Military Medical Ethics Module

Goal: to understand the principles of ethics involved in military medicine

Objectives: upon completion of this module, the pediatric resident will:

- Define mixed agency
- Understand the Geneva Convention
- Read the 3 cases and be prepared to discuss them

Knowledge Summary

I. Mixed Agency
   a. Definition: Balancing needs of the military, mission, unit versus the individual patient

II. **General Rule of Thumb #1**: The mission and military unit as whole must be preserved in order to save a larger number of personnel over a single individual.

   a. Example: A commander is an impaired status secondary to mental illness such as bipolar disorder. The physician has a duty to remove the commander from the theater of operation in order to preserve the unit and mission. Although the exact diagnosis does not need to be revealed, the commander inability to effectively lead needs address and commander relieved.

III. **General Rule of Thumb #2**: If the mission or military unit and large personnel are not compromised, then the individual confidential health information and status should be maintained. Try to maintain HIPAA training.

   a. Example: Homosexual soldier has a specific infection c/w sexual orientation. The doctor may use discretion to not reveal this "secret" and the patient's right of confidentiality, even though it is contrary to military law. The mission and unit are not compromised.

IV. **General Rule of Thumb #3**: The role of the physician in a combat theater is to treat and conserve the fighting strength.

   a. Example: A soldier with combat fatigue secondary to recent traumatic loss of members of his unit presents for somatic complaints due to fear and stress of returning to combat. The physician places the soldier on two days of light duty and then recommends returning to combat role and rejoin his unit.

V. Geneva Convention for Medical Personnel

a. Medical personnel are recognized in protected status.
    i. If captured, medical personnel should be utilized to care for fellow prisoners, casualties and basically retain their role.
    ii. If captured, medical personnel should be repatriated to their own country
    iii. Medical personnel may use force and weapons “if they are fired upon or their patients are fired upon.”
    iv. Medical personnel are not permitted to discriminate between enemy and their own military when providing care. Triage as always in emergency situations.
    v. Medical personnel can be collateral damage when individual attachments in combat units.
    vi. Medical personnel should provide all belligerents wounded in combat the same level of care provided to allied forces.
        1. Informed consent
        2. Same standard of care
        3. Absolutely no medical research

b. Distinctive Medical Emblems
    i. Recognized emblems
        1. Red Cross
        2. Red Crescent
        3. Red Shield of David
        4. Red Diamond

    ii. Protected status granted to facilities and vehicles with these emblems
        1. Protected status is waived and not granted if the facilities and vehicles are involved in holding weapons, sites of offensive operations, or concealment of non-medical and non-wounded personnel.

c. “Healed” belligerents are returned to capturing unit and subjected to the units’ law process. Torture is unacceptable and illegal.

VI. Summary of Military Medical Ethics

a. First of all, be the best doctor that you can be. Care for your patients whoever they are.
b. Use common sense! Use discretion to maintain confidentiality as best as possible. Do not focus on laws and lawsuits.
c. You recommend as a physician, the unit commander is the ultimate authority.
d. Remember the Hippocratic oath.

Case 1: The General's Psyche

You are a new graduate of WRAMC pediatric residency program and have been placed in a billet as field surgeon. You are currently deployed with an infantry brigade at a Forward Operating Base in Iraq. The unit is running combat search and destroy missions on enemy insurgents in multiple areas within the combat theatre. The brigade commanding officer is a Brigadier General and he has multiple units operating throughout the country. The General has told the infantry unit physicians' assistant on several occasions that he is having difficulty sleeping and requests sleeping pills. The General indicates that he has lost several soldiers and this "weighs on his mind." This is reason he is having trouble sleeping. The physician assistant prescribes Ambien for sleep difficulty and the General returns several times for medication refills. Meanwhile, the General continues to carry out the unit's daily business and makes critical decisions without any further evaluation.

Finally, the physician assistant brings the prescription history and the General's difficulty sleeping to your attention because the General's aide, a young captain, indicates that the General is losing a lot of weight over the last 3 months. As a matter of fact, the General has dropped approximately 20-30 lbs. Therefore, you obtain this information and instruct the General to come to the battalion aid station for a complete physical examination and possible lab tests. The General receives the instruction but indicates that he is flying to a different FOB tomorrow and will be gone for one week. He refuses to be seen until he attends this trip because he is scheduled to attend yet another funeral ceremony for one of his soldiers at this FOB. You tell the General that is not a good idea and insist that he come to BAS but he refuses and goes on his trip.

Upon return, the General does come to the BAS and cooperates fully with a complete history and physical examination. The General indicates that beside the weight loss, he has significant polyuria and polydipsia along with occasional headaches and difficulty sleeping. He also is having dreams and difficulty focusing at times. This weight loss occurs despite a vigorous appetite and work-out regimen. His physical exam is fairly benign, but the urine dipstick reveals greater than 1000+ mg/dl of glucose and a glucometer reading of serum glucose at 680 mg/dl. Obviously, the General has diabetes and needs treatment with insulin and this is not available in the BAS. The General becomes very nervous once his lab results are revealed to him. He indicates that nobody within the unit outside his aide should know anything about his health status. Furthermore, the lab tech and medics involved in his case must be informed of his confidentiality. You agree and make the medical unit aware of patient confidentiality even in a war zone.

The General then refuses transport out of theatre. However, this is what is required, given his diagnosis. Members of the chain of command, including several Colonels on the General staff are placing pressure on you to indicate his health status and reveal his diagnosis. Even the Brigade Surgeon, a podiatrist not involved a patient relationship with the General, is applying pressure on you to tell him the diagnosis and involve him in the General's care. Thus, you are presented with several ethical dilemmas.

The General's Psyche

Question #1:

a. Is the General in an impaired commander status?
b. Does the General have the capacity to exercise sound judgment and make critical decisions?
c. If the General continues to refuse to leave theatre, what should the physician do?

Question #2:

a. Should you violate the General's Confidentiality and tell his staff officers?
b. Or the Brigade Surgeon?
c. Does HIPAA apply in a war zone?
d. What avenue should the physician pursue if the pressure from higher - ranking officers continues?

Question #3:

a. Discuss balancing the needs of the military versus the needs of the patient as it pertains to this case.
b. Indicate what action should be taken against the physician assistant for prescribing the sleeping pills, if any?

Case 2: The Detainee Dilemma

You are a new graduate of the WRAMC pediatric residency program and stationed with a unit deployed to the Iraqi theatre of operation. To make matters worse, you have a chance to excel as the physician in charge of a detainee medical hold facility. You have the ability to show your skills as a medical asset to the brigade's higher brass as you set up the medical field facility. In your medical company, you have two 20 cot medical field tents and 15 medics to run this detainee hold area. You have no nursing assets, but you have another pediatrician who is also a field surgeon. You have a military police company with appropriate numbers to guard and protect you and your medics. You place a red cross and red crescent on the field hospital. You are ready to take on patients. The 40 cot holding facility fills quickly as a major offensive against an insurgent city occurs and the coalition forces complete the mission in timely and the patients come "rolling in." Most have surgery at the Theater Support Hospital and then placed in your care. Your medics work in good Army fashion and learn to hang antibiotics and some nursing skills in addition to their medic skills.

The medical field hospital has multiple areas of lighting as well as the red cross and red crescent on the tents. Thus, they became a magnet of the local insurgent mortar attacks on a daily basis. Furthermore, more bad news strikes as a JAG officer shows up at the facility in order to investigate a MP assertion that the patients are not being given assess to tobacco products and not given to ability to work or enough recreation time. In addition, the MP charged that even though an interpreter was present 24 hour per day and the detainees were informed of their injuries and surgeries that would be taken place after consent, a lot of the detainees were of different Arab nationalities and did not fully understand. Therefore, they could not consent to the surgeries. Now you face the JAG officer and the following questions:

Question #1:

a. May you take down the Red Cross and Red Crescent to protect your patients and medics?

Question #2;

a. Are the detainee patients entitled to tobacco products in accordance with Geneva Convention, even if it hinders wound care, healing, etc.?
b. Are the detainee patients entitled to recreation and work schedules?

Question #3:

a. Do detainees have the right to refuse surgery or treatment?
b. Do you have to provide nationality specific Arab interpreters for the detainees in order to obtain appropriate informed consent?
c. Where do you place the detainees after they are "healed"?

Case 3: Iraqi Child or Enemy Combatant or Both

You unit is co-located with a Forward Surgical Team (FST) outside of Fallujah, Iraq, in support of brigade operations in the city. Late one evening an infantry unit evacuates to the FST a 15 year old Iraqi national with gunshot wound to the sole of the foot. There is extensive injury and damage to the foot and the orthopedic surgeon takes the child to the operating room for debridement. After completion of surgery, the casualty is transferred to the patient hold tent, where he comes under your care for post-op management. He is in significant pain, requiring morphine and Demerol for control.

At this point, the brigade surgeon arrives with a Military Intelligence interrogator. They explain that the casualty was a member of an RPG team that ambushed an infantry patrol earlier that evening. In the subsequent firefight and chase, the casualty was captured. Based on other intelligence gathered that evening, MI strongly believes your patient is heavily involved with the local insurgents and could have information vital to the brigade's mission. To obtain this information he needs to be interviewed as soon as possible, but he is still sedated from surgery and pain medications. The brigade surgeon suggests using Narcan to wake him up and "encourage" cooperation.

What is your response?

In subsequent conversations with the infantry soldiers, you suspect that the casualty may have been injured while already in our custody.

What do you do with this information?