

# Chapter 22

## SOCIETAL INFLUENCES AND THE ETHICS OF MILITARY HEALTHCARE

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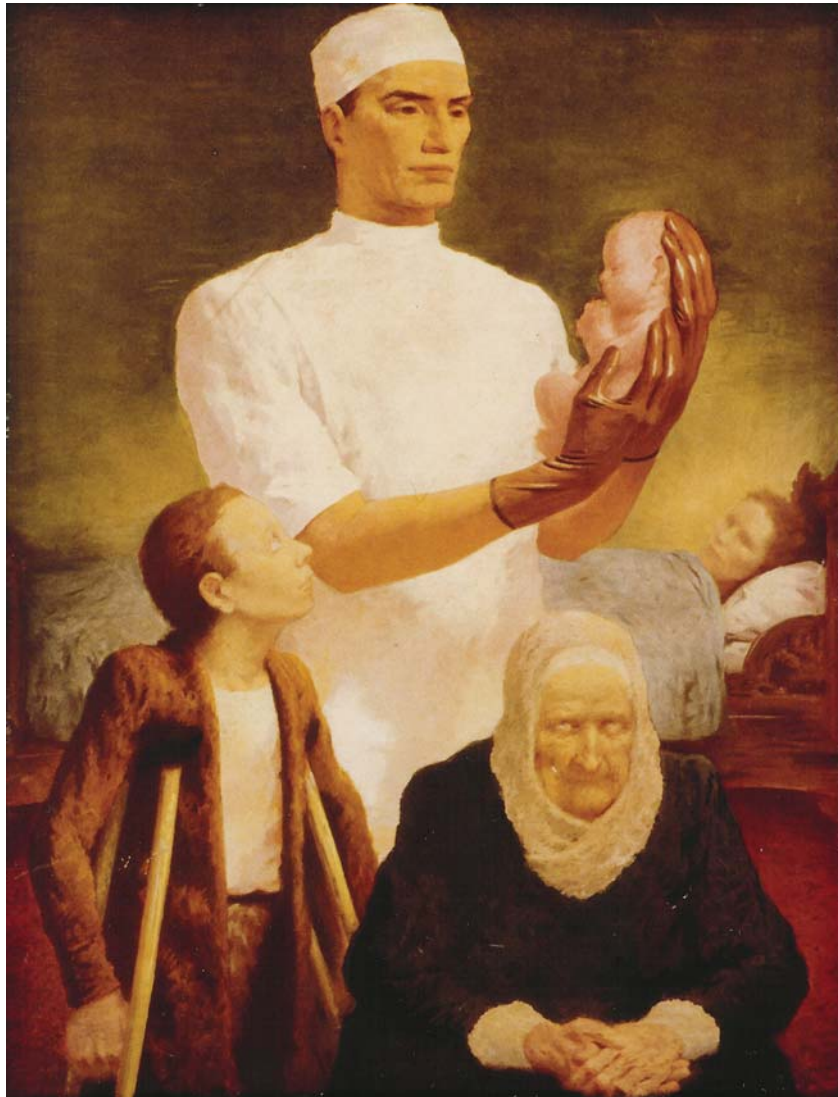
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J.O. Chapin

*The Doctor*

1944

The fourth of seven images from the series *The Seven Ages of a Physician*. The image portrays people in varying conditions, from the healthy newborn to the elderly woman. Within the military community there is a strong sense that military medicine will care for service members and their families from the cradle to the grave in exchange for the sacrifices that military life entails.

Art: Courtesy of Novartis Pharmaceuticals.

## INTRODUCTION

Military healthcare within the American armed forces is confronted by many challenges as it responds to the changing cultural environment of its host society, and a force that is currently composed of volunteers. As the demographics of the military force have changed in recent decades (more married personnel with families), the practice of military medicine, that is, battle-related care, has moved toward the practice of medicine in the military—care of military personnel and their family members. Further, in the aftermath of the large military mobilizations for World War II, Korea, Vietnam, and the Persian Gulf, veterans have increasingly been a part of the military healthcare system. These are obviously two quite different orientations. A significant component of this changing landscape has been an increasing division of moral-ethical considerations reflected within the larger American society. The questions are twofold: What *ought* or *should* military healthcare be? For whom should it *so be*? The pragmatic question that evolves, then, is for what and for whom is military medicine responsible?

The response of military healthcare to societal influences has been, and will continue to be, shaped

by two additional concerns. First is a growing recognition of the viability of the multidimensional conceptualization (physical, mental, and social) of well-being as argued by the World Health Organization.<sup>1,2</sup> By this is meant all aspects of the patient, not only as these aspects affect the results of the medical care, but, just as important, as the medical care affects the total patient. Second is a recognition of the importance of successful voluntary resocialization of healthcare personnel, as well as the consumers. Resocialization should be understood as a social-psychological process that functions to quickly transform the basic values, beliefs, motivations, and self-image of individuals. Examination of change within military healthcare in light of societal influences such as gender, those related to sexual preference, veterans' issues, and politics, will be under the umbrella of these dual perspectives of general well-being and voluntary resocialization. Thus, it is not enough for the military healthcare system to simply adjust its services to meet the physical needs of this expanding pool of patients. It must also adjust to meet the expanding views of this population of patients as they reflect the overall society from which they come.

## GENERAL WELL-BEING AND VOLUNTARY RESOCIALIZATION

The concept of overall well-being presents a challenge to medicine in general, but especially to military medicine, as the latter is indeed medicine within the context of the military. Voluntary resocialization is, likewise, an influence on the ethics of military healthcare. What, then, is well-being and what is its relationship to voluntary resocialization?

### Conceptualization of Well-Being

An emerging conceptualization of health status recognizes that it is a multidimensional phenomenon. In past decades a patient was often viewed as a human biological entity presenting with a specific complaint that a physician would address (ie, "the gallbladder in Room 110"; Chapter 3, Clinical Ethics: The Art of Medicine, discusses this in greater detail). The World Health Organization (WHO) addressed the goal of achieving a state of complete physical, mental, and social well-being for each individual. Its conception of health recognizes the complexity of all individuals, which is what medicine men and witch doctors of preliterate communities did when they treated the "whole man" for presented symptoms. How can one reconcile this

multidimensional approach to healthcare with the mission of the military in general and military medicine in particular?

The answer is that it is recognized that the primary objective of the armed forces is to maintain a state of operational readiness. Although the variables that contribute to such a state are numerous, it is doubtful that any are of greater importance than the physical well-being of military personnel. Social well-being variables such as family stability, role integration, and active participation with healthcare providers are likely to be important contributors to the efficiency of a system that is primarily focused on this physical well-being. A multidimensional approach, although at first glance seeming to be an additional tasking for the military, actually contributes to the military mission by increasing the well-being of soldiers, their families, and veterans. It is a combat multiplier.

Identification and quantification of relevant dimensions, however, can be difficult. Although dimensions of health such as mortality and life expectancy are clearly of high importance, and easily can be assessed quantitatively, many other salient dimensions, particularly those germane to social

well-being, are more qualitative in nature. Nonetheless, through a mixture of quantitative and qualitative interests, a more eclectic perspective of health appears to have grown in importance to contemporary healthcare consumers—including those eligible for military healthcare. This already complex issue is exacerbated by a continual expansion of the concept of social well-being that has necessitated a broadening of the scope of military medicine. Furthermore, because of constant personnel turnover, the evolution of any concept, including well-being, can be more rapid than it would be in a group that was relatively stable in terms of membership. It thus becomes necessary for the military to constantly resocialize its new members and, at the same time, be altered itself. Before examining this latter dynamic, it is important to first explore voluntary resocialization as it is experienced by the new member of the military.

