susan Hunston and Geoff Thompson, eds., *Evaluation in Text: Authorial Stance and the Construction of Discourse* (Oxford: Oxford U.P., 2001).

This duality is also present in the two jurisdictions' differences in relation to focus: upon a closer review of the Table of Contents, it is possible to notice a contrast between the civilian medical sections of the document, which deal with the universal medical ethics principles (autonomy, beneficence, non-maleficence, justice) that are at the heart of bioethics, and military ethics' core military values (loyalty, duty, respect, selfless service, honor, integrity, personal courage),²⁸ which are clearly listed in the related sections of the *Guidelines*. The principles of civilian medical ethics reflect abstract ideals and hypotheses that are formulated from a centrifugal discursive approach aimed at humanity as a whole. They reflect the previously outlined considerations on the Hippocratic Oath and often criticize the military's seemingly rigid approach. In contrast, the sections on medical ethics from a military perspective are grounded, centripetal, and based on the beliefs of a specific, hierarchical community whose aforementioned values are ingrained in military ethos and prevail regardless of the physician's branch of service. Furthermore, they display all of the idiosyncratic features of military institutional discourse, such as clearness of structure, certainty of conceptions, permanentness of phraseological units, plurality of special military lexis, and abundance of reductions and abbreviations.²⁹ The acronyms, along with commonly confused concepts (e.g. asymmetric warfare, triage, and cultural competency), are explained through narrations, definitions and appendixes to make them easier for non-experts to understand.

Another detectable linguistic peculiarity that emerges in the military sections consists in their extensive use of the passive tense and equivalent expressions. As highlighted in the table below, these are much more common in the "Principles and practice of military ethics" section and implicitly transmit the lack of complete freedom and agency over professional activities that are necessarily typical of the military and all those associated with it:

Section	# words	# passives
Executive Summary	6632	30
1. Introduction	1913	19
2. Principles and practice of medical ethics	6365	49
3. Principles and practice of military ethics	5289	62
4. Ethical issues in military medical settings	4048	23
5. Ethics education and training	3932	23
6. Conclusion	1162	16

Table 1: Frequency of words and of passive expressions for each section³⁰

²⁸ Mehlman and Corley, "A Framework for Military Bioethics", 4-5.

²⁹ A.F. Mammadzade, "Lexical Features of English Military Discourse", *Вісник Запорізького національного університету*, 1 (2013), 139-142: 141.

³⁰ Author's elaboration (number of words excluding references).

The most present passive forms are verbal collocations using the ‘auxiliary be + participle’ form that is commonly found in legal English³¹ through modal and lexical verbs indicating legal obligation even in collocations that are not perceived as legally binding in general English: provided (10 occurrences), required (9 occurrences), expected (9 occurrences), made (7 occurrences), obligated (6 occurrences), asked (6 occurrences), used (6 occurrences), given (5 occurrences), maintained (5 occurrences), needed (5 occurrences). This may be seen in the examples below, all taken from the section on military ethics:

- (4) Military health care professionals are also expected to take care for detainees, enemy combatants, nonstate actors, local nationals, and coalition forces. (EGP: 37)
- (5) in the combat or austere environment, challenging decisions have to be made by relatively junior primary care physicians (battalion surgeons). (EGP: 37)
- (6) a lack of clarity in policies regarding the level of detail that should routinely be provided to commanders regarding a military member’s health status and treatment. (EGP: 38)
- (7) U.S. personnel can be challenged to maintain quality control in a clinic setting staffed with medical personnel of forces from developing nations. (EGP: 41)

Another common presence throughout the document consists in the use of metaphors, and more precisely war and martial metaphors, for “The ideological filter encased within the war metaphor is ‘militarism’, defined as a set of beliefs and values that stress the use of force and domination as appropriate means to solve problems and gain political power”.³² Indeed, expressions like “conflict” (31 occurrences used in an internal, metaphorical sense in the internal document), “moral injury” (11 occurrences), “salvage” (1 occurrence), and “to be outside the fight” (1 occurrence), are frequent in health care discourse in general to evoke strength and victory over illness and injury.³³ However, in this document, the terms “salvage” and “conflict” are used in their literal, and not rhetorical, sense in the sections on military medical ethics, and the war metaphors are interestingly present in reference to the external and internal conflict and damage brought by war to military health care providers when they are not free to act according to their individual moral compass. While this may seem like a contradiction, it actually represents a discursive strategy to acknowledge military medical

³¹ Giuliana Garzone and Rita Salvi, *Legal English, 2nd edition* (Milano: Egea, 2007).

