

Box 1 UN principles for military support to humanitarian missions

- ⇒ Use of a military force should be a last resort to fill a critical humanitarian gap.
- ⇒ Military assistance should be requested by the host nation or humanitarian agencies and the response remains civilian-led at all times.
- ⇒ Military support should provide a unique capability or a response time that civilian agencies cannot meet.
- ⇒ Use of military assets should be clearly limited in time and scale.

extensive economic, political and security agenda and not by the need to relieve the suffering of a crisis-affected population. The use of medicine or healthcare as a diplomatic tool is an attractive one, particularly in defence. It is seen to 'transcend traditional and more volatile and emotional concerns'.¹⁰ It can, therefore, be a more anodyne way for UK defence to build and strengthen relations with countries outside of existing alliances. Despite the hard-headed approach, there are real potential benefits for health and healthcare systems (and therefore for patients), both for the DMS and its partners. The US Department of Defense (DoD) uses the term global health engagement¹¹ and describes its benefits as improving their force health protection and medical readiness as well as that of partner nations; increasing interoperability by building partner health capacity and combatting global health threats.¹¹ Interestingly, it also discusses supporting humanitarian assistance and disaster relief initiatives as part of global health engagement. Underlying all of this, however, is that it advances US national security interests.¹¹

TIMESCALE AND SCOPE OF ACTIVITY

Humanitarian assistance takes the form of direct assistance, indirect assistance and infrastructure support.¹² While the DMS is unlikely to be the first preference for delivering humanitarian medical support, it has in the past been 'the only part of the UK health sector that can respond in the tight timescales required'.¹³ Even though civilian organisations such as the WHO approved UK Medical Team¹⁴ now offer a similar capability, the DMS could still be an attractive option for a government response to a humanitarian crisis.

Operation GRITROCK, the British military deployment to assist the multiagency

Comparison between Defence Healthcare Engagement and humanitarian assistance

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ABSTRACT

Humanitarian assistance and Defence Healthcare Engagement have traditionally both been taught on the Medical Humanitarian Stabilisation Operations Course. However, the two activities are distinct. This paper outlines the critical differences between them, focusing on their specific purposes, scope, timescales and ethics. Humanitarian assistance will remain a distinct activity with a focus on the relief of suffering, guided by international norms, while Defence Healthcare Engagement will encompass a broader range of activities, less constrained by internationally agreed principles. This presents an opportunity for the Defence Medical Services to directly contribute to projecting UK influence, preventing conflict and building stability. However, it requires the Defence Medical Services to take responsibility for the ethical issues that Defence Healthcare Engagement raises. This paper recommends the development of an ethical framework that reconciles the strategic aims of Defence Healthcare Engagement with maximising patient welfare at the tactical level. This is a paper commissioned as a part of the Humanitarian and Disaster Relief Operations special issue of *BMJ Military Health*.

INTRODUCTION

Defence Engagement emerged as a core defence task following the National Security Strategy and Strategic Defence and Security Review (SDSR) 2015.¹ Defence Engagement is 'how the UK employs defence assets and activities to achieve influence without the use or threat of force'.² More recently, this definition has expanded to include preventing conflict and building stability.³ Defence Healthcare Engagement (DHE) is 'the use of UK military medical capabilities to achieve Defence Engagement effects in the health sector'.⁴

SDSR 2015 established the Centre for Defence Healthcare Engagement (CDHE)

to 'share [Defence Medical Services (DMS)] medical best practices with allies and partners and play a significant role in extending UK soft power internationally'.⁵ CDHE has established a Faculty of Defence Healthcare Engagement, with the Medical Humanitarian Stabilisation Operations (MHSO) Course providing entry-level education on DHE.⁴ The course traditionally focused on humanitarian assistance but is now entering into the arena of DHE. In its redesign, it is having to ensure that the two activities are not blurred, as they remain fundamentally different, with distinct purposes, separate timescales and different ethical considerations. Crossover carries considerable risk to civilian programmes (both in terms of their operations and potentially their physical safety) and significant reputational risk to the DMS. This paper aims to explain these critical differences, including ethical considerations for both planners and those delivering operational effect. This is a paper commissioned as a part of the Humanitarian and Disaster Relief Operations special issue of *BMJ Military Health*.

