LIMITS OF LOYALTY AND OBEDIENCE: DOES THE MILITARY PHYSICIAN SERVE TWO MASTERS?

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No man can serve two masters.
For either he will hate the one
and love the other; or he will
sustain the one and despise the
other. — Matt vi:24

INTRODUCTION

For two millenia and more, physicians in the West have tended to assert the primacy of the individual patient over against the claims of institutions or of societies. But clearly, tensions have always existed, more wrenching at some times than at others. And in no milieu, perhaps, is this potential conflict more obvious than in that of military medicine. Even the seeming synonyms, "military physician" and "physician in the military", bespeak a certain bias as to perceived roles. Am I primarily "military" or primarily "physician"?

In this context, then, I propose to discuss issues of loyalty and obedience as demanded of the military physician and to contrast them with those of his civilian counterpart. Furthermore, I will make no distinction between the requirements exacted of the military physician in time of war as opposed to those in time of peace. In civilian medicine, after all, there are stressful situations — epidemics or natural disasters, for example — that are entirely analogous to those encountered by the military physician in wartime.

SPECIFIC DIFFICULTIES

Confidentiality: This, it would seem, is an area in which the professional ethical strictures imposed on the civilian physician may commonly be abrogated in the military. But on reflection it

becomes apparent that confidentiality has never been an absolute value in civilian medicine nor has it been ignored in the military. Civilian physicians are required by law to report certain communicable diseases to public health authorities and such injuries as gunshot wounds to the police. Similarly, the military flight surgeon is required to report medical unfitness for flying status to the operational commander. Note that these situations are not, strictly speaking, violations of patient confidentiality, since the action is essentially predetermined and generally known. There is therefore little distinction in these instances between the loyalty and obedience required institutionally of the military physician and that demanded by society of his civilian counterpart. In point of fact, the military patient's perception of his military physician as a member of the same organization with obvious institutional responsibilities thereto — as manifest by the wearing of a uniform and possession of a military rank — may make issues of confidentiality less opaque than in civilian medicine, where the demands of certain third parties for confidential information may not be suspected by the patient. But, despite evolving experience (1), ambiguities are inevitable, and the medical officer can draw neither comfort nor guidance from these concluding words of Knoll (2):

> The military physician should be aware of the absence of a doctor-patient privilege in military law, and should be cautious in his assurances to his patients that the information they may divulge to him will be kept confidential. His ethical duty not to reveal the

> secrets of his patient is still applicable to his practice, but must give way to his official duties as a military officer when the two are in conflict and a clear legal obligation requires him to speak.

And what of thornier issues of confidentiality in military medicine? May a commander demand personal information of a general nature about subordinates that was garnered in the course of a psychiatric interview? No more than in civilian life, unless authorized beforehand by the patient. Note that I evade the issue of breaking a professional confidence if the physician acquires information about a threat to others (2, 3). As a non-psychiatrist I do not often encounter such difficulties and as a physician interested in medical ethics I have not resolved the dilemma to my own satisfaction. But that is not the point. My thesis is that, in general, the professional ethics related to confidentiality in the military are quite similar to those encountered in the civilian sector. As Hundert (5) states:

> Examples in which doctors are forced to act as "double agents" (as when psychiatrists are called on by society to protect society from dangerous mentally ill people and not just serve their patients) highlight the difference between morality in the narrow and broad senses, <u>but these levels of complexity are always operating</u> ... (italics mine)

Nevertheless, the basic concept of medical confidentiality —

once deemed as sacred and inviolable as the seal of the confessional is for priests — has continued to erode as Western medicine loses its roots. This is not necessarily a greater problem in military medicine than elsewhere, but its potential for becoming so must be recognized. For instance, there is some evidence to suggest that military personnel are more trusting of the confidentiality of civilian than of military physicians. Thus a study (6) under military auspices of risk factors in 20 military personnel with human immunodeficiency virus (HIV) infection found that only 20% were homosexual or bisexual. It was therefore concluded that heterosexual transmission is much commoner than has been appreciated. However, when subsequently interviewed by civilian case-investigators a full 70% admitted to being homosexual or bisexual (7). Rightly or wrongly, therefore, it would seem that military personnel may view the military physician as renouncing the professional ethic of confidentiality in favor of loyalty and obedience to the organization. If this is so, it requires renewed emphasis on confidentiality of medical information by both medical officers and, perhaps a fortiori, by line officers.

