

INVITED COMMENTARY

What can we learn from U.S. military nursing and COVID-19?

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1 | INTRODUCTION

The devastation of the COVID-19 pandemic to citizens of China, Italy, Brazil, and the United States, as well as other parts of the world, has been overwhelming (Borghese & Braithwaite, 2020). With reported deaths over 865,000 worldwide, the virus has stretched the capability of the global healthcare system to respond (World Health Association [WHO], 2020). Among those at risk of dying are the healthcare professionals caring for victims of the pandemic. The number of deaths of nurses and physicians grows each day (In Memoriam, August 30, 2020). In many instances, these seem to have been needless deaths because of our failed public policy regarding the management of the COVID-19 pandemic (Why wasn't, 2020). Most nurses would not have anticipated being exposed daily to life-threatening situations in modern healthcare settings.¹

2 | MILITARY STRATEGIES (EVIDENCE BASED) APPROACHES TO PROTECTING NURSES

Nurses have a history of working in dangerous situations since their origins. In the beginning, nurses were primarily men serving the injured during the Crusades, where they not only participated in battles but also cared for the sick and wounded. The modern nursing movement began with Florence Nightingale, a woman of privilege, who recognized the need to create an organizational structure that would provide a safe, clean, and compassionate environment for

those that were wounded and sick. Nursing's roots in military environments offer valuable lessons for working in the era of the COVID pandemic.

Although nurses have been on the frontline caring for the wounded and sick throughout history, nurses typically have been sheltered from the intense combat environment, and thus, few have been killed. Given the magnitude of World War II, it is important to note that only 201 USA military nurses died (US Army Center of Military History, 2003). The military has created a system in which its nurses are shielded from exposure to combat (Berry-Cabán et al., 2018). The same cannot be said for civilian healthcare organizations where the inability to protect working nurses has led to a death toll from COVID-19 that now exceeds that of the number of nurses who died in WW II (Babb et al., 2020).

3 | STRATEGIC PLANNING—MISSING IN ACTION

The military plans extensively for war with a focus on the means to achieve their mission. Through war games and other simulations, strategic plans are developed to manage care for the sick and wounded. Comprehensive planning includes assuring adequate facilities, equipment, supplies, and healthcare personal are available to meet the projected need. Perhaps most important is the planning to protect military healthcare assets. Without adequate healthcare, many of the wounded will die.

During the COVID pandemic, these basic strategic planning procedures were not adequately addressed by the civilian agencies responsible for providing adequate supplies, equipment, and personnel. The importance of strategic planning seemed to be ignored by U.S. Federal agencies; this lack of a strategic plan created an ethical and moral issue that has led to countless deaths (Berlinger et al., 2020).

¹The views expressed in this article are those of the author (Robert L. Anders, Dr. PH, MS, ANEF, FAAN, LTC USA (Ret), Professor Emeritus, University of Texas at El Paso) and do not reflect the official policy of the Department of Army/Navy/Air Force, Department of Defense, or U.S. Government.

The military uses a variety of strategies to create an overall framework designed to protect their healthcare professionals. These strategies involve activities that are structural, psychological, and training related. Bottom-line strategic planning is critical if the mission to 'conserve the fighting strength' is going to be met. In the case of a pandemic, while the agencies responsible for planning include both government and civilian sectors, the need to plan to meet the mission of providing healthcare while protecting healthcare assets is similar. Some examples from successful military planning are useful to illustrate steps that could be taken during a pandemic.

4 | DEPLOYMENT

In WW II, nurses were trained as one unit and were sent overseas as a group and, for the most part, they stayed with one unit until the end of the war. In Vietnam, Afghanistan, and Iraq, the nurses typically deployed individually and thus did not have the benefit of a cohesive unit for support. The use of travel nurses to support local hospital staffing during the COVID pandemic is similar. Travel nurses, who are typically placed in an unfamiliar environment, away from family, friends, and nursing colleagues to care for critically ill COVID-19 patients, might benefit from a more cohesive support group.

