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Abstract

This paper reviews the ethical tensions and the dual loyalty conflict between following military orders and professional codes of conduct. All competent patients have a right to refuse medical treatment. However, maintaining confidentiality is not an absolute right. In the military, a doctor may have a dual loyalty conflict between obeying military orders and following professional codes of practice. This can become exacerbated when a doctor in a military environment does not consider all the parties' interests. This paper suggests that dual loyalty conflict in military healthcare practice in this environment is best managed via a discretionary ethic-role. This then allows independent clinical judgment while at the same time minimizing ethical dilemmas, harm, and conflict to a third party such as a military commander.

KEYWORDS**:** military healthcare; confidentiality; refusal of treatment; dual loyalty conflict; PTSD

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In healthcare, dual loyalty occurs where the clinical role conflicts between the personal interest of the patient and the duty to another such as an employer (Williams, 2009b). As mentioned by Benetar and Upshur (2008), "moral obligations are beyond those incumbent on many other members of society" especially Military Healthcare Professionals (MHCPs). Therefore, for the MHCP, these simultaneous obligations create inevitable ethical tensions and conflict (Rascona, 2007; International Dual Loyalty Working Group, 2002). On occasions, they also cause professional compromise, as they need to balance the conflict between patient care and obeying military orders (London, Rubenstein, Baldwin-Reagaven, & Van Es, 2006). For example, in the British Armed Forces, the Ministry of Defence (MoD) states that medical treatment must be within the "constraints of Armed Forces medical policy" and medical needs must be subjected to "military and professional constraints" (Ministry of Defence, 2007, paragraph 1A6, p. 1A2). This, therefore, emphasises a need for a MHCP to balance the medical needs of his patient with his military duty (Clark, 2006). It also limits how a MHCP can practise his healthcare profession in the military. Contrarily, the MoD also states that it recognises that "medical judgment and ethics" cannot be ignored and compromised (Ministry of Defence, 2007, paragraph 1A6, p. 1A2). Although not a military document, this view is shared by the International Dual Loyalty Working Group (London, et al, 2006), which summarised that the "overruling identity and priority" of a MHCP should be "that of a health professional" as the patient's clinical needs are sacrosanct (Annas, 2008, p. 1087).

This paper presents a vignette to consider the ethical tensions and the dual loyalty conflict between following military orders and professional codes of conduct, concerning medical confidentiality of a competent patient-soldier refusing medical treatment in a non-

operational environment. In the context of a vignette, this paper suggests that dual loyalty conflict in military healthcare practice in a non-operational environment is best managed via a discretionary ethic-role (Howe, 2003). This, then, allows independent clinical judgment while at the same time minimizing ethical dilemmas, harm, and conflict to a third party such as a military commander (Williams, 2009a). By reference to the vignette, that places the law in the context of a military non-operational environment with a patient suffering from Post Traumatic Stress Disorder (Hughes & Huby, 2002; Williams, 2009a). This paper also explains the English law relating to refusal of medical treatment and patient confidentiality.

Vignette

Sergeant Green, a serving Non-Commissioned Officer in the Coldstream Guards, has been in the army for twenty years. He has experienced numerous operational deployments, having served in Northern Ireland, the Balkans, Iraq, and, more recently, Afghanistan. In his last operational tour eighteen months ago, he witnessed several of his comrades being killed and maimed by local insurgents during firefights or localised small battles. His military General Practitioner, Major Smith (a senior officer) has just recently diagnosed him with Post Traumatic Stress Disorder (PTSD), a psychological disorder, in response to severe traumatic experiences. Major Smith recommends that Sergeant Green immediately start treatment to overcome this psychological illness with a military Clinical Psychologist. Sergeant Green is otherwise a fit, healthy, and competent adult.

As Sergeant Green is due to return to Afghanistan in six-weeks' time for a six-month tour, he refuses Major Smith's offer of treatment. He is worried about his future career in the army since, if he starts treatment, he will not be able to deploy back to Afghanistan with his comrades and is unlikely to be promoted to the next rank. For the same reasons, Sergeant Green will not give Major Smith his consent to disclose his psychological illness to his Commanding Officer (CO), a lieutenant-colonel (a higher ranking senior officer than a

major). Major Smith, however, has a military obligation to inform Sergeant Green's CO that he is currently unfit to deploy. However, as it will leave the CO without an experienced soldier on the operational tour, it is inevitable that the CO will want to know the exact reasons why Sergeant Green cannot deploy.

In Major Smith's medical opinion, Sergeant Green is not currently medically fit to return to Afghanistan, but with his refusal to accept treatment and without his consent to disclose his illness to his CO, Major Smith is uncertain what to do. He has a professional duty to maintain Sergeant Green's confidentiality, but also a military obligation to follow military orders in only allowing soldiers to deploy on operations if they are medically fit. He is also concerned the CO, as a higher-ranking officer, will demand to know the reason why Sergeant Green cannot deploy. Major Smith is, therefore, concerned about possibly breaching Sergeant Green's confidentiality.