### **Perspective on Resocialization**

In response to the primary goal of maintaining operational readiness, a major issue for the military relates to the transformation of a civilian mentality, formed on the basis of internalization of larger societal norms, into a military mentality—that is, to mold someone who can be counted on in combat, who will crawl through mud, remain for long periods in ice and snow, survive in desert conditions, who will kill when necessary, and who will give up his life if required. How is this transformation achieved?

The answer is resocialization. This phenomenon contrasts with continuous socialization, which is a slow, gradual process that incorporates into an existent base new material that is reasonably consistent with that which has been learned in the past. In comparison, resocialization represents a transformation process that is intense, occurs more rapidly, and is designed to change the basic values, beliefs, motivations, and self-image of persons.

Even with the recent emphasis on downsizing, approximately 150,000 persons enter the military each year. These new recruits have experienced at least 18 years of continuous civilian socialization. They come into the military with an identity molded by arrangements in the outside world. In order to generate operationally prepared military personnel, new members are stripped of the support that has been provided by these arrangements. Any number of techniques are utilized to accomplish this goal. Barriers are established to isolate the person

from the outside world. This is accomplished by limiting visitation, free time, and time away from the military installation. Claims to past statuses (education, occupation, income, social position) are denied. Trainees are instead responded to in terms of their military status. An important component of this transformation is a replacement of one's "identity kit." Those things that people employ to control how they appear to others—hairstyles, cosmetics, jewelry, clothes, cars—are taken away and replaced by a standard issue or "look," which is uniform in character and uniformly distributed.

From the standpoint of the military, institutional identification fosters organizational commitment; internalization of institutional values influences performance. Internalization will develop intrinsic motivation so that individuals will follow orders if they identify with the institutional values, norms, and goals. The experience of going through "hard times" together (ie, basic training, military academies, or officer candidate school) will promote group identification, commitment, and cohesion. All of these traits are important for military effectiveness. Indeed, it is argued that the stress experienced in training will help prepare the new member for stress that might be experienced later on the battlefield.

Given the severity of traditional training methods and environments, the military eased many of the more demanding parameters, especially those in basic training, with the advent of the All Volunteer Force (AVF) in 1973. This decision was based on the perception that insufficient numbers would volunteer to undergo the traditional rigors of training. However, widespread dissatisfaction with an absence of challenge was registered by recruits, drill instructors, and other training personnel. Consequently, disappointment with lesser expectations resulted in a return to more traditional training methods and procedures.

Since the advent of the AVF, the recruitment and resocialization processes of the military have undergone change, which has been identified by Moskos in his discussion of the institutional/occupational thesis.<sup>3</sup> According to Moskos, on the organizational (macro) level, the military is experiencing a change from an institution to an occupation. On the individual (micro) level, the military is becoming a job in the workplace. This contrasts strongly to the military as a "calling," in the classical Weberian sense, that the traditional military was perceived to share with the clergy and educators.

The shift from an institution to workplace in-

volves a shift from concern with collective well-being to assumptions about self-interest. Accordingly, military recruiters now emphasize financial and job-related aspects. The United States has traveled a long distance from the traditional “Uncle Sam Wants You,” to the slogan of the 1990s—“It’s a Good Place to Begin,” or the more current “I Am an Army of One.” Moskos views this change as a linear development. Interestingly, Segal argues that this is more similar to a wave, or curvilinear, pattern. That is, at any given time, and dependent on world conditions, if the military must enter into combat, a return to an institutional format will be observed.<sup>4(p72)</sup> When the going gets tough, the tough get “gung ho,” and the job gets transformed into a calling.

Regardless of which perspective one embraces, and even with a focus on marketplace considerations, the military is, and will remain, at least subtly, different from the civilian society. The organizational view remains vertical as opposed to horizontal, that is, military people see themselves as having something in common with those above and below them hierarchically and in different jobs while civilians are more likely to view people who have the same job, even if in another organization, as their primary reference group. Role commitment in the military, then, is much more diffuse. Military personnel perform a much wider range of tasks, including things that are not part of the “job.”

Furthermore, integration of the family and the military is more intense than that of the family in civilian occupations. The family is seen as an adjunct to the military system, with institutional demands extended to family members. However, an increasing number of civilian spouses do not believe the military has, or should have, the right to expose them to demands. This civilian-military competition has generated the “greedy institution” conflict argument advanced by Coser,<sup>5(pp89-100)</sup> whereby the military and civilian family members compete for the time and energy of the service member. Accordingly, the resocialization efforts of the military cannot be directed exclusively toward the military members, as they are also part of a family unit.

### **Resocialization and Military Medicine**

Ethically the parameters of healthcare concerns, as they apply to the military, must embrace all of these issues as components of medicine in the military, and must be cognizant of the specific demands of military medicine as they relate to operational

readiness. Although it is generally assumed that military healthcare personnel can make the transition smoothly from the practice of general medicine in the military to the practice of military medicine, most cannot. Indeed, Llewellyn has noted that, “the practice of medicine and surgery in peacetime prepares physicians for war as well as civilian police department duty would prepare infantry for combat, or as well as commercial aviation experience prepares pilots for close air support in wartime.”<sup>6(p192)</sup> The point is further emphasized by Smith, who has posited that recognition of the theoretical and practical differences of military medicine and practicing medicine in the military will have dramatic effects on combat preparedness for military healthcare personnel.<sup>7</sup>

The ability to make this transition will depend on the success of resocialization efforts for those who will be called upon to practice military medicine. Complicating the transition is the fact that adaptation to military medicine environments is becoming more demanding as the technological development of weapons continues on a more sophisticated path. Practitioners of military medicine must be familiar with any number of potential dangers that are generally not present in the larger society. Among these are the increased lethality and accuracy of modern weapons, including precision guided-missile threats; major threats of tissue damage through burns, blasts, and crush injuries; and the practice of preventive medicine to reduce the impact of environmental stresses, diseases, and accidental injuries.<sup>7</sup>

It should be further noted that the threat of increased missile usage, nuclear or otherwise, has served to democratize the risk factor of modern warfare. The idea of “democratization of risk” was initially introduced by Lasswell in 1937 as a component of his garrison state construct. His concern was generated by the weapon delivery capacity of the airplane. In the interim, with dramatically increased sophisticated delivery systems, in conjunction with the large areas that would be affected by the destructive power of modern weaponry, “democratization of risk,” in effect has expanded to place everyone at risk.<sup>8</sup>

It may well be that military healthcare personnel will have to be more widely dispersed in order to treat those injured over a much wider area. Given this scenario, it is virtually inevitable that the primary mission of military medicine would be compromised, and would give rise to some questions of ethical consideration.

## OVERVIEW OF SOCIETAL INFLUENCES

As America enters the 21st century, it is clear that healthcare is experiencing a major transitional period. As a part of the American culture, military medicine is similarly engaged in altering its parameters, especially in terms of access, quality of care, and cost. Further, it is increasingly recognized that the sense of well-being of military personnel is dramatically affected by the sense of satisfaction with the health of each family member and the delivery of healthcare to all family members. Additionally, the decision whether to remain in the military will be influenced by similar perceptions of those who have previously served and who are eligible for healthcare benefits.<sup>9(p1)</sup> That is, are veterans, with whom military personnel interact or learn about, satisfied with the manner in which military healthcare has met their needs once they are no longer in uniform?

The complexity is increased by two important concerns: (1) the sociodemographic diversity of persons currently serving and those eligible for military healthcare benefits; and (most important for this collection of works) (2) the ethics of military medicine. The following is a discussion regarding ethical delivery of military healthcare to this diverse consumer base within a constantly changing environment.

Despite the focus of this volume, some may perceive a discussion of ethics as superfluous. Most persons see themselves as being ethical people who, when confronted by a choice, do the right thing. Nevertheless, there is a current explosion of interest regarding ethical considerations that is affecting a vast array of social institutions, including that of medicine. Indeed, every medical school now has at least one ethicist as a faculty member. Further, bibliographic citations germane to ethics have expanded to where they can only be described as voluminous.