³² Peter B. Kraska and Victor E. Kappeler, “Militarizing American Police: The Rise and Normalization of Paramilitary Units”, *Social Problems*, 44.1 (1997), 1-18.

³³ James Compton, “Shocked and Awed: The Convergence of Military and Media Discourse”, in Peter Wilkin and Mark J. Lacy, eds., *Global Politics in the Information Age* (Manchester: Manchester U.P., 2006), 39-62; Jan Chovaneec, “Weapon of Ms Destruction: The Subversive Role of Linguistic Creativity”, *Slovak Studies in English*, 3 (2011), 82-93; Rose K. Hendricks et al., “Emotional Implications of Metaphor: Consequences of Metaphor Framing for Mindset about Cancer”, *Metaphor and Symbol*, 33.4 (2018), 267-279; Jing-Bao Nie et al., “Healing without Waging War: Beyond Military Metaphors in Medicine and HIV Cure Research”, *The American Journal of Bioethics*, 16.10 (2016), 3-11; Kayhan Parsi, “War Metaphors in Health Care: What Are They Good for?”, *The American Journal of Bioethics*, 16.10 (2016), 1-2.

professionals' difficulties and recalls the language of their professional environment:

- (8) the very act of experiencing, witnessing, or participating in troubling events can undermine a Service member's humanity. An act of serious transgression that leads to serious inner conflict because the experience is at odds with core ethical and moral beliefs is called moral injury, which can be long lasting and painful. (EGP: 1-2)
- (9) Acknowledge the moral injury that may occur as a result of encountering an ethical dilemma and incorporate practices that enhance resiliency and assist professionals in coping with and recovering from these injuries. (EGP: 4)
- (10) In all settings, military and civilian, health care professionals face innumerable conflicts in the practice of their vocation. They might face inner conflicts over the morality or appropriateness of certain medical procedures at the beginning or end of life. They might face conflicts over the best use of scarce resources. Conflicting roles and expectations of how one fills multiple responsibilities and obligations can place the health care professional in a difficult and ambiguous situation. Potential ethical conflicts between professional standards and other values, commitments, or interests can become even more acute when health care professionals work in military environments. (EGP: 1)

The dichotomy between military and civilian medical ethics is also present throughout the document when it comes to precision in indexicality and information in the presented case studies. In fact, the civilian medical ethics perspective is the most critical of the two and often takes an 'accusing' stance in relation to current military protocol; however, its arguments are often less persuasive due to its vaguer indexical expressions and frequent lack of clear reference to time, place or circumstances, as emerges in the excerpts below:

In both the military and civilian settings, a health care professional may be required, by law, to breach patient confidentiality....

In some cases, a Service member may be required to receive treatment for an infectious disease, such as tuberculosis, even if he or she refuses treatment, in order to protect the health of his or her unit.

In both the military and civilian settings, a patient with an infectious disease may be quarantined against his or her will.... (EGP: 10)

The parts relating to military ethics, on the other hand, indicate rules and policies that are in force, with detailed explanations and precise discourse indexicality. This conveys the overall impression that there is already an efficient procedure in place based on experience and implementation, rather than principles and ideals, as may be seen below:

In the context of health care, one such example is a DoD policy on influenza vaccinations. It is DoD policy that "all Active Duty and Reserve personnel be immunized against influenza with vaccines approved for their intended use by the Food and Drug Administration [FDA] and according to the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP)." The point here is that the unit benefits if all are immunized, and

immunizations maintain the health of the force. In this example, no individual may value their personal preferences over that of their unit. Moreover, military personnel are sometimes asked to incur risks not asked of civilians. In addition, DoD can also request approval to administer a non-FDA approved (i.e., experimental) vaccine, particularly if it is believed that such vaccines provide a critical potential countermeasure to a possible and plausible biological attack. (EGP: 25)