By using this vignette this paper considers the following:

1. Does Sergeant Green have the right to refuse medical treatment?
2. What is the duty of confidence expected by Major Smith to Sergeant Green in a non-operational environment?
3. Does Major Smith have a legal and ethical responsibility to inform the CO of Sergeant Green's psychological illness?
4. When there is a dual loyalty conflict between either following professional codes of conduct or military orders concerning a patient suffering from Post Traumatic Stress Disorder, what is the best solution and what is the most appropriate way to deal with this problem?

Discussion

Although not an absolute duty, the duty to safeguard medical confidentiality arises from the ethical principle of beneficence (Plambeck, 2002). However, despite soldiers

subverting many of their rights in the military such as freedom of expression and speech, it remains questionable if soldiers should also subvert their healthcare rights and MHCPs should undermine their own professional autonomy (Visser, 2003). British service personnel are subjected to the domestic law of the country they are serving in and British military law. This is so that British service personnel are treated fairly and consistently wherever they are serving in the world (Ministry of Defence, 2007, paragraph 110). Therefore, in consideration of whether Sergeant Green could refuse the offer of medical treatment, guidance can be sought from Justice Benjamin Cardozo in *Schloendorff v Society of New York Hospital* (1914, paragraph 126) when he famously stated that a competent adult has a right "to determine what shall be done with his own body." Furthermore, in English law, unless declared otherwise by a medical practitioner and as long as the patient is of "sound mind," a competent adult is presumed to have the capacity to consent and refuse medical treatment (Mental Capacity Act, 2005). This is even if that decision is considered as eccentric and the patient could die (GMC, 2011). Moreover, in *Re C (Adult, refusal of treatment)* (1994), the court determined that even if a patient has a mental or psychological illness and decides to refuse medical treatment, it does not automatically call into question the patient's capacity to make his own decisions. The General Medical Council's (GMC) *Consent Guidance* (2008) further outlines the presumption of capacity. Therefore, in following the law, it appears that Sergeant Green is able to refuse medical treatment for his PTSD. Being in the military and having a psychological illness does not prevent Sergeant Green from making his own decisions regarding acceptance of medical treatment (Mental Health Act, 1983; Mental Health Act, 2007; General Medical Council (GMC, 2008a, p. 27).

The practical significance of being able to refuse treatment is that it enables a patient to have trust and confidence in their healthcare practitioner (Dimond, 2003). It also helps to maintain a successful professional relationship (GMC, 2008a*)*. In further consideration of

whether if it is right for Major Smith to allow Sergeant Green to refuse medical treatment, the World Medical Association's (WMA) Declaration of Geneva (1948) stated, "the health of my patient will be my first consideration. I will not use my medical knowledge to violate human rights and civil liberties, even under threat." Moreover, the WMA International Code of Medical Ethics stated, "A physician shall be dedicated to providing competent medical service in full professional and moral independence with compassion and respect for human dignity" (1949). Accordingly, in adhering to the law and ethical principles, Major Smith must allow Sergeant Green as a competent adult to refuse medical treatment (GMC, 2011).

The difficulty for Major Smith in Sergeant Green refusing medical treatment, however, is that in the context of the vignette, it is intrinsically linked into whether Major Smith should respect Sergeant Green's confidentiality (Carey, 2009). As such, Major Smith should warn Sergeant Green about the consequences of refusing to consent to treatment (GMC, 2009). The legal basis for protecting confidential information was examined in *Campbell v MGN Limited* (2004). This case considered the necessity to balance the right for confidential information to be protected with the right of freedom of expression as the European Convention of Human Rights and Fundamental Freedoms (ECHR) protected both rights (Nursing Midwifery Council, 2009). Article 8 of the ECHR protects confidential information whereas Article 10 of the ECHR protects freedom of expression. In *Campbell v MGN* (2004, paragraph 1012), Lord Hoffman concluded that "… [B]oth reflect important civilised values, but, as often happens, neither can be given effect in full measure without restricting the other…" Protecting a patient's medical data is also important as was emphasised from the case of *MS v Sweden* (1999, paragraph 41) where the court stated that "respecting the confidentiality of health data is a vital principle" so as to "preserve his or her confidence in the medical profession and in the health service in general."