The growth of public interest in ethics has significantly influenced the manner in which researchers plan and conduct their research, as well as the way in which practitioners present themselves to consumers of their skills. Although initial concern focused on biomedical research and the clear potential for harm to those willing to participate in such empirical efforts, attention has expanded to include any area of inquiry or presentation that involves human respondents. This does not mean that researchers or practitioners were previously without ethics or concern for human respondents or consumers, but such concern had traditionally been

passed from generation to generation by word of mouth, mentor to student, and in the classroom. That practice has been supplanted with more “formalized” concern.

Ethical concern is not limited to researchers and practitioners. Governmental policy, as it effects eligibility for receipt of care, is also of significant interest. That policy has changed substantially over the past several decades in response to events within the overall society. During the 1960s, for instance, America witnessed a number of radical movements, with subsequent social change. The civil rights movement, beginning with the 1954 *Brown v Board of Education* desegregation decision, grew at the same time that emerging feminism reflected a substantive ideological shift in appropriate-inappropriate social roles for men and women, and the antiwar movement, in protest of America’s involvement in Vietnam, forced many citizens to reevaluate the right and proper role of the government and the military in political policies. The occasion of these historical benchmarks signaled cultural changes that were inevitably to find expression in altered sociodemographic profiles within the US armed forces.

Significantly, gender, racial and ethnic identities have been differentially represented following the advent of the AVF. That is, the number and proportion of minorities (women, African-Americans, and Hispanic Americans) serving in the armed forces have increased. As a part of the larger society, military policy and engagement were inevitably and inextricably interwoven by both the civil and the equal rights movements.

The changes that have occurred were not isolated to active duty concerns. From the perspective of veterans of US military service, the importance of ethical considerations has been further underlined by the controversies regarding the legitimacy of posttraumatic stress disorder (PTSD) as a psychiatric diagnosis, and the consequences of exposure to Agent Orange during the Vietnam conflict. In the face of a decade of extreme opposition, veterans of the Vietnam War were successful in getting PTSD included in the American Psychiatric Association’s third edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), published in 1980, as well as the subsequent revised version (DSM-III-R). They also gained treatment and compensation for health conditions associated with exposure to the herbicide, Agent Orange. The narrative of these two

struggles is offered through Scott's examination of the politics of readjustment of Vietnam veterans.<sup>10</sup> He describes the inevitable imbalance between the indebtedness a nation has to its warriors and the postwar unwillingness to provide adequate gratitude and retribution. Such issues provide strong support for the importance of the ethics of policy formation and implementation. Although Scott has chronicled some dramatic victories for the Vietnam veteran, recovery has been less than total.

The ethical considerations of political policy for the Vietnam veteran may be mirrored by similar considerations for Persian Gulf veterans whose illnesses, including fatigue, rashes, and tumors, have stymied researchers. Reaction to the so-called "Gulf War syndrome" has been more complicated as a number of expert panels have failed to locate evidence of a new or unique Gulf-War-related disease. Nevertheless, there does seem to be a medical consensus that the variety of symptoms presented by Persian Gulf War veterans may be connected to their service within that environment.

In contrast to the political battle that raged over PTSD, Congress quickly responded to the presentation of Gulf War illnesses by providing temporary disability benefits, funding for additional research, and allocating funds for marriage and family counseling. This recognition of the legitimacy of presented symptoms, which are possibly reflective of exposure to health-threatening stimuli while in the service of the United States, suggests a more appropriate ethical posture.

Additionally, the Veteran's Administration has responded favorably by making available a complete physical examination to all Persian Gulf veterans; a 24-hours-per-day information center; a designated physician at every VA medical center to accommodate examinations, receive updated information and educational materials, and to provide follow-up care; and Persian Gulf Referral Centers.<sup>11</sup> More than 100,000 of the approximately 697,000 men and women who served in the Persian Gulf War (1990–1991) have reported symptoms. This number may expand in the future.

Despite the early congressional response, the Department of Defense (DoD) was cautious in its response to these reports of exposure to various

agents. Ultimately, President Clinton, in an unusual move, appointed an oversight board to assist the direction of the DoD investigation.<sup>12</sup> An initially emphasized hypothesis of the cause of the Gulf War symptoms was stress. Additional inquiry has resulted in the acknowledgment that these symptoms may evolve from any number of environmental substances including the above noted depleted uranium, pesticides, battlefield drugs, and even nerve gas. Unfortunately, the absence of baseline data on the health of military personnel, and the lack of reliable exposure data renders it difficult to be specific in the identification of the cause(s) of the symptoms.<sup>13(p1)</sup> The cause(s) of Gulf War illnesses, however, as well as the treatment of such, continue to be influenced by an inextricable entanglement of political, medical, and social pressures.

In essence, it is here argued that there is a growing recognition that military healthcare must be responsive to the changing environments of the civilian society that it serves. Although it is widely acknowledged that the military engages in dramatic resocialization efforts in order to satisfactorily train personnel for operational readiness, social changes may dictate modification of those resocialization efforts, including the breakdown of artificial barriers and facilitation of interactive cooperation, in terms of the delivery and receipt of military healthcare for persons of different subcultural backgrounds.

The dual perspectives of general well-being and resocialization have not been traditionally included under the healthcare umbrella. They are addressed here, however, in recognition of the appropriateness of the World Health Organization's objective of health and social well-being. Further, exclusion of specific social variables such as racial-ethnic health considerations, family health, and health issues unique to women and homosexuals may have been due to a belief that these concerns were of a temporary nature. It is not likely that these issues will "fade away." Assuming for a moment, however, that these social concerns are all passing societal fads, a great deal of transferable insight might be gained by the study of any social pathology. The parallels that are currently being drawn between the integration of African-Americans and women as minority components of the military offer but one example.

## GENDER CONSIDERATIONS

A discussion of military healthcare delivery to women must include a number of population segments. Principal among these are the women who

serve as members of the military, and those who are civilian spouses (also often referred to as "military wives") of military personnel. Although civil-

ian men may be spouses of military personnel, the overwhelming majority of civilian spouses are female. Beyond personal health issues, these military wives are concerned with family health issues, and these will be addressed in this section as well.

### **Women in the Armed Forces**

Historically, one of the central concerns regarding women's utilization in the military has been the effect of service on their health. Similarly, concern has been expressed regarding the effect of women's health status on operational readiness.<sup>14(p75)</sup> During World War II, for instance, gynecological and obstetrical issues were the most frequently cited concerns regarding women's participation in the armed forces.<sup>15</sup> Although women did have 36% more sick calls than men, 70% more colds, and twice the rate of dysentery, pregnancy rates were so low that a special pregnancy policy was not enacted.<sup>15</sup> Indeed, the higher sick call rates for women were viewed positively as they were perceived by the Surgeon General's Office as preventive medicine. In contrast, men were much more likely, for example, to seek medical treatment for pneumonia, rheumatic fever, and other conditions that called for longer hospital stays<sup>15</sup> and therefore functioned as a greater interference to the maintenance of operational readiness.

There has been a very large increase in the proportion of the armed services composed of women since the advent of the AVF in 1973. When America's armed forces began to draw their personnel from volunteers, women made up less than 2% of America's military manpower. The female proportion today is closer to 14%, although the percentage of women within the individual branches differs significantly. The US Air Force is the most receptive, with approximately 18% of its members being female, while the US Marine Corps is the least so, with only 5% of its membership composed of women.<sup>16</sup> These differences likely reflect the differing missions of the services, the former being more technological, while the latter is more directly involved in combat. Definition of appropriate roles for women to enact within the military also has undergone significant expansion. Women are now included within the complement of combatants, although the individual branches of the service have expanded their numbers and opportunities differentially.

In response to the changing roles of women in the military, the Department of Defense appointed a task force in the late 1980s to study relevant issues. One of these concerns was the adequacy of medical care for women's health needs.<sup>17(p32)</sup> As be-

fore, the focus was on the effect of service on women's health, and the effect of women's health on operational readiness. Health issues that women have in common with men were also addressed. For example, although significantly greater for men, women also compromise readiness through illicit drug usage, smoking, and their consumption of alcohol. Heavy drinking and being able to "hold one's liquor" have traditionally been assessments "of suitability of the demanding masculine military role."<sup>18(p133)</sup> Resocialization efforts are reflected in DoD policy that is oriented toward preventing and minimizing pejorative effects of heavy alcohol, drug, and tobacco use on military performance, and to encourage behavior that would contribute to optimum health and fitness.

In a methodologically sophisticated comparison of data gathered from five worldwide surveys of military personnel, Bray and colleagues<sup>19</sup> determined that the overall use of these substances among military personnel has declined due to effective preventive substance use programs, the promotion of health programs, reduced rates of smoking and illicit drug usage within the civilian population from which military personnel are recruited, and an overall improvement of quality of recruits. Because some female and male recruits continue to use these substances the proposition that missed duty time can and will result from these poor health habits can be reasonably advanced.

On another dimension, it is clear that each environment in which persons are located presents a different set of physical and chemical agents that may serve as health risks. Although this is obviously true for male and female personnel, the expanding military occupational opportunities for women members of the military offer additional concern. For instance, according to Kanter,<sup>20</sup> women may experience stress because of their minority status within a predominantly male institution. (He also notes that women would be expected to experience greater stress until their numbers exceed 15%–20% of the total.) Although the frequency of sexual harassment is not currently quantifiable, it is nonetheless a stressful experience for most women.

Hoiberg and White<sup>14</sup> posited that these environmental, occupational, and social-psychological factors might well contribute to an increased risk of ill health among female military personnel. In the early years of the AVF, as the number of women, and their proportion of the total force, began to increase, their hospitalization rates for virtually all diagnostic categories, as well as for psychosocial stress related disorders such as transient situational



disturbances, neuroses, personality disorders, and gastrointestinal problems, were higher than those reported for men.<sup>14(p75)</sup> However, in a 15-year longitudinal study of the health status of enlisted women in the US Navy, and a comparison with women members of other branches of the service, Hoiberg and White concluded that the overall health levels of female military personnel had not worsened, but actually improved.<sup>14(pp89-90)</sup> This is likely to reflect a time of growing numbers and expanded occupational opportunities. Increases and decreases in hospitalization rates, dependent on diagnostic categories, were seen during this 15-year period, as were variant rates across cohort groups. One important category that reflected an increase in hospitalization rates was that of pregnancy. Indeed, this category accounted for one-third of the admissions during this 15-year period. (It should be noted that the overwhelming majority of women in the military are within the fecund age range as defined by the Bureau of the Census, ie, 15-44.)

This rather dramatic observation provides an opportunity to examine a military healthcare policy from practical and ethical perspectives. Traditionally, female military personnel who became pregnant were automatically discharged. Pragmatically this policy might have reduced immediate healthcare costs. However, long-term financial expenditures were probably increased because of it. Among other cost considerations, such as uniforms and equipment, recruitment and training expenses related to replacement efforts most certainly exceeded the price of treatment for pregnancy and delivery.

Further, as the AVF has expanded its reliance on females to satisfy manpower needs, the value of retaining trained personnel has increased. This is particularly important to note as women are invited to join the ranks of an increasing number of military occupational specialties. As more women avail themselves of this opportunity, the issue of training costs, including time required to complete training, for highly skilled personnel becomes a more central concern.

The ethical argument fits "hand in glove" with the practical considerations. From an ethical perspective, it is clearly unfair to punish females for becoming pregnant by expulsion when the participation of a male is required for the attainment of that status. Further, it has been suggested that women might be less inclined to experience long and difficult training if they were confronted with an automatic discharge if they became pregnant. Therefore, it is argued here that the change in pregnancy policy of the military that permits women

who become pregnant to remain in the military if they wish, reflects an ethically correct decision. This change is also perceived to be economically sound, and to contribute positively to the primary goal of operational readiness.

Similarly, a second major category of admissions are those for conditions related to pregnancy. These include spontaneous abortions, disease of the ovary, and symptoms of the genitourinary system. In the same manner that the above argument regarding pregnancy was advanced, it is perceived to be crucial, from an ethical perspective, to afford this category substantial analysis. Are these conditions reflective of possible exposure to occupational reproduction hazards, such as biological or chemical agents, radiation, or high stress levels?

Data from the Hoiberg and White study indicate that women are most susceptible to stress-related conditions during the first year of their service. These data indicate a need for a more comprehensive effort to prepare women for a military career. It is my opinion that the more recent move toward gender-mixed basic training is an ethical and responsible move toward that end, and reflects a major change in the thrust of military resocialization efforts. Candidly, however, the large number of sexual abuse cases experienced by the armed forces during the second half of the 1990s generated substantial additional reconsideration of this issue.

Hospital rates for mental disorders, respiratory and infectious diseases, as well as accidental injury rates declined during the time of the study. The improvement of occupational training methods has influenced the latter.<sup>14(pp79-90)</sup> All of these conditions have been aided, however, by the collective DoD directives mandating a healthier lifestyle. These directives have become an inherent component of the resocialization process of military personnel.<sup>21</sup>

Although these data are encouraging and represent findings that are similar to those noted for civilian workers, the military must provide somewhat different specialty practitioners. Military medicine was specifically designed to provide as efficient care as possible to those wounded in battle. For the most part, this called for a physician staff composed primarily, if not exclusively, of battlefield surgeons. The importance of this component to victory may be noted by a historically greater loss of personnel for medical reasons than loss to enemy fire. For example, during the War Between the States (ie, the American Civil War) it is estimated that the ratio of deaths from disease versus combat was 2:1 for Union forces and 3:1 for Confederate forces.<sup>22</sup>

With the dramatic increase in female personnel,

in conjunction with the force becoming one in which the majority is married, specialists of a wide variety, including obstetricians, gynecologists, pediatricians, and psychiatrists, have become ethically, if not legally, mandated. This change in medical personnel has required a substantial resocialization effort, especially of the senior commissioned and noncommissioned officers who came into the military when it was predominantly a bachelor and male-dominated institution.

### **Military Care Issues Related to Military Spouses and Children**

Although the primary mission of the Military Health Services System (MHSS) is to maintain the health of military personnel for the purpose of operational readiness, the military medical system provides care to family members and retirees and their family members where space and professional services are available. Even though the reduction in force size has affected the number of potential beneficiaries, there remain within the present military healthcare system approximately 8.5 million persons eligible for healthcare programs.<sup>23</sup> A substantial proportion of those eligible are civilian spouses and dependent children. It is impossible for military medical care providers to accurately predict for whom or for what reason care will be requested from the potential consumer population. It must be recognized also that healthcare demands will come from multiple sources competing for scarce resources (ie, competing branches of the services including base hospitals, PRIMUS [Primary Care for the Uniformed Services] and NAVCARE [Navy Care] clinic facilities, Uniformed Services Treatment Facilities, TRICARE [Tri-Service Care], Medicare, Veterans Administration hospitals, and other third-party insurers, including health maintenance organizations [HMOs] and preferred provider organizations [PPOs]).<sup>24</sup> In response to the complexity of beneficiaries, the provider network and expanding costs, DoD has initiated implementation of a new management initiative labeled TRICARE.

Since 1967 civilian healthcare has been provided to military dependents, retirees, and retiree's dependents through the fee for service Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS was initiated to provide healthcare benefits to retired personnel until they were 65 years of age and eligible for Medicare. The proportion of the eligible population of beneficiaries grew from about 8% in 1950 to over 50% in 1997.

A similar rise in the number of beneficiaries occurred after the armed services became an all volunteer force in 1973. This signaled the beginning of a growing population of active duty personnel who are married. Although civilian spouses and children could receive healthcare at military medical facilities, such care was available also through CHAMPUS. Beginning in 1995, DoD began to provide beneficiaries with TRICARE, or three selection options. The three legs of this program include: (1) receipt of care through a DoD managed health maintenance organization (HMO); (2) receipt of care through a preferred provider organization (PPO); or (3) continued use of CHAMPUS.<sup>25</sup>

As noted, an important reason for the advent of TRICARE was to reduce healthcare expenditures. Success has not been achieved on this dimension. As a result, additional action is under consideration. One idea currently being tested is Medicare subvention funding. Under this program, MHSS would receive payment from Medicare for care provided military retirees 65 years of age and older. Reactions to this program have been mixed.<sup>26</sup> Other options for retirees currently under consideration involve extending access to the Federal Employees Health Benefits Program (FEHBP) and extending eligibility for TRICARE.<sup>26(p2)</sup>

In light of the smaller number of active duty personnel, a 15% reduction in military medical personnel, and one-third fewer military hospitals, some students of military healthcare have, less generously, proposed a major curtailment of those eligible to receive military healthcare. The argument is to serve only active duty personnel. Although this type of proposal is not likely to be seriously considered, it does symbolize the vulnerability of ethical and moral considerations when confronted with the reality of economic constraints.

Beyond the organization of care options, mention should be made of complaints about care received in military medical facilities. Such complaints have been ongoing since the availability of healthcare to military dependents (after the Korean War) and continued into the 1990s. Some consumer criticism is justified and some can be explained by factors unique to the military. For example, because military personnel and their family members are a transient population, due to the reassignment system, there is limited opportunity to maintain continuity of care. Continuous care provided by the same healthcare professional(s) has long been a significant variable in accounting for the degree of satisfaction expressed by consumers of healthcare. Patients utilizing civilian health maintenance organi-

zations have, in recent years, expressed the same dissatisfaction. Burrelli<sup>27</sup> has noted that mobility also contributes to dissatisfaction because of an inconsistent quality of services offered at different installations. Indeed, it can be argued reasonably that because mobility increases one's exposure to treatment by multiple healthcare professionals there is an inevitable increase in recognition and awareness of the disparity of care offered.

Dissatisfaction, of course, can be profitably used to identify areas of concern that can and should be addressed. With regard to this discussion, one of the most important latent functions of healthcare, as provided by the military, is the level of satisfaction registered by all members of the family unit. Orthner<sup>28</sup> and Stanley, Segal, and Laughton<sup>29</sup> have noted in research regarding family contributions to work commitments that spouse support was the most important predictor of a career commitment among married men in the military. Thus, satisfaction with healthcare received by a civilian spouse and

children disproportionately influences reenlistment decisions.

This is increasingly important to recognize within the AVF, where maintenance of the historical 50-50 mix between careerist and first-termers is sought. Ensuring that one of every two volunteers reenlists requires addressing the concerns of these people. Given that the majority of the force is now married, the contentment of the civilian spouse assumes additional importance. Discontentment with military healthcare may encourage a larger proportion of first term enlistees to decline an invitation to remain. Indeed, the availability of military healthcare has traditionally been a more important part of the recruitment and retention strategies for military personnel than for private employers. As such, healthcare is a critical issue for the overall strategic posture and effectiveness of US military organizations. (Exhibit 22-1 offers background information on healthcare for military family members and suggests a system for providing that care in the future.)

## SEXUAL PREFERENCE

It is difficult to conceive of any issue that has or could generate the level of controversy observed regarding issues of sexual preference for individuals serving in the US armed services. Viewed retrospectively, the integration of African-Americans and the increasing acceptance of women in roles previously considered inappropriate, including that of combatants, have been hugely successful in resocializing those who so strongly resented the presence of African-Americans and women. Indeed, the old traditional notion that democracy has no place in the military, and would only serve to undermine good order, is no longer chanted with such reverence. Similar success in the area of acceptance of sexual preference, and with it the integration of homosexuals into the military, however, is more problematic.

The United States is not the first country to debate the issue of homosexuals serving in the military. Most Western democracies with an industrialized economy have confronted this issue in one form or another. Inevitably, industrialization, accompanied by urbanization, has functioned to introduce dramatic social change. One significant evolution has been the democratic ethos that extends the equality of citizenship rights to previously excluded categories of persons,<sup>30(p261)</sup> for example, within the US military. This process has served to enhance capability and increase manpower, and has resulted in the integration of African-Americans

and the increasing acceptance of women in nontraditional military roles.

The social-historical context of the country, the military, and their interrelationship will be the backdrop in determining future policies and practices regarding homosexuals within the US military. Scott and Stanley<sup>30</sup> have suggested that the issue of homosexuality provides a series of challenges to the military, not as a causal variable, but as one of the changes introduced through modernization. Indeed, prior to the evolution of any degree of tolerance for homosexuality, the traditional reproductive and economic functions of the family experienced significant redefinition.<sup>30(p262)</sup> The weakening of institutions has resulted in placing greater priority on individualism, personal freedom, and satisfaction than on group interests. However, dispute associated with issues surrounding homosexuality continues, as is noted by the moral imperatives articulated by the conservative perspective and the emphasis on civil rights and equality of opportunity presented by more liberal advocates.

Societal views of homosexuality have undergone change in the past few decades. Pursuant to general *American Psychological Association* guidelines, more persons now perceive homosexuality as a lifestyle, deviant or alternative, chosen or genetically determined, than as a pathology. An increased level of tolerance has resulted in greater support in public sectors such as employment and housing, but

## EXHIBIT 22-1

### THE PAST, PRESENT, AND FUTURE OF HEALTHCARE FOR RETIREES AND FAMILY MEMBERS

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Although the statutory authority for the provision of healthcare was not clear historically, the origin of the belief that easy-access and high-quality healthcare is a right of members of the military and their family members as well as retirees and their family members has been explained by Burrelli.

Health care for retirees and dependents has always been considered a somewhat ancillary function of the military health care system. Prior to 1956, the statutory authority to provide health care to retirees and dependents was not clear. The Dependents' Medical Care Act (Public Law 84-569); June 7, 1956; 70 Stat. 250) described and defined retiree/dependent eligibility for health care at military facilities as being on a space available basis. Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space available basis. This legislation also authorized the imposition of charges for outpatient care for such dependents as determined by the Secretary of Defense. Although no authority for entitlements was extended to retirees and their dependents, the availability of health care was almost assured given the small number of such persons. Therefore, while not legally authorized, for many the "promise" of "free" health care "for life" was functionally true. This "promise," it is widely believed, was and continues to be a useful tool for recruiting and retention purposes.<sup>1(p2)</sup>

Even though it is impossible to predict the rate of usage by those who perceive themselves to be eligible, the annual requests by number and cost have consistently surpassed the estimates put forth by the Department of Defense.<sup>2(p551)</sup> If the "promise" of "free" healthcare "for life" is to continue within an increasingly complex environment, attention must be directed to the manner in which it will be delivered. Blair, Stanley, and Whitehead<sup>2</sup> have proposed a stakeholder management strategy to transform the complex relationships within and between the variety of organizations comprising the military healthcare system into a logical, systematic framework that can be communicated and acted on, such as that proposed by Blair and Fottler.<sup>3(p556)</sup>

Stakeholders within the military healthcare system are numerous and any effort of management will be complex. They include beneficiaries, providers, politicians, and a number of special interest groups such as the American Medical Association (AMA) and the American Association of Retired Persons (AARP). Military healthcare also exists in the public sector and is thereby the target of political pressures from diverse patient groups represented by enlisted and officer, active and retired, and veterans groups as well as that of the US Congress. Clearly, interests and motivations of these diverse stakeholders are not always congruent. However, to survive the dramatic changes currently facing the military healthcare system, healthcare leaders must improve their management of internal and external stakeholders.