DIFFERENT PURPOSES

Humanitarian assistance is fundamentally driven by the need to 'save lives and alleviate the suffering of a crisis-affected population', underpinned by the humanitarian principles of humanity, impartiality, neutrality and independence.⁶ Armed forces must comply with a range of key principles mandated by the UN Civil-Military Guidelines (Box 1).⁷

While there will likely be an underlying political motivation for the UK to deploy military resources for humanitarian assistance, tied to the broader security strategy, this should not be the primary reason for the deployment.

By contrast, DHE falls under the wider Defence Engagement strategy; part of 'fusion doctrine',⁸ using cross-government strategies to promote British interests globally. It involves 'strategy and deliberate planning, characterised by a long-term, collaborative approach'.⁹ The decision to undertake DHE activity will, therefore, be driven by the UK's more

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effort of controlling the Ebola epidemic in West Africa is a recent example of humanitarian assistance. The Department for International Development (DFID) was the lead government department, with the Ministry of Defence (MOD) providing DFID with a specific range of rapidly deployable capabilities.¹³ At the tactical level, the deployment was under the remit of the Combined Joint Inter-Agency Task Force, led by a senior DFID official. The deployment was unambiguously time-limited (although the end-date for the deployment was delayed), and throughout the deployment, the force had its own logistical supply chain and deployed medical system to reduce any negative impact on the host nation's resources.

This deployment was unexpected, reacting to a widely unforeseen epidemic causing a humanitarian crisis in West Africa, that had the potential to undermine global health security. These reasons combined to form a political imperative to deploy British military personnel, including medical staff. Future humanitarian deployments are likely to be similarly unexpected and reactive, where a humanitarian need combines with the political will to deploy the military. These deployments are likely to remain bound in scope and time, with an identified end-point.

Formal DHE is still in its infancy but could comprise a much broader range of activities, from large joint medical training exercises with partner nations to a longer-term focus on strengthening and improving health systems involving small numbers of DMS personnel. Collaborative working with partner nations gives opportunities to share best practice, and military-military working can be the best way of doing this.

Operation PANAKA was the first independent DMS DHE activity since the concept was formalised. Between April and May 2016, 12 DMS nurses and doctors deployed to Combined Military Hospital Rawalpindi, Pakistan to carry out various quality improvement programmes.¹⁵ The DMS nurses set up a programme to focus on nursing hygiene, nursing leadership and female empowerment. These are areas that the DMS can contribute to that link with the UK government's aims of empowering women and girls around the world,¹⁶ as well as strengthening the defence relationship between the UK and Pakistan. While continuing these core activities, it has also expanded into other areas, for example, supporting the implementation of an emergency medicine programme in the Pakistan military.

This venture has involved civilian and military actors in both countries and serves as template to ensure the flow of best practice between both sectors of the health economy. Similar DHE activities could be replicated in future with small teams of DMS professionals engaging with a specific partner nation's forces over a period of time, embarking on training, quality improvement or interoperability. There is no uniform time limitation for DHE activities, which could range from a few days to long term engagement activities lasting years.

DHE could be solely used for building military medical partnerships. However, improvements in health can bring additional stabilisation benefits including strengthening governance, economic performance and playing a role in conflict prevention,¹⁷ in line with the aims of current fusion doctrine.⁸ Therefore, for maximum benefit, DHE activity must deliver a positive health impact. Conversely, DHE activity that is seen not to benefit recipients and shows no tangible benefit to health or health systems may result in a loss of UK influence. Previous doctrine recognised this, recommending that health sector development does no harm, is clinically appropriate, culturally sensitive, coherent, has civilian primacy and is coherent with indigenous healthcare.¹⁷