One common argumentative strategy concerns the military and civilian communities' proposals for further research and implementation throughout the entire document. Such advice is presented by means of dialogical 'findings' and 'recommendations' subsections that are located after the descriptions of practices and legislation that are currently in place. These are regularly composed by: a statement on the current situation (the presence of defective – or absence of necessary – procedures and practices); the presentation and illustration of the complicating factor or consideration that raised the issue (usually introduced by the contrastive discourse marker 'however'); the recommendation, with occasional references to deriving benefits. The finding-recommendations pairs therefore follow a theme-rheme structure to present known information to non-experts and introduce new aspects to reflect on. The efficacy of these proposals is strongly correlated to the amount and precision of technical information, which in turn depends on whether the finding is linked to a complete void or to the need to integrate and improve a practice or institution that is already in place. This difference may be observed upon comparing two such findings-recommendation pairs: (10) is generic and therefore arguably less helpful because it does not provide any details or concrete suggestions, while (11) contemplates the enhancement of existing resources and can therefore draw on preexisting terms and materials as an indexical and conceptual starting point:

- (10) Finding 9: DoD does not have an online portal to provide efficient access to medical ethics information and resources.

Recommendation 9: DoD should create an online medical ethics portal. At a minimum, it should include links to relevant policies, guidance, laws, education, training, professional codes, and military consultants in medical ethics. (EGP: 43)

- (11) Finding 16: Joint Knowledge Online provides a Basic and Advanced Course in Medical Ethics and Detainee Health Care Operations. These courses provide valuable information for deploying health care professionals on ethical issues related to the care of detainees.

The current implementation of the course could be improved to provide more efficient communication of the concepts and scenarios covered. In addition, it would be beneficial to have a course covering basic principles of medical ethics for all health care professionals.

Recommendation 16: To enhance health care practices in the military operational environment, DoD should:

- a) Update the Joint Knowledge Online Medical Ethics and Detainee Health Care Operations courses to improve the efficiency with which the information is communicated and maintain currency of the

material.

b) Create a medical ethics course to cover key principles, ethical codes, and case studies applicable to both garrison and deployed environments, in addition to providing resources and appropriate steps to take when assistance is needed in resolving complex ethical issues. This course should be required for all health care professionals. (EGP: 56)

The factors that have been analyzed in this section highlight the presence of an unbalance and a perceivable lack of solid connection between military and civilian medical ethical values and practices, and the resulting difficulty in arguing possible common solutions. The texts reflecting the military perspective discursively hold the upper hand when it comes to precision and confidence in the conveyed information since they refer to specific rules and regulation. They therefore tend to sustain established practices while admitting that they could be improved. In contrast, the civilian medical ethics approach represents the more revolutionary side by openly questioning current practices in their entirety in view of a more universal humanitarian approach to decision-making in ethical and bioethical medical issues but doing so without proposing concrete alternatives.

5. Conclusions

The present Critical Discourse Analysis, assisted by qualitative findings and carried out on the Defense Health Board's *Ethical Guidelines and Practices for U.S. Military Medical Professionals*, has revealed a number of relevant findings. *RQ1*, as regards the macrostructure, underlined the forward-thinking aim and structure of the document, with its combination between knowledge dissemination and discussion. *RQ2* expounded on the difficult, and often misunderstood, position of military medical professionals on many levels due to their dual loyalty and oath. The *Guidelines* were presented upon completion yet remain unimplemented, officially due to changes in presidential administration and chains of command, but very probably, in light of linguistic and discursive analyses, also partially due to a certain degree of looseness in structure and lexical choice. This may be reflected, as *RQ3* pointed out, in its unbalanced discursive perspective, which presents significant points of disagreement between civilian and military medical ethical and bioethical practices. Moreover, the document presents considerations that undermine the potential persuasiveness of the arguments and solutions that are advanced. The qualitative analysis has underlined that the excessively rigid and deontic discourse of military ethics is compensated by its greater specialization and experience, while the field of civilian medical ethics comes across as insightful and well-intending but rather vague and impracticable in its descriptions, examples, and proposals. Any future reworking of such a document or procedure would require the sections on civilian medical ethics to present detailed case studies, along with indications of the rules and education curricula that need to be changed by using precise indexical markers and more confident lexical choices, as well as more (both active and passive) verb tenses and dynamic modality to show action and change. On the other hand, the military perspective should be better integrated with the other sections and discuss how its values and

regulations could be more compatible with individual needs. This would enable military medical ethics and culture to be more comprehensible to civilian professionals and the new legal subjects who are compelled to prevail upon these twofold obliged professionals in hitherto un contemplated circumstances that impact on medical ethics and bioethics debates and cultures.