Sources: (1) Burrelli DF. *Military Health Care/CHAMPUS Management Initiatives*, CRS Report for Congress 91-420F; Washington, DC: Congressional Research Service, Library of Congress; May 1991: 2. (2) Blair JD, Stanley J, Whitehead CJ. A stakeholder management perspective on military health care. *Armed Forces Soc.* 1992;18(4):548-575. (3) Blair JD, Fottler MD. *Challenges in Health Care Management: Strategic Perspectives for Managing Key Stakeholders*. San Francisco: Jossey Bass; 1990.

most persons remain reluctant to extend equal opportunities in the more personal areas such as the right to marry or adopt children. Hesitancy about the latter holds implications for the status of homosexuals in American society. The US military is inevitably affected by this conflicting configuration of tolerance and intolerance. By altering the exclusionary ban within the military, powerful feelings and political components, in and outside of the military, continue to experience confrontation.

It can be argued that the general phenomenon of modernization has worked to weaken the boundaries between the military and society and that the meaning of service has been altered. Traditionally, military service was perceived as a rite of passage

into manhood and an obligation of citizenship. More recently, serving in the armed forces has begun to be viewed as a right versus obligation of citizenship, and represents a path through which additional rights may be achieved. As Moskos' institutional/occupational thesis has suggested, military service is now viewed as affording employment opportunities and benefits, rather than as a "calling."

The collective role of the military has also undergone change. Although the central role remains that of maintenance of operational readiness (ie, to protect and defend the nation), supplemental tasks (ie, peacekeeping) and humanitarian functions (ie, relief and rescue missions) have emerged. These changing roles have encouraged successful resocial-

ization efforts toward the inclusion of previously excluded groups, especially women. Demand for traditional masculine skills has been replaced, or at least reduced, by the increasing need for technical, administrative, clerical, social work, and healthcare functions.

Despite these restructuring changes, resistance to the integration of homosexuals remains strong. This resistance, however, is not universal, and evidence indicates that it is much more likely to be expressed by male than female service members. Males have reported a variety of concerns regarding such issues as potential threats to morale, cohesion, and effectiveness associated with the integration of homosexuals. Although advocates of civil rights and equal opportunity for homosexuals have argued similarities with the integration of African-Americans and women, a number of differences can be identified. Skin color, race, and gender are seen as simple biological traits. In contrast, homosexuality has behavioral components that challenge traditional values that are expressed in assumptions about morality, sexuality, and masculinity. Given that the presence of women called into question the military as a masculine domain, homosexuality extends the question.

The variable of timing, in conjunction with other issues of importance to the society, is one of the most important determinants of the likelihood of an element of social change being adopted or rejected. The timing of the introduction of the ideas of integration of African-Americans and women are illustrative. Successful integration of African-Americans was aided by the military necessity of manpower for the Korean War. Integration of women was facilitated by the move toward the AVF and personnel needs related to technology. However, contemporary reduced manpower needs do not argue for recognition of homosexuals. Further, cultural ambivalence and an absence of a supportive legal environment will likely impede the integration of gays and lesbians into the larger society and the military as a microcosm thereof.<sup>30(pp262-263)</sup>

Nevertheless, homosexuality in the military continues to receive increasing attention from academic and lay publications. The complexity of the issue from the perspective of individual and civil rights, legalities of exclusion-inclusion, profiles of other nations' integrative efforts, and debate regarding ethical and moral considerations precludes easy and simplistic solutions, such as the current "Don't Ask, Don't Tell" policy. However, the thought and reason represented in a continued dialogue will enhance understanding and provide a backdrop for the evolution of social and military policy.

## **The Impact of Acquired Immunodeficiency Syndrome**

Practitioners of healthcare within the military have long dealt with sexually transmitted diseases (STDs). Venereal diseases such as syphilis or gonorrhea, however, were primarily transmitted through heterosexual intercourse. In order to respond appropriately to an STD that was originally related to homosexual behavior, some resocialization effort was required in order for military healthcare professionals to begin to accommodate those persons infected with the human immunodeficiency virus (HIV), which can become acquired immunodeficiency syndrome (AIDS). AIDS is a contagious and fatal disease that has generated considerable controversy throughout the world. Upon the discovery of AIDS in 1984, initial research indicated that the virus was transmitted sexually through bodily fluids, the sharing of needles by intravenous (IV) drug users, or contact with tainted blood. Although one can obviously contract HIV / AIDS through any number of activities, including heterosexual intercourse, AIDS cases in the United States had been concentrated among those individuals engaging in homosexual acts and IV drug usage. These high-risk behaviors had accounted for the vast majority of all AIDS cases.<sup>31(p453)</sup> Increasing incidence of transmission through heterosexual contact will alter this profile in years to come.

Perhaps a brief note regarding progress in the treatment of those experiencing HIV / AIDS will be helpful. The very early research for drugs to block the replication and growth of the virus experienced a dramatically positive result with the discovery of azidothymidine (AZT). This drug, first tested with patients in July 1985, was demonstrated to have such efficacy in retarding the disease progression that the US Food and Drug Administration (FDA) approved it for marketing in March 1987.<sup>32(p159)</sup> Inevitably, such success elevated expectations for a cure to be developed quickly. However, only four additional drugs, zidovudine, didanosine, zalcitabine, and stavudine, all with limited effectiveness, were licensed by the FDA through the following decade. This slowing of progress introduced the question of whether a combination of drugs could enhance the success of AZT.<sup>32(pp159-161)</sup>

In response, a number of research protocols with various drug combinations were initiated. Early results of some of these combinations are promising for those fortunate enough to have access to, and respond to, such therapy. The "cocktail" mixture of drugs seems to have slowed the progression of the disease and stimulated hope for many. As

with the introduction of AZT, however, the hope may well be false hope. That is, some may believe that if they become infected it will not constitute a significant problem because of the available drug therapies.

AIDS has been 100% fatal in the past. Even though the cocktail has had dramatic effects on the progression of the disease, it is too early to cite a cure, or even permanent management of the disease. Further, and as with other diseases, HIV/AIDS is hosted and develops differently in different individuals. It must be remembered that each of us is a unique biochemical organism. Consequently, no two persons will receive treatment modalities with precisely the same results.

While the incidence of AIDS has continued to increase within the general population, the rate among military applicants has declined, as has the number who originally tested negative, but subsequently registered a positive result—the seroconversion rate.<sup>31(p454)</sup> These positive observations concerning military applicants are reflective of the ability of the Department of Defense to assume the lead in dealing with contagious diseases. Because of the military's ability to introduce large-scale observation and treatment, it has become an ideal institution within which at least some societal policies can be introduced and examined.

The assumption of an active role by the military regarding HIV/AIDS, however, has not been embraced by all armed forces personnel. Initially, the human immunodeficiency virus and AIDS were identified primarily among homosexuals and IV drug users, and that perception has been slow to change. These are categories of persons whom the military has prohibited from enlisting in the past. Even though the military in the mid-1990s introduced the "Don't Ask, Don't Tell" policy for homosexuals, the implementation and interpretation of this policy have been inconsistent within and across the services. Controversy regarding individual civil rights and privacy versus protection of the general public has surrounded DoD policy related to those who test positive. In addressing the operational readiness of the force, DoD policy has attempted to balance these competing perspectives.<sup>31(p462)</sup>

### **Military Policy Regarding Acquired Immuno-deficiency Syndrome**

Among the US civilian population, concern with HIV/AIDS is functioning to pressure legislators throughout the country to pass laws to protect the public. This reflects a shift of focus from earlier laws

to protect the civil liberties of HIV-infected persons, to laws that, in some cases, punish those who knowingly place others at risk of contracting the virus. At least 29 states have enacted such legislation.<sup>33</sup> Current DoD policy calls for repeated testing of personnel, screening of blood supplies, and the development of educational and surveillance initiatives. Beyond these considerations, and similar to the evolving national orientation, continued involvement in sexual relations by those positively tested, without informing their partner(s) of their infection, can and has resulted in courts-martial.<sup>34-36</sup> Conversely, civilian dependents of military personnel who test positively for HIV/AIDS offer a different set of concerns as they cannot be forced into testing, and are outside of the sociomedical constraints of the military.<sup>31(p470)</sup>

In addition, current policy does not call for the removal of HIV-infected persons from the military environment. It is clear that if such an aggressive policy were adopted, the rights of the uninfected, civilian and military, would be more protected and the readiness of the force would be enhanced. However, pursuit of such a restrictive policy would violate some perceptions of civil rights. Indeed, it can be argued that the overall morbidity rates of the entire society could be reduced by mandating thorough physical exams every year, 6 months, or 3 months, declaring every product linked with cancer illegal, introducing a required level of physical fitness, body fat percentage, strength level, and so forth. Parenthetically, it should be noted that physical fitness parameters of well-being have already been institutionalized within the US military. Societal introduction of these considerations, however, would require an abrogation of individual freedom and are clearly counter to the idea of well-being on the mental and social dimensions.

An ethical, practical, and legal posture of the DoD represented by a stringent policy to protect people in foreign countries from infection by service persons assigned to military installations outside of the United States. DoD policy requires military personnel who test positively for HIV/AIDS to return to the United States, and those already infected with the virus are not assigned to foreign installations. At this time, military personnel infected with HIV/AIDS are treated similarly to personnel with other contagious, debilitating, or life-threatening illness, even though the condition presents concerns that other diseases do not. Most importantly, most of those infected are homosexual males or intravenous drug users. Historically, these two categories have either been excluded from military

service or have been the targets of antagonism. With the introduction of testing procedures, persons so categorized, especially homosexuals, feared a “witch hunt” and the employment of “Gestapo-like” tactics in locating and sanctioning them. However, comments of this nature have diminished considerably, a fact that points to a more sound policy.

Distribution of negative and often untrue informa-

tion remains a concern for US foreign relations. One claim, put forth by Soviet scientists and later retracted, argued that AIDS was a biological war product engineered by US Army scientists.<sup>31(p472)</sup> The consequences and concerns are exacerbated for US military relations when such pejorative propaganda is subscribed to by the uninformed and isolated, especially in the less-developed countries of the world.

## VETERANS' HEALTHCARE ISSUES AND THE POLITICS OF ELIGIBILITY

During times of relative peace it is probable that competing dimensions for the provision of healthcare converge more acutely at the issue of healthcare for non-active-duty military beneficiaries, especially for those who enjoy veteran status. Given the reality of finite resources, and especially during periods of budgetary restraint, the ethical questions of who is to be afforded healthcare, and where, are underscored.

Historically, the evaluative manner in which the culture reacts to a given military engagement helps to define the manner in which returning veterans adjust to reentry into civilian life. Scott has identified two significant reasons that healthcare issues are important for the readjustment of the veteran.<sup>10(p592)</sup> The first is that healthcare issues are related to what the society defines as normal experiences of military personnel during and after a war. Second, the issues of liability and compensation for injuries and disabilities acquired as a result of military service become pressing questions. With the implied subjectivity of these two statements, determination of eligibility for medical attention by veterans can easily become a controversial issue. Again, Scott is helpful in describing the dilemma that has characterized requests by veterans for medical treatment and compensation for service-connected injuries and disease.<sup>10(p594)</sup>

First, requests may be reflective of unanticipated consequences of new weaponry. If presented pathologies exceed current parameters of understanding, eligibility for healthcare may be denied. Indeed, it is almost certain that such will occur following each armed conflict in which the United States is involved. Clear knowledge of effects from short- and long-term exposure to US weaponry is not known (for example, exposure to Agent Orange during the Vietnam conflict), let alone the arsenals of enemy forces. Again, economic and ethical considerations coincide. That is, an argument for reduced medical expenditures from a finite budget may well transcend ethically appropriate considerations. Further, and unfortunately, when a mo-

dality of treatment is granted, it may be the product of misdiagnosis.

Second, service-connected health problems of veterans may not surface until more than a year after their discharge. Diseases that are not manifested for more than a year after service exposure increase the difficulty of establishing a cause-and-effect relationship. Competing explanations for the occurrence of the disease may be introduced without a satisfactory way of judging the relative merits of the counterhypotheses.

Third, conflict arises between the perception that the veteran is deserving, and the finite resources available for the provision of care. As Scott notes, “the certification of sickness among veterans...often is bitterly contested as altruistic service clashes with fiscal constraints and political realities.”<sup>10(pp594-595)</sup> It is clear that presentation of symptoms of health problems and consequential treatment is more expansive, and considerably more complex, than these two variables. Among others, political and economic variables, in conjunction with ethical considerations, must be included.

In order to facilitate an understanding of the political complexity of veterans' healthcare issues, it is necessary to turn to some distinctions that medical sociologists have traditionally found helpful. Specifically, social scientists have differentiated the terms of disease, illness, and health,<sup>10(p593),37</sup> and provided a number of approaches for their examination. *Disease* is used to identify some impairment to bodily functions; *illness* refers to the self-perception that one does not feel well or that something is wrong; and *sickness* is used to define the affirmation by a medically certified practitioner that one has a disease or is legitimately not feeling well.

Interpretation of these distinctions is further assisted by an understanding of a variety of behavioral-science approaches. Mechanic has identified four of these.<sup>38</sup> The first is the cultural approach, which focuses on the manner in which illness is perceived, presented, and received. For example, differing lifestyles and values are reflected in sig-

nificantly different health patterns for divergent work and family organizational patterns. In essence, an individual's reception or rejection of changes for a healthier lifestyle will reflect the values of the cultural or subcultural environments.

The second is the social-psychological approach, which overlaps with the cultural, and is concerned with social interaction, communication, and how people influence each other. This approach is particularly interesting in the American culture because independence is so highly valued. Despite the general emphasis on efficacy, many social areas, including healthcare, are perceived by many as a reflection of their development, social position, and life situation.

The third approach is social. Overlap with the other approaches is again observable. Followers of this orientation are concerned with how people accommodate social demands within their physical and economic environments. This approach also encompasses legitimacy to the claim of illness, and appropriate enactment of the sick role.

The societal approach is the final orientation and, despite clearly being related to those previously noted, it is the one that is most germane to this discussion. This focus is on the relationship between health and other social institutions, including the armed forces. Although the societal approach might be more abstract, it does hold that different social components can be identified and the relationships between them can be examined, for instance, the relationships between health institutions, the armed forces, law, and family.

Finally, clarification is afforded by two perspectives that influence reactions to this distinction of terms and approaches.<sup>10,39</sup> The most prevalent is the objectivist school. According to this perspective, evidence of disease will accumulate, thereby inviting discovery. Although not devoid of political considerations, advocates of this methodological position believe that through the appropriate employment of scientific tools, factual evidence of sickness will become "objectively" observable.

The objectivist perspective is rather sharply contrasted by the constructivist school, which holds that legitimization of a sickness is primarily a political process. Proponents of this view identify specific types of evidence and employ available resources to validate any claims of sickness. Constructivists do not subscribe to the necessity of a linkage between injury or disease and the probability of recognition. Rather claims are advanced by persons able to gain the attention and respect of appropriate (ie, powerful) persons.