An additional difficulty for Major Smith is that confidentiality may have to override other considerations that a doctor may have. This is because although Sergeant Green must be Major Smith's first concern before any other consideration (GMC, 2006; Nursing Midwifery Council, 2008), Major Smith also has a military duty to follow military orders in only allowing fit soldiers to deploy. In the interest of the military, informing the CO of the soldier's condition may override that of maintaining the patient's confidentiality. With Sergeant Green refusing medical treatment, however, it makes it difficult for Major Smith to justify without breaching confidentiality to the CO the reason why this soldier cannot deploy. The CO as a senior officer may order Major Smith to tell him why Sergeant Green cannot deploy. Following military orders and adhering to military discipline is the "backbone that promotes efficiency in the Armed Forces" (Soldier Management, 2004). Murray (Cramer, 1921, p. 774) describes following military orders as, "…the long-continued habit by which the very muscles of the soldier instinctively obeys the command; even if his mind is too confused to attend, yet his muscles will obey." However, although military orders and discipline are evidently necessary, in the context of the vignette they become an almost physical impediment for Major Smith in deciding what course of action to take. This is because although confidentiality is a professional core value, it appears to be in conflict with the military core value of obeying orders (Kipnis, 2006).

Solving ethical problems is easier than attempting to solve an ethical dilemma where one party is likely to be aggrieved of the decision that is made (Tschudin, 1992). When there is a conflict in determining the correct action, ethical problems should be divided between ethical dilemmas and tests of integrity (Coleman, 2009). There are several options to choose from when faced with an ethical dilemma and a person can, therefore, have difficulty in deciding what the correct option is to take. With a test of integrity, however, it is obvious what the correct option is to take since the distinction between bad options and good options

is clear. A more exact way of dealing with a situation when there is dual loyalty conflict between following professionals codes and military orders is given by Edmund Howe (2003). Edmund Howe's (2003) model enables a logical discussion and subsequent analysis of military medical dilemmas in diverse military environments. This model allows a more precise concept of professional-military conflicts by arguing that MHCPs are governed by three role-specific ethics, which involves the person following each role strictly. These consist of (i) a medical role-specific ethic, (ii) a military role-specific ethic and (iii) a discretionary role-specific ethic. Howe (2003, pp. 333-334) suggests that with a medical role-specific ethic, MHCPs would follow professional codes of practice and put their patients first. With a military role-specific ethic, MHCPs would follow military orders above everything else (Howe, 2003, pp. 333-334). Finally, the third role is where the MHCP uses some discretion in deciding when and whether the needs of the military are absolute (Howe, 2003, p. 335). Using Howe's three-dimensional model, Major Smith is faced with three options.

Option 1

With a medical role-specific ethic, Major Smith would follow professional codes of practice and legal obligations and would make Sergeant Green as his patient, his first concern (Howe, 2003; GMC, 2006). He would give him his undivided attention (Rubenstien, 2003). He would also respect Sergeant Green's confidentiality. Patient confidentiality arose from the Hippocratic Oath in the 4th century BC and is now enshrined in the Declaration of Geneva where it states a physician will "respect the secrets which are confided in me, even after the patient has died" (WMA, 1948). The General Medical Council (2009, p. 6) also states, "confidentiality is central to trust between doctors and patients" and that those patients have a right for their confidential medical information to be respected. This further emphasises that there must be trust and an understanding about what passes between the doctor and the

patient. The Nurse Midwifery Council (2009) also emphasises the importance of maintaining patient confidentiality for a trustful relationship between healthcare practitioner and patient.

The difficulty, however, in following a medical role-specific ethic is that although Major Smith would be practising clinical independence (Williams, 2009a), it would increase the tensions of the dual loyalty conflict. This is because Major Smith would not consider breaching Sergeant Green's confidentiality to the CO as professional obligations would clearly make his patient his sole concern (GMC, 2009). In contrast, the duty to follow and obey military orders would undoubtedly conflict with this position (Howe, 2003). In such circumstances when following professional obligations, Major Smith would be taking an absolutist approach, as he would consider that his professional responsibility to Sergeant Green is his first and only concern above everything else (Ministry of Defence, 2007). Wolfendale (2009) would consider this action a mark of professional integrity and not military insubordination. Equally, Kipnis (2006) would assert that absolute confidentiality without any disclosure to a third party is the only way to solely respect a patient's medical privacy.

However, although Major Smith's actions would demonstrate that confidentiality and privacy is necessary to maintain patient and professional autonomy irrespective of the environment, this approach is effectively saying that he does not consider the military consequences of his actions. His actions may be perceived as military insubordination as he would fail to inform Sergeant Green's CO as to why he cannot deploy. Consequently, Major Smith may be acting legally and ethically in one sense in upholding Sergeant Green's confidentiality. But, militarily he would be compromising legality and acting unethically by not informing the CO (Yeo, 1989). In addition, by taking a medical role-specific ethic, it is also unlikely that he would allow Sergeant Green to deploy because irrespective of respecting his confidentiality, this soldier would still be medically unfit to deploy on an operational tour.

Option 2

In contrast, to a medical ethical approach, Major Smith may decide to follow a military role-specific ethic and believe that MHCPs should follow military orders above everything else (Ministry of Defence, 2007). With this approach, Sergeant Green's healthcare needs, and his confidentiality become secondary to the military need, which is to follow military orders. This may seem unethical to a civilian doctor, but in the military, