

**DIMENSIONS
OF
MILITARY MEDICAL ETHICS**

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Should Military Physicians Refuse to Prescribe?

Karen D. Brandon and K. Waugh Zucker

Military physicians at a small medical facility serving primarily obstetrical in-patients, who are military dependents, are asked by the parents of minor females to prescribe birth control for the girls. Because doing so would violate the moral and religious beliefs of some of the physicians, those offended (apparently most of them) refuse to prescribe the requested birth control drugs or devices. Following the line of thinking that "to refer is to provide," or that *referring* is just as wrong as *providing*, these physicians also refuse to refer the patients to practitioners who would willingly provide the requested prescriptions.

The situation lasts until a climate survey taken of personnel on the installation reveals that families are having problem obtaining birth control for their daughters. The hospital commander reacts by issuing an order requiring military physicians to prescribe the requested birth control unless they can give medical reasons why it should not be prescribed. This is not well taken. The commander reconsiders and requires only that the physicians who object to prescribing birth control refer the requesters to other physicians who do not share their objections.

Some Questions:

Do physicians have a right to refuse to participate in treatments which violate their moral or religious beliefs? If so, do physicians who serve military or other captive populations have the same right? Is referring for treatment the same, ethically, as providing the treatment? If so, is there both a right to refuse to provide a treatment and a right to refuse to refer? And, do physicians who serve the military, or other populations whose access to medical care may be limited, have those rights? Are there legal ramifications to refusing to prescribe or to refer? Might these properly affect command decisions? Has the Joint Commission addressed this problem? [Yes, but only insofar as it has stated that there must be a "mechanism for addressing these concerns."] If so, what are the ethical and legal ramifications of failing to consider that guidance?

God Will Intervene

K. Waugh Zucker

An obese but small-framed woman (gravida 3; para 2), who has received no prenatal care from these physicians or at this facility, is believed by physicians to be three to four weeks past her due date. Doctors estimate the baby's weight at 14 pounds and judge the woman incapable of delivering the child vaginally. Birth weights of her two previous children, each born within a week of the due date, according to her report, were 6 lb 4 oz and 7 lb 10 oz. She is a practicing Mormon. She tells her physicians either --and there is significant disagreement as to the exact statement-- "The Lord told me I can deliver this baby normally" (clearly meaning vaginally) or "The Lord told me I would deliver this baby normally."

The pertinent conversation went something like this and was repeated four times::

Dr. Your pelvis is too small for you to deliver this baby. It is too big to get through the vaginal canal, and it must be delivered now.

Patient. I understand. You've all said that.

Dr. Then, we have your permission to do a C-section?

Patient. No.

Dr. But . . .

Patient. Night before last, the Lord told me . . .

Dr. The baby needs to be delivered now. It is too big. Your uterus could rupture, and we might not be able to save either of you. This situation is not good for your baby.

Patient. You don't understand. I'm going to deliver this baby normally.

Note: The patient is oriented as to time and place. She demonstrates above average intelligence. She is on no mood altering or pain relieving/anesthetic drugs. Her spouse says that only she and God *know* if He talked to her, but that he believes her and agrees with her -- the proper action is to trust in God.

Some Questions:

Is this woman competent? Is her stated belief evidence of a delusion? Even if she can risk her own life should she be allowed to risk that of her unborn child?

Rob, now Robin: A Transsexual in the Workplace

Stephen Elgin

Rob is a well respected, civilian, physician assistant, working in a military hospital. His examining room reflects his professionalism and the regard in which the community holds him; his master's degree and several professional certifications are displayed alongside mementos of appreciation from Rotary, Lions, and Boy Scouts of America. All Rob's life he has felt he was a woman trapped in a man's body.

After years of counseling, he has been accepted in a sexual reassignment program at Johns Hopkins, has begun to take hormone therapy, and has been told to begin living and dressing as a woman. Rob tells his supervisor of his plan on Friday. He wants to begin dressing as a woman as of the following Monday and asks that he be called Robin.

Some Questions:

What if anything must/should Rob/Robin's current patients be told? What if they no longer want to see her? What about new patients? What workplace accommodations, if any, must/should be made? How should Rob/Robin be treated? The first line supervisor thinks Rob/Robin should be shown the door.

Request for an Abortion

K. Waugh Zucker

A 34-year-old dependant wife (Joan) of an enlisted man (John), paygrade E-6, was determined upon examination to have a brain tumor, a particularly nasty and invasive tumor expected to kill her within weeks without treatment and within months with treatment.

Joan is pregnant –about 16 weeks. She had been using birth control, and she and John had not planned this pregnancy. They thought their family was complete with their three children, Katy (5), Lynne (4), and Jason (2). However, as they thought about the situation, they decided it was fine and that they would like to have another child. They told their closest friends and family about the pregnancy. Now, this –the brain tumor.

Joan wants an abortion. She says that she knows how grave her situation is and that she wants to be with her family as long as she can. If she is pregnant, no doctor will give her the radiation therapy she needs. (That seems to be true, at least at this military facility and at civilian facilities within the metropolitan area.) She wants an abortion. Her family agrees and her clergyman understands.

Joan's oncologist recommended an ethics consultation. At the consultation, he laid out her medical situation, and she made her plea for an abortion; her husband sat by her side and nodded in agreement. The military lawyer handed out copies of the federal law:

RESTRICTION ON USE OF DEPARTMENT OF DEFENSE FUNDS AND FACILITIES FOR ABORTIONS (10 USC 1093)

(a) Restriction on Use of Funds. Funds available to the Department of Defense may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.

(b) Restriction on Use of Facilities. No medical treatment facility or other facility of the Department of Defense may be used to perform an abortion except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest.

Some Questions:

Is this a matter of ethics or law? Is the woman's life being endangered by the fetus being carried, albeit unlikely that she can carry it to term? Does *endangered if*, the language of the statute, mean something different than *endangered by*? Is the quantum of life that the woman might gain by an abortion and radiation relevant?

Disclosure v. Confidentiality

Anonymous

You are a social worker, psychologist, psychiatrist, or doctor. 1LT Kelley Brown presents to you at your clinic and reports that she was sexually assaulted last night. She indicates that she knows her assailant but will not give you his name and says she will not identify him to anyone. She wants to "talk about it" but does not want either her commander or law enforcement personnel notified.

Some Questions:

What do you do? What if you do not report the incident and, when she sees you again three days later, she identifies her assailant to you as CPT JB. What, if anything, do you do now? What if there was a Department of the Army policy that required any sexual assault to be reported to the MPs? What if the policy required any identified assailant to be reported by name?

Patients before Rules?

Richard Griffith

After 50 days in the theater, you have the routine down. You are awake all day because of the noise, awake all night because of the noise, and patients arrive in large groups whenever you are actually sleeping. Lately the acuity of the wounded has been rising. Your small clinic is stretched to its maximum capability and you need more doctors with additional skills.

The clinic is collocated with an aeromedical staging facility that has three physicians assigned. While these doctors are assigned to provide advanced primary and stabilizing care to those patients awaiting evacuation to Germany, the staging facility has several Critical Care Air Trauma Team (CCATT) crews attached that are responsible for providing ICU-level care during the evacuation out of the theater.

One night, after an attack, your nurse calls down to the CCATT tent and asks for an extra set of hands. The response from the officer in charge was immediately positive and he dispatched several personnel to assist your clinic. Throughout the next few weeks, this relationship develops and the CCATT physicians, nurses and technicians provide critical intensive care support as needed to your clinic patients.

One day the CCATT team supervisor (stationed three countries away) calls and demands to speak to the clinic commander. She reminds the commander of the strict Air Force crew rest procedures and insists that the commander desist in using her CCATT teams to support clinic patient care. The clinic commander outlines the type of care the wounded patients require and asks the CCATT supervisor to bend the rules. She declines and insists in speaking the CCATT officer in charge at the forward area and orders him to cease supporting the clinic.

Some Questions:

When do military administrative rules override the needs of the patients? What obligation does a military provider have when a military order is not in the best interest of the patient? Can you weigh the immediate needs of the clinic patients against the future needs of aeromedical evacuation patients who may not receive care from properly rested CCATT provider teams?

Being a Team Player...