ETHICS

The ethics involved in a military humanitarian assistance deployment will be influenced by the UN OCHR recommended practices published in 2018.⁷ The guidelines clearly state that humanitarian activities should be performed by humanitarian organisations, with the military support 'to the extent possible, not encompass[ing] direct assistance, in order to retain a clear distinction between the normal functions and roles of humanitarian and military stakeholders'.⁷ Any military assistance must not create a dependency on their resources and should complement the larger humanitarian plan.⁷

Military medics may be compelled to volunteer for a humanitarian deployment, with a motivation to use their skills and knowledge to relieve human suffering. This does, however, have the potential to create ethical dilemmas, in which military personnel view their work primarily as a humanitarian, having similar motivations to those working in the non-governmental sector.¹⁰ Draper and Jenkins describe this on Operation GRITROCK, where the DMS run Ebola Treatment Unit

consistently ran under capacity due to the rules of eligibility:

'There we were sat in the best treatment facility in the whole of Africa, fantastic equipment and staff...products that were expiring each week and getting thrown away...sat there in a facility that I think only had about four patients in it at the time... a complete catastrophe going on all around us ...and people really struggled with that.'¹⁸

These ethical dilemmas will continue to arise in future humanitarian deployments. Commanders and planners will need to ensure that the operational plan, particularly the medical rules of eligibility, is complementary to the efforts of the wider humanitarian community, that individual clinicians understand their role in the overall humanitarian effort and that the plan maintains the distinction between military and civilian actors. The humanitarian principles of humanity, impartiality, neutrality and independence will remain the basis for ethical decision making on a humanitarian deployment.¹² Where ethical dilemmas arise, military medical personnel should be given the space to discuss these issues with both command and senior clinicians.

The ethical principles surrounding DHE are complex, particularly as the basis for the deployment will be to further the defence interests and influence of the British government. DHE must be ethically grounded,¹⁹ but in stark comparison to humanitarian assistance, there are no universally accepted guidelines or principles for this activity. DHE is for the foreseeable future likely to be self-regulated. This highlights a research gap for a DHE ethical framework to be devised. It is essential that at the very least, DHE activity does no harm. Well-intentioned DHE activity could have unintended, harmful consequences such as undermining an already established health system or creating a culture of dependency.

Clinicians may feel ethically exposed if working with a partner nation that has a different ethical framework. Differences in attitudes to patient confidentiality, autonomy, involvement in decision making and gender roles are all areas for potential ethical dilemmas. Clinicians will remain bound by the ethical principles of autonomy, beneficence, non-maleficence and justice²⁰ as well as by their professional codes of conduct while conducting DHE. A General Medical Council (GMC) registered doctor should 'make the care of [their] patient [their] first concern'.²¹ This is in contrast to DHE, whose underlying

rationale is furthering the UK's influence on the global stage, and perhaps undermines the notion of medical impartiality.

RECOMMENDATION—ETHICAL FRAMEWORK FOR DHE

There is a need for the DMS to develop an ethical framework for DHE that can reconcile these ethical tensions. This framework could allow well-designed DHE activity to further the UK's interests at the strategic level, while at the tactical level, give medical personnel the freedom of action to conduct engagement that prioritises patients' welfare. Ethical principles used in the humanitarian or development sectors could be useful in developing this ethical framework, as well as past experience in the military medical contribution to security and stabilisation.¹⁷ In the meantime, those involved in DHE should adapt existing military medical ethical frameworks for this activity.^{22 23}

CONCLUSION

DHE is a growing field for the DMS and distinct from humanitarian assistance. Until recently, the MHSO course has been the entry-level educational programme for both, giving DMS personnel a basic grounding in these two types of activity. Their purposes remain distinct. Humanitarian assistance is primarily concerned with relieving suffering while DHE is there to further the interests and influence of the UK. Humanitarian assistance is likely to remain reactive and short-term, while DHE could have a variable timescale and scope. The ethics surrounding humanitarian assistance is driven by the wider humanitarian community as well as the DMS, while there is a cogent need for the DMS to develop an ethical framework for DHE activity.

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