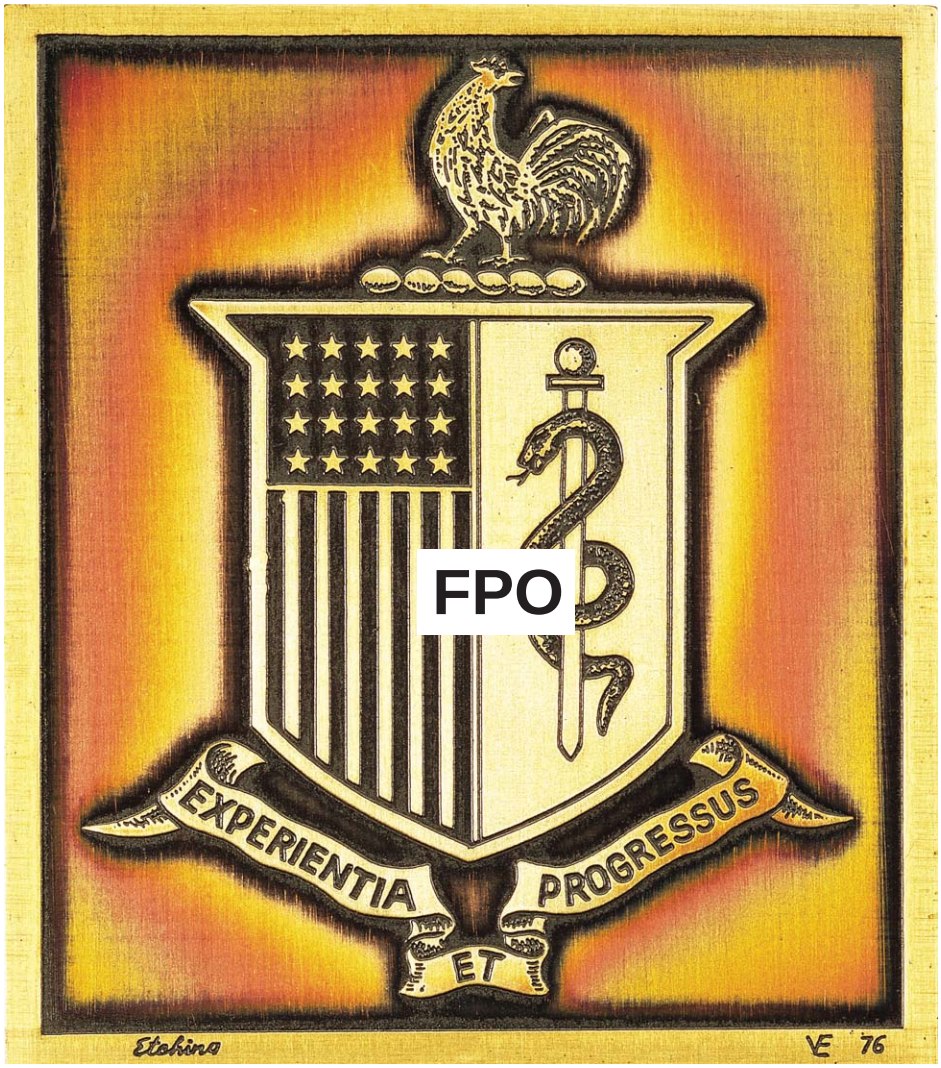
MILITARY MEDICAL ETHICS
Volume 2



The Coat of Arms
1818
Medical Department of the Army

A 1976 etching by Vassil Ekimov of an
original color print that appeared in
The Military Surgeon, Vol XLI, No 2, 1917

The first line of medical defense in wartime is the combat medic. Although in ancient times medics carried the caduceus into battle to signify the neutral, humanitarian nature of their tasks, they have never been immune to the perils of war. They have made the highest sacrifices to save the lives of others, and their dedication to the wounded soldier is the foundation of military medical care.

Textbooks of Military Medicine

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The *Textbooks of Military Medicine* series was conceived in 1987 by then Colonel Russ Zajtchuk and made a reality by Donald P. Jenkins, PhD. A mission of the Borden Institute, the TMM series is published under the aegis of The Surgeon General of the US Army. The Borden Institute draws on Army, Navy, Air Force, Public Health Service, and civilian resources to develop these volumes.