Richard Griffith

Late one night, an Army Humvee pulls up behind your small, forward clinic into the "special patient's" parking area and two sergeants step out. They are guarding a man, apparently an enemy prisoner, with a black cloth bag tied over his head covering his eyes, ears and mouth. As they enter the facility, you note the man is bleeding from cuts on both of his lower legs.

In accordance with your normal protocols, you move the patient to an enclosed and cordoned off area of your clinic and begin your examination. You ask to have the cloth bag removed so that you can interview the prisoner and complete your examination. The guards decline stating security concerns and your safety. "Besides," says one, "you can see he just needs his legs looked at. " Refused the ability to complete an examination, you ask the patient what happened and realize he doesn't speak English. "Well, I at least have to be able to talk to him," you exclaim. "No need to talk, Doc, " says one of the guards, "just fix the patient."

You decide that providing at least some treatment was perhaps the important issue here, your technician assists you in binding the patient's wounds. One of the guards steps forward, "Hey Doc, I think this guy might be in some pain ...can we dope him to make him comfortable?" "These are mostly superficial and some Motrin should do it, " you say. "No, I think he is going to need something stronger, " he responds, "he is in a lot of pain and we don't want him to be uncomfortable! " Laughing, he adds, "You know, they are a little easier to talk to with the "good stuff" in their system . . . helps the war effort! "

Some Questions:

Should you proceed to provide care without the patient's consent? Can you adequately treat the him without any ability to communicate with him verbally, or even with gestures? What do you do? How far do you let others go in "assisting the war effort"? How do you determine the guard's true intentions? Is the patient really in pain (how can you tell without communication)? How far should medicine go in supporting intelligence gathering activities?

But I Want . . .

Richard Griffith

As the chief of staff of a medical clinic in a forward area, you are constantly struggling with providing care with severely restricted resources. Medical re-supply is particularly poor, and items you need are typically weeks and weeks behind the projected delivery schedule.

This last week, your general and orthopedic surgeons have approached you with "concerns" about their ability to perform surgery. The general surgeon is particularly displeased with the inability to get face masks for the surgical suite and also unhappy that the back up power supply for the suction machine is down. The orthopedic surgeon is displeased because he cannot acquire a particular type of orthopedic bracing device for distal radius fractures and cannot acquire blades for his giggle (bone) saw. They both want the OR closed until the administrative section can "get its act together" and the clinic can start providing the best quality of care. "Besides," the ortho doc says, "Command might actually try to fix this if we refuse to see patients! "

You know that your medical supply situation is not unique. Army physicians just across the road are shipping equipment and supplies that they purchased with their own money in through the US Mail. Last week your four-bed inpatient unit was using coffee cans for bed pans since supply ran out of plastic bed pans when the nursing technicians threw the last of them away by mistake. It doesn't seem like anyone cares about this problem!

Conversely, just last week you had eleven critical patients show up at your clinic in the middle of the night when enemy forces shelled an Army housing area; three of those folks needed emergent surgical attention. Just closing your doors in the hopes that "command" might pay attention doesn't seem the right option for this situation.

Some Questions:

What is the standard of care in this type of situation? Can your providers, should your providers, make do with less than they are used to, or make do with less than they believe the patients' deserve? Do you do a longer term good by shutting your doors temporarily?

Interrogation Techniques

Tom Jefferson

You are caring for a wounded insurgent in the emergency department of a combat support hospital (CSH; pronounced "cash"). He is seriously wounded, but stable, now that your team has two IVs in and his bleeding is under control. TS, a US civilian who you've been told is involved in *intelligence*, comes to the patient's bedside. He requests that you inject some normal saline into the insurgent-patient's IV, while an interpreter questions him. You do so. The patient becomes very distressed during the questioning. When you ask about it, TS says, "I told him it was truth serum." You tell TS to stop the questioning and protest until he does so. The next day, your commander takes you aside and angrily tells you to "get with the program."

Some Questions:

How could you have handled the situation in the emergency department differently? What, if anything, do you do next?

Practicing on the Dead

Tom Jefferson

You are a physician with a forward support medical company. When a wounded American dies shortly after arriving at your facility, the physician's assistant with you says that he would like to practice placing a tracheostomy in the decedent, in case he needs to do it to save some soldier's life. He asks if you will talk him through it?