Medical Evaluations for Administrative Purposes: A second area testing the limits of loyalty and obedience of military medical professionals is that of medical evaluations for administrative purposes. A commander may find that getting a troublesome individual out of his unit may be accomplished more easily and expeditiously on medical grounds rather than by administrative means. Needless to say, a medical officer who permits himself to be suborned in this fashion is in violation of basic professional ethics. But this rather crude scenario is not only uncommon but also, in its very overt limning, provides no true ethical challenge. Of more moment is the subject of psychiatric evaluations for administrative purposes.

Here, it would seem, the physician can easily become a double agent unless he is aware of the possibility and has sufficient ethical mettle to resist. According to Jeffer (8), "the entire effort is to create a situation where commander, psychiatrist, and soldier are united in a common effort to find the best possible solution". As Jeffer concludes:

> Psychiatrists are frequently called upon to evaluate individuals for judicial or administrative purposes. These evaluations are frequently seen as an invalid area for psychiatric expertise, or as an uncomfortable and unrewarded necessary evil. The author has found that, within the military, the utilization of an active consultation model for administrative evaluations allows for a positive and productive involvement in the administrative process. Additionally, the development of reporting vehicles, which combine the psychiatric and legal vocabularies, enhances the consultative role and diminishes misunderstandings and unnecessary adversary confrontations. In the military, administrative evaluations can become the first step in primary prevention consultation.

And though he does not accept the inevitability of yielding to

the bureaucracy, Morgan (9) is perhaps less sanguine than Jeffer that such a conflict of interest can be resolved ethically by the military physician:

> The physician who accepts payment for his services from an institution rather than from the patient may have some conflicts, but his independence and professional judgment may remain unchanged vis-a-vis the patient. ... But as the bureaucratic nature (and power over the physician) of the organization increases, such independence is much more difficult to achieve. He may often become the captive of his employer and find it more difficult to justify what he does as service to the patient. The military psychiatrist often falls into this latter group.

The Military Physician versus the Military Health-Care Bureaucracy: After a long latent period that some would describe as typical, the fiscal constraints of today's medical technology have finally been recognized by the military health-care bureaucracy. In essence, this pits optimal medical care for the individual against the monetary resources of the medical department. And needless to say, the latter competes in turn with the many non-medical entities of the organization which it serves. Again,

a tension, the attempted resolution of which is the proper concern of bureaucracies. But I am concerned here with the role of the individual military physician, since, properly speaking, moral decisions can be made only by an individual moral agent and not by committees. Both "peer review" and "utilization review" have been implemented to address the fiscal constraints of modern health-care. These have not only produced value conflicts for the individual practitioner but also, according to Giordano (10), "have become institutionalized in the military medical system". He concludes:

> ... it seems clear that whatever solutions are tried, they must include a sensitivity to the basic value system that permeates medicine. Any proposed solution that is inconsistent with this value system will founder. Clinicians can no longer practice within the military medical setting with a blithe disregard for fiscal constraints, and rightly so. However, in the pressure to bring ... medical costs under control, we must remain aware of some of the basic value conflicts. ... It would seem that both the clinicians and the monitors of health-care delivery must develop some knowledge of the tenets of each other's creed and be prepared to accept some compromises in

their value systems in the
search for solutions.

In the arena of health-care costs, then, there would seem to be some limits to the loyalty and obedience demanded of the military physician by his organization. No one, however — at least at this juncture — is willing to essay a precise delineation of these limits. And perhaps wisely so. Some tensions are resolved by a rupture ...