Except for WW II, most military deployments were for 6 months to 1 year. The shorter experience is thought to help reduce the stress of being in a combat situation for a more extended period. The travel nurse example is similar, with most having contracts of around 3 months, thereby having a shorter exposure to the high stress of caring for COVID-19 patients. The shorter assignment, like those used in the military, does seem an appropriate avenue to help minimize prolonged stress and fatigue.

However, permanent staff caring for COVID-19 patients are not afforded this shortened experience. Consideration in planning for mobilization of permanent staff should be given to limit nursing duty times to ensure safety of the nurses from contamination and to reduce stress. The military ensures during deployments of a year of more that nurses have time to leave the practice setting for respite from the stress of the hospital. The takeaway message is to plan for the deployment of nursing staffing, provide adequate orientation time, and ensure there is sufficient time and support to prepare nurses to care for critically ill COVID-19 patients. Lastly, providing time away, if only a long weekend, to leave the weight of caring for COVID-19 patients can help with stress management.

5 | POST-TRAUMATIC STRESS DISORDER (PTSD)

Although PTSD is not a new phenomenon, the thought that military nurses during WW II could have PTSD was discounted. The prevailing thought was that PTSD could only occur in combat situations

(Lucchesi, 2019). The Vietnam War revealed how prevalent PTSD was among nurses. Experts in mental health now agree that PTSD can affect both military and civilian nurses. At some point in their careers, as many as 28 percent of nurses experience PTSD (Brownlow et al., 2018). The military has significant support systems for individuals who have or may develop PTSD (Miao, Chen, Wei, Tao, & Lu, 2018). The impact of PTSD in civilian nurses caring for COVID-19 patients is expected to be as significant, if not more so, as it has been for military nurses (Chiappini et al., 2020). There is an ethical and moral obligation to provide for the mental health needs of the nurses caring for COVID-19 patients (Menon & Padhy, 2020).

6 | SURGE STAFFING

The lack of sufficient nursing staff and the capacity to manage a surge of patients in both the military and COVID-19 are commonalities. Sometimes the number of patients during war and at peak spread of the pandemic is overpowering and overwhelming facilities and personnel. The military invests in extensive training for non-professional healthcare medics who perform complex supportive services beyond what the civilian sector allows. These medics enable the professional staff to safely manage many critically ill patients. Having this level of providers could be very useful, particularly to nurses caring for COVID-19 patients during surges.

7 | TRAINING

Military nurses attend numerous training exercises, all designed to prepare the nurses for combat. In the summer of 1970, as a young Army Lieutenant, I attended a 'boot camp' for new nurses. In addition to learning about the Army, we went to a special training area to learn about conditions in Vietnam. We were led into a simulated Vietnamese village where we were ambushed and had to learn on the spot how to care for the wounded. Mass casualty exercises helped to prepare us for combat nursing. A national strategic plan on how to prepare nurses and others to care for COVID-19 was largely missing. Each hospital, with limited guidance from the U.S. Centers for Disease Control, was expected to create its own protocol (Cortez, Tozzi, & Bloomberg, 2020). Often conflicting information provided by Federal agencies was changed to accommodate political perspectives. Another moral and ethical issue thus was created as Federal agencies charged with protecting the public often based their responses on political perspectives (Anderson, 2020).

8 | CHAIN OF COMMAND

The chain of command is a foundational concept in the military. Every military member is required to know their respective chain of command. The concept means there is a definitive hierarchy of individuals responsible for achieving the mission from the first-line

supervision to the commanding general or admiral. The command and control specifically identify the accountability of each supervisor and team member. Using a well-defined accountability structure fosters the successful completion of the mission.

In the COVID-19 response, the command and control function, at least in the United States, was missing. There was no national leadership to direct the overall management of the COVID-19 response. The lack of leadership meant local and state agencies had to 'fend' for themselves, creating competition to obtain needed personal protective equipment (PPE), ventilators, other supplies, and medications. The lack of leadership combined with no national planning created a moral and ethical failure resulting in needless deaths (Berlinger et al., 2020).