Some Questions:

What advice would you give the PA? What if the decedent had been an enemy insurgent? What if you were stateside? Is this an ethics question? Why or why not?

Where Does She Go?

Tom Jefferson

You are a physician on a Navy hospital ship off the shore of Iraq. One of your patients is a 7-year-old girl with extensive, full-thickness burns suffered when coalition soldiers shot at her family's auto at a checkpoint and the vehicle exploded when hit. Her mother survived; her father died. Your ship is scheduled to return to the US. The regional civilian medical structure remains tenuous, with overcrowding and shortages of intravenous antibiotics and surgical teams, especially for burns. You are the one who must determine the child's medical disposition. You may either send her to the local hospital or try to get her accepted at the US military hospital in Germany. She has a better than 50/50 chance of surviving, albeit with scars and disabilities, in the US system, but the odds are strongly against her survival if she remains in country.

Some Questions:

Where should she be sent? You remember that Colin Powell said, about Iraq, "You break it, it's yours." Is the obligation different because she was wounded by US forces?

Limitations on Use of Blood

Tom Jefferson

You are the deputy commander for clinical services (chief doc) at a combat support hospital. It is early in the conflict, so the timely replacement of medical supplies is likely, unless the tactical situation changes unexpectedly. Surgeons are operating on a soldier who is so severely wounded that his clotting mechanisms have begun to fail. He has already received 8 units of packed red blood cells (RBCs) and 4 units of fresh frozen plasma (FFP). The lab officer comes to you with a request for 6 more units of RBCs, 4 more of FFP, and a 6-pack of platelets. You remember that the medical brigade (higher headquarters) has placed a limit of 12 units of blood products for any one surgical patient in the combat zone.

Some Questions:

Is the blood limit an ethics-based decision; i.e., is the rule ethically defensible? How can you balance this patient's acute need against the brigade policy for the combat zone? If the patient is an enemy insurgent, how does that affect your analysis?

Evacuation Is Not Possible

Author Unknown

You are a member of a medical treatment facility deployed in a combat environment in the first week of hostilities. Your facility has received a large number of patients from the units that you are supporting.

Presently, your patient census is at 87% of capacity, with 53% of the patients in the *expectant* category. You have patients with abdominal eviscerations, extensive head wounds, and a four-soldier tank crew with 30% to 55% body surface area, full thickness burns.

Aeromedical evacuation is not possible because the enemy presently maintains air superiority. Land evacuation from supporting units will take three hours to arrive at your location. Your unit has suffered the loss of 40% of its personnel and equipment. You have not been resupplied in two days. Your supply level of bandages, IV fluids, and medications, particularly morphine, is nearly depleted.

Your unit has just received orders to displace to a new location and to be prepared to accept new patients from intensified fighting. Your unit cannot evacuate the patients you presently have to another treatment facility. Your unit does not have the equipment or personnel to relocate with your present patient population.

Military Triage Categories in order in which patients will receive care

Immediate - life sustaining attention is required and the patient is expected to recover

Minimal - least severe injury

Delayed - care is not immediately required

Expectant - the patient is expected to die; palliative care is provided

Problem:

Your commander directs you to 1) formulate possible courses of action, 2) analyze each course of action ethically, and 3) recommend the best course of action.

What Have We Done?

Anonymous Graduate Student

Just after dawn, a horrendous blast shook the camp. Medics ran toward the scene. They found several slightly injured Americans; they were walking and talking, and, almost miraculously, had suffered only minor lacerations. On the ground lay a badly wounded man who appeared to be an Iraqi. They grabbed him and rushed him to treatment. Doctors, nurses, and medics worked methodically, as a well trained team. The wounded Iraqi who had apparently been carrying a bomb on his body would live, at least for now. He had no arms, one salvagable leg, and was almost certainly blind.

Some Questions:

Should his life have been saved? Should he be evacuated to Germany (Landstuhl Army Medical Center) for further care? Does it matter what his life will be like if he survives to be returned to Iraq? Does it matter why he was saved? One of the doctors suggested that he might have information about who was supplying these bombs or the supplies needed to build them.