THE FINAL ARBITER

An eleven-point code of "Ethics and Professional Relationships" for health-care practitioners in the military was made available to the Committee on Medical Ethics in the Military at the November 1985 meeting of the Society of Medical Consultants to the Armed Forces. Virtually all of the statements in this code, as in most similar compilations, are bland generalities to which no reasonable person could object. But "Principle 11" raises a significant difficulty. It reads: "Government service or employment, as a public trust, requires that the health-care practitioner place loyalty to country, ethical principles, and law above private gain and other interests." Fair enough, as far as it goes. But the assumption is that "country", "ethical principles", and "law" are always in harmony. Only a moment's reflection is needed to show that this is not necessarily the case. Their posterity both in and out of medicine have never managed to forgive those Nazi physicians whose loyalty and obedience to "country" and "law" superseded that to the long-established "ethical principles" of their profession. But where <u>does</u> one turn when such a collision is inescapable and one must act? Despite its negation by many modern philosophers and

psychologists, conscience — an informed conscience — must remain the final arbiter of individual moral behavior in such situations.

When the military physician's duty of loyalty and obedience conflicts with his ethical standards he is morally obligated to adhere to the latter. In most instances of this nature some accomodation — "compromise" is too value-laden a term — is reached. But when one side, or the other, or both remain adamant, confrontation is inevitable and the conclusion preordained. Thus the well-publicized Vietnam-era case of Captain Howard B. Levy, who was court-martialed for his refusal, on grounds of conscience, to provide medical training to non-medical Special Force troops for use in Vietnam (12, 13). Prescinding from such ancillary issues as politicization of the medical enterprise, rejection of proffered alternatives, possibly confused data base, and ethical scrupulosity (14), the right of Captain Levy to reach his personal moral decision was in full accord with traditional medical ethics (15). He set his limits of loyalty and obedience ... but the Army did not concur.

Other military physicians in other milieux have adapted in other ways to the potential conflict between the requirement of loyalty and obedience to the organization and that of adherence to one's moral principles. Thus Edward M. Colbach, a Berry Plan psychiatrist, reported for active duty during the Vietnam War despite his strong reservations about its moral legitimacy (16). He shortly found himself in Vietnam as a combat psychiatrist. There his 12-month tour included participation in Medical Civil Action Patrols (MED CAPS), an experience that "degraded whatever medical ethic I still held onto" and that "certainly was demeaning of the Hippocratic Oath". Based as they are on his service as a

combat psychiatrist, his views on the limits of loyalty and obedience are particularly cogent:

> (I) ... have always believed that there probably is such a thing as a just war. St. Augustine and St. Thomas Aquinas first defined this. Essentially a just war is one that is initiated by legitimate authority with good intentions and for a good cause. War should be waged only as a last resort and always with the most limited means. Whether the Vietnam conflict fits these criteria or not is really beyond me to say. I did accept it as a just war when I agreed to serve in it.
>
> And once having acquiesced to my role as a military psychiatrist, I then had to accept that my obligation to my individual patient was far superseded by my obligation to the military and, eventually, to my country. This focus is the main ethic of military psychiatry.

Finally, brief mention is due biological warfare research, an area that necessarily involves physicians but which seems the very antithesis of the healing ethic (17). The distinction between "offensive" (and therefore morally unacceptable) and "defensive" (and therefore morally acceptable) biological warfare is a specious one that does not alter the ethical equation. One

might legitimately argue — though I do not (18) — that to require a military physician to participate in such endeavors would exceed acceptable limits of loyalty and obedience. Other targeted research, such as that relating to sickle cell trait in healthy military personnel, has less obvious ethical dimensions but could still pose a moral dilemma for some physicians in the armed forces (19).

CONCLUSION

As with the practice of medicine in general, military medicine may occasion ethical conflicts for the physician. These generally derive from tensions between the rights of the individual patient and those of the organization to which he belongs. Even in the military — or perhaps <u>especially</u> in the military — there are limits to the loyalty and obedience that the organization may demand of the physician. Analogous limits are seen in the civilian sector. Although medical ethical conflicts are inevitable in the military as elsewhere, they may be minimized by fostering an understanding of their origins and a program for their resolution. An informed conscience remains the final arbiter of any individual moral decision and — for the military physician — defines the limits of his loyalty and obedience.

Exculpatory Note:

I am fully aware that there are women physicians -- my wife is one, my daughter is a medical student — and I know, too, that there are women physicians in the military. With this acknowledgment, therefore, I justify my exclusive reliance on male pronouns in the foregoing for the sole purpose of avoiding awkward syntax.

— E.G.L.

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