9 | ETHICAL CONFLICT

The Hastings Center, an international leader in bioethics, published an ethical framework for healthcare institutions and guidelines for institutional ethics services responding to the coronavirus pandemic (Berlinger et al., 2020) (see Table 1). The first of the three ethical principles is to prepare for uncertainty. The COVID pandemic, caused by a novel virus about which little was known, implies that institutions, nurses, and other healthcare workers must plan and prepare for uncertainty as best they can. The lack of Federal government preparedness and limited availability of resources added to the uncertainty for healthcare providers as well as the public. The lack of national leadership was particularly apparent in Italy, Brazil, and the United States (Castro, 2020; Rucker et al., 2020).

Military nursing historically plans and prepares for combat, the outcome of which is also uncertain. A key goal in military strategic planning is to ensure protection of the healthcare personnel by having adequate supplies, equipment, and medication. Without a strategic plan with a defined control and command structure, the military would have more difficulty providing care to sick and wounded troops. Failure would mean a moral and ethical dilemma where personnel are asked to fight without the availability of medical support if injured or sick. The failure of the Federal government to plan per the Hastings Center Ethical Framework (Berlinger et al., 2020) creates an ethical issue. Failure to adequately plan a response to COVID-19 meant the death of thousands of people.

TABLE 1 Hasting center ethical framework for healthcare workers

Three Ethical Duties

1. To prepare for uncertainty
2. To protect the welfare of staff and the safety of vulnerable populations
3. To guide the extent of emergency treatment and the quality of care in the crisis

Source: Berlinger et al. (2020).

The failure of the Federal government to plan for the pandemic is akin to the above example of the military not preparing its healthcare resources for use in combat. This lack of planning thus created a moral and ethical dilemma resulting in the needless deaths of citizens, including nurses (Why wan't it, 2020).

10 | MILITARY AND NURSING CODE OF ETHICS

The International Council of Nurses (ICN) Code of Ethics for Nurses, as revised in 2012, provides an ethical framework for nurses. The Code has four fundamental responsibilities. A central premise is that nurses have a primary obligation to provide nursing care to anyone who needs it (ICN Code, 2012). In the United States, the American Nurses Association (ANA) Code of Ethics for Nurses with Interpretive Statements (ANA, 2015), supported by the ICN Code, is the current ethical guide for nurses. Nurses have a responsibility to incorporate the Code into their practice. The Code ensures that safety and well-being are protected, promoted, and restored; disease and injury are avoided; and distress is relieved in the treatment of individuals, families, groups, communities, and populations.

Military nurses in the United States follow the ICN and the ANA Codes of Ethics as well as the Uniform Code of Military Justice (UCMJ). The UCMJ defines military criminal law and procedure and serves as the basis for the management of military discipline (U.S. Congress, 1958). The Ethical Guidelines and Practices for U.S. Military Medical Professionals Report (Annas & Crosby, 2019) guides military medical personnel. Both are guiding principles in providing healthcare to military personnel and eligible beneficiaries. The ICN, ANA Code of Ethics with Interpretative statement, and the UCMJ plus the military ethical guidelines offer an ethical framework for nurses as they practice within the context of the COVID-19 pandemic. Asking nurses to work in unsafe situations due to inadequate PPE, long hours without adequate respite where errors are more likely to occur, and to face long-term consequences of mental and emotional strain, presents an ethical violation of the ICN, ANA, and military ethical guidelines.

11 | CONCLUSION

The COVID-19 pandemic, while making a terrible impact on our lives, also provides an opportunity for a better response to future pandemics. Military nursing offers some valuable lessons for the civilian sector, with notable key strengths of rigorous strategic planning and a defined command structure. Military nurses also have the benefit of defined ethical guidelines to support their practice. The civilian sector has largely failed to plan and to exert any consistent leadership regarding the approach to management of this pandemic. The ethical issues created by these failures are blatant. Non-military nurses have an ethical responsibility to speak out, so not another nurse dies because of inadequate planning. Let us learn from our

colleagues in the military how we can support and learn from each other. We must do better!

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