Despite the general prevalence of, and subscription to, the objectivist school of thought in the determination of cause-and-effect relationships (presentation of empirical data and analysis), the constructivist perspective is a more salient guide to an understanding of the adjustment of veterans and military-related healthcare issues. This is precisely for the reasons previously noted—veterans' expectations exceeding society's willingness to provide; unintended consequences from exposure to new technology; and the strain introduced by disorders delinquent in their appearance. Ethically, this scenario presents an unfortunate juxtaposition between societal expectations and responsibilities. A traditional and widely held belief is that when one is asked to serve the country as a member of the armed forces, all medical and healthcare needs will be accommodated. This implied social contract does not come with exceptions denoted by asterisks.

Given that military service may well extract the ultimate cost of one's life, denial of medical treatment for presented symptoms that carry the possibility of being service connected is seen as representing a denial of ethical responsibility. It might well be argued that such denial, subjectivist or not, is particularly troublesome in light of the extensive healthcare that has been provided veterans who have presented non-service-connected conditions for treatment. Clearly, veterans of all wars present readjustment needs. The manner in which these needs, medical or otherwise, are met will maximize or minimize the readjustment difficulties. Retrospectively, it appears obvious that responses to veterans needs are more positive for those armed conflicts that the public favored, most notably World War II; while conflicts that concluded in a stalemate—the Korean War—or in a perceived defeat—Vietnam—result in less favorable or supportive action.

The presentation of the same or similar symptoms by veterans of different confrontations can and has resulted in dramatically different levels of acceptance and treatment. Ethically, registered differences in public perception and treatment modalities cannot be justified, and represent an area in need of examination. As noted earlier, the issue is illustrated by the American veterans of the Vietnam War who were forced into major controversial subjectivist battles to gain answers and treatment for the troubling and serious health problems related to PTSD and exposure to Agent Orange, the defoliant herbicide. Examining relevant issues in a chronological sequence, and identifying the protagonists and antagonists, Scott developed a sociology of veterans' issues.<sup>39(Chap9)</sup> He emphasizes that "prob-



lems that lack effective advocates generally escape our attention."<sup>39(pxvii)</sup> Veterans of Vietnam have benefited from strong advocates, although the path toward recognition of PTSD as a legitimate basis for medical attention, and validation of conditions resulting from exposure to Agent Orange, was a cyclical and undulating one.

Indeed, given the controversy the war generated, the heterogeneity of those who served, and continuous changes within the political landscape, (eg, successive presidents, directors of the Department of Veterans Affairs [DVA], and budget directors), the confrontation process was not a continuous or linear evolution. It is noteworthy, and perhaps surprising, that the major opposition came from "The Iron Triangle." This is a collective composed of the Department of Veterans Affairs, Disabled American Veterans, and the House Committee on Veterans Affairs. The core of the argument again focused on a finite level of resources. Veterans of World War II and Korea dominated the patient lists of the VA during the 1960s. These were men reaching middle age and whose presentations of disease, illness, and sickness were overwhelmingly (85%) nonservice connected. Younger Vietnam veterans changed that scenario with presentations requiring treatment and rehabilitation for war-sustained injuries and diseases. This resulted in great financial and manpower stress to the system.

One of the most challenging areas was that of PTSD. The difficulties and chronology of finally getting this condition entered into the American Psychiatric Association publication *Diagnostic and Statistical Manual III* is well chronicled by Scott.<sup>39</sup> He similarly presents the decade-long struggle to earn legal culpability for conditions believed to be the result of exposure to Agent Orange.<sup>39</sup> Once that was determined, and the appeal process completed, the DVA extended the presumption of service con-

nection to Vietnam veterans presenting any number of diseases, most notably non-Hodgkin's lymphoma.

In sum, the politics of the health component for the readjustment of the Vietnam veteran transcended the legal, political, economic, and family institutions as well as that of the military. As such, the societal approach was clearly reflected, although with significant influence from the cultural, social psychological, and social approaches. Additionally, the politics of legitimating PTSD and Agent Orange as causative factors of disease represent a classic illustration of the constructivist approach, and ultimately an ethical victory. The achievement of these victories required a successful resocialization effort for a large number of diverse persons and institutions. One of the important segments of the resocialization effort was communicating the multidimensional nature of well-being.

One result of the Vietnam veterans' movements may be the emergence of a politically more sensitive and caring posture toward veterans. Although an accurate assessment of long-term results will require an extensive period of time, some preliminary evidence is available. It can be noted, for example, that there seem to be no parallel experiences described by veterans of the 1983 Grenada expedition, the 1986 Libyan strike, or the 1988 invasion of Panama, probably due to the short duration, minimal casualties, and limited combat engagements.

Unfortunately, veterans of the Persian Gulf War (1990–1991) have mirrored the Vietnam case by presenting a variety of symptoms for which the causes are not very well understood. Political sensitization and appropriate ethical considerations have been reflected, however, by virtue of the passage of a temporary disability benefit package for these veterans in conjunction with a substantial award for research and marriage and family counseling.

## CONCLUSION

Healthcare issues are increasingly complex as they reflect sociocultural and ethical considerations of a given society. The military, although representing a society, is also a specific subunit of the whole. Thus, it is necessary to understand the underlying perspectives of resocialization of healthcare personnel as well as those who are potentially in receipt of such. The multidimensional orientation toward well-being espoused by the World Health Organization can be of help.

Military healthcare, in conjunction with the healthcare of the American society, is experiencing a major transitional period. Emphasis has been

placed on the needs and interests of persons serving in the armed forces, their civilian family members, and veterans, vis-à-vis increasing sociodemographic diversity. Recent demographic changes in the composition of the AVF have resulted in consideration being given to the availability and distribution of healthcare to women who serve, and to those who are civilian spouses. Gender considerations have created a need for evaluating health risks in terms of assignment as women become eligible for more nontraditional military occupational specialties; a need for an expanded availability of different specialists; and attention to the potential of additional

stress as representatives of a minority of those serving. Satisfaction with personal healthcare, and that received by children in military families, is perhaps the most important variable in determining whether the civilian spouse will encourage reenlistment. In this regard stakeholder management is very important to achieving satisfaction.

A significant contemporary issue with healthcare implications is that of sexual preference. Although some might compare the integration of homosexuals in the military with that of African-Americans and women, a similar transition does not appear to be likely. The difficulty is exacerbated by the concern that HIV/AIDS, although it can be transmitted via heterosexual activity, has been overwhelmingly passed from one person to another through the sharing of needles in intravenous drug usage and homosexual behavior.

All who serve in the military risk life, limb, and well-being. However, some service-connected diseases and disabilities are slow to be officially recognized because of political difficulties. In particular are those conditions that might result as unanticipated consequences of technological developments for new weaponry; presentation of symptoms that might not be manifest for some time (perhaps a year or more); and the contrast between what the veteran is perceived to deserve and the inability, due to finite resources, to completely or even adequately

address that perception.

There are a number of ways to understand these complex healthcare issues. Distinguishing between disease, illness, and sickness helps clarify the issues as do a number of behavioral-science approaches. I offered two perspectives, objectivist and constructivist, to help navigate the maze. Ultimately, legitimization and treatment of veterans for conditions believed to be the result of exposure to the herbicide defoliant Agent Orange, and for those veterans suffering from posttraumatic stress disorder evolved from the constructivist approach, which functions to certify sickness through an inherently political process.

How the dramatically complicated military healthcare picture will be accommodated in the future is, of course, unknown. However, the "sociology of veterans' issues," generated by Scott, through the constructivist approach, has clearly influenced the US Congress in the direction of a more ethically sensitive reaction to veterans presenting symptoms of the Gulf War illnesses.

It is anticipated that future military healthcare efforts will be responsive to the variables noted in the sociocultural landscape throughout this chapter. Additionally, it is expected that greater attention will be directed toward the resocialization of providers and recipients, ethical issues related to care, and a multidimensional conceptualization of what constitutes well-being.

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