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Art: Courtesy of Novartis Pharmaceuticals.

MILITARY MEDICAL ETHICS
VOLUME 2

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Foreword

These two volumes of the *Textbook of Military Medicine* address medical ethics within a military context, a heretofore essentially unexplored field. Military medical care is practiced across a wide spectrum of settings, ranging from garrison medicine, through deployments for Operations Other Than War (OOTW), and extending to massive deployments of personnel and materiel in a large-scale conventional war. Within a peacetime garrison setting, military medical ethics has many similarities to civilian medical ethics and usually uses the same decision-making processes. It is similar in that the patient–physician relationship is generally the same, as are the goals of therapy. Patient autonomy takes priority in clinical decisions. However, the very nature of the military mission, especially when it involves deployment or combat, precludes military medical ethics from being identical to civilian medical ethics. Within military medicine, there is a significant dichotomy between medicine's healing and the military's injuring. Conflicts can arise between duties to the patient and to the command structure. The battlefield introduces totally unique stressors and criteria for decision making. These differences demonstrate the need for these two volumes and their exploration will be its primary emphasis.

The study and discussion of military medical ethics is inherently controversial and troubling. Those who serve in the armed services understand the complexities and problems that the military mission can introduce to the delivery of effective medical healthcare. For instance, rarely does the issue of national security play a role in the day-to-day medical decisions in a civilian setting. The military, however, as the sentry and defender of the nation, is tasked with maintaining security. Survival of the nation can be a powerful driving force behind medical decisions, whether they are correct, just, or legal. One need look no further in our own past than the recently revealed radiation experiments from the Cold War era to understand this. Certainly the lessons to be learned from the perversion of medicine in Germany and Japan, both before and during World War II, are ones to be carefully examined and never forgotten. We constantly strive to remember those lessons, to learn from them, and to attempt to ensure that we do not repeat the travesties of the past. It is all too easy to look at others' sins and be smug in our own virtue. While controversy is seldom comfortable, it should always be instructive. An excellent organization is willing to publicly examine and discuss its mistakes and to learn from them. *Military Medical Ethics* is offered in that spirit. These volumes may offend. They may stir emotions. They are intended to illuminate. If we cannot bear to look at past mistakes, particularly when they are ours, we cannot learn from them and therefore we cannot prevent them in the future.

I strongly encourage all military medical officers, commanders, and others involved in ethical decision making in medicine study this two volumes. Examine your responses and analyze your decision-making processes. Those who are willing to give the supreme sacrifice in the service of their country are entitled to nothing less than the best ethical decisions made in providing superior medical care to them and their families.

Lieutenant General James B. Peake
The Surgeon General
US Army

Washington, DC
April 2003

Preface

Volume I has discussed the separate fields of medical ethics and military ethics, as well as the synthesis of the two fields in the discussion of profession of the military physician. Volume II continues this discussion by noting that medical ethics in the military is more than just the mere combining of the ethics of the two professions in the persona of the military physician. The underlying tension generated by mixed agency will permeate the chapters in this volume. This tension emerges most clearly when caring for casualties of combat. As the chapter on battlefield medical ethics so aptly describes, the pace and chaos of the battlefield put physicians in situations of making immediate life and death decisions. Furthermore, the practice of medicine in this ferocious environment requires professional military medical training. The lack of resources—whether time, personnel, equipment, supplies, or safety—thrusts the military physician into situations so hostile that his skills, morality, and ethics can all be challenged. This environment is one that his civilian colleagues are likely to never experience, and thus are likely to never fully understand or appreciate. But military physicians know, even if they have not yet cared for combat casualties, that doing so is the apex of their careers—what they have prepared to do, and what they are willing to sacrifice even their own lives in order to do. Thus it is not an exaggeration to say that the battlefield is the crucible of military medical ethics.

Medicine in the service of the State, however, can be seductive and corruptive. We offer four chapters detailing several examples in which unethical decisions were made under the pressure of national security issues. The first reviews the already well-documented crimes against humanity committed by the Nazi regime and punished by the Nuremberg Tribunal. The Nazi doctors were not forced into evil; many freely chose it. The next two chapters (one on the hypothermia experiments at Dachau and the other on the biomedical research programs of the Japanese during the same era) demonstrate the widespread corruption of medical ethics when medicine in the service of the state went without challenge. Some of these transgressions were prosecuted; others were not. The fourth chapter in this discussion concerns American covert and deceptive medical research during the Cold War era. Some may blanche at the inclusion of a chapter on American misdeeds in the same section that chronicles the horrors of the German and Japanese death camps. While American research efforts were not as *malevolent* or *extensive* as those of other countries, they nonetheless violated the ethic underlying the patient–physician relationship—"firstly, do no harm."

The four chapters that comprise the discussion of medicine in the service of the state are followed by two chapters that examine the issues of medical research during that era, and bring it forward through the history of military medical research. Although the chapters have a certain historical flavor, inasmuch as they acknowledge the misdeeds of the past, they also describe how these research programs evolved. In their evolution we see a turn away from pursuing whatever was necessary to protect the country, even if it was at the expense of individuals, toward ensuring ethical research. Thus, the theme for these two chapters is very straightforward: Medical research in the military is carefully controlled to protect the rights of individuals, while ethically pursuing the knowledge necessary to protect the health of service members and thus to support the military mission. The second of the two chapters has, as attachments, several of the most important documents pertaining to the ethical conduct of research, including *The Belmont Report.*

Medicine in the military is practiced in a variety of contexts, with a variety of patients, all of which necessitates an understanding of the ethics of patient healthcare in a diverse world. Just as there are a variety of patients (including family members and veterans), there are also a variety of healthcare professionals who comprise the healthcare team. Nursing, in particular, addresses the individuality of patients and functions as a bridge between the needs of the patient and the services of the physician. Chaplains are another key component in the healthcare team, for they bring with them an understanding of the spiritual needs of patients as they confront what can be life-altering events or illnesses. Their ability to understand social and cultural differences of patients is particularly valuable in an increasingly diverse military population that also deploys to other cultures to offer assistance.

Medicine in the military is influenced by the society—its ethics, customs, and laws—that it seeks to protect. This societal influence is most apparent as it relates to medicine in the military and the care of its beneficiaries. Military medicine in combat is governed by the Geneva Conventions. These specify the

rights and responsibilities of healthcare professionals and injured or captured combatants.

As the mission of the military continues to evolve, so, too, does the role of military medicine, especially in operations other than war. We present two chapters dealing with the most prevalent forms of military medical assistance to other nations. These missions can, at the same time, be both inspiring and frustrating to those tasked to carry them out. Understanding the ethic of military medicine, especially in these austere environments, is of benefit to all participants to help them navigate through the many obstacles that can be found in unfamiliar surroundings. Not only will military missions evolve; military medicine will evolve as well with the development of new technologies for treating military personnel. Without an adequate appreciation of military medical ethics, some may find these new technologies so tantalizing that the basics (as they have been presented in these volumes) of medical ethics—autonomy, beneficence, nonmaleficence, and justice—may be set aside.

What, then, is the military physician? What have we concluded about this professional in this exposition of military medical ethics? We can state it simply: We believe that the military physician is first and foremost a physician, and secondarily an officer. Yes, the physician is a uniformed service member and is subject to the same rules and regulations, as well as loss of autonomy, as other service members. But most of the time military physicians primarily serve as physicians caring for individual service members. These service members understand that sometimes physicians will have to put the needs of the individual aside for the needs of the mission, but troops must also remain confident that their doctors will do that only when absolutely necessary.

The editors intend these volumes to challenge the reader to examine his profession—both medicine and military—and begin to critically evaluate the position he will take on ethically challenging issues. There is a rich history of military medicine that includes examples of both good and evil. Our intention is for today's military physician to learn from past errors, to live up to the excellent models of the past, and to grow into the future. Military medicine is a moral profession, but we must be vigilant to guard against challenges that threaten this.

Colonel (Retired) Thomas E. Beam
Formerly Director, The Borden Institute
US Army

Washington, DC
April 2003

The current medical system to support the U.S. Army at war is a continuum from the forward line of troops through the continental United States; it serves as a primary source of trained replacements during the early stages of a major conflict. The system is designed to optimize the return to duty of the maximum number of trained combat soldiers at the lowest possible level. Far-forward stabilization helps to maintain the physiology of injured soldiers who are unlikely to return to duty and allows for their rapid evacuation from the battlefield without needless sacrifice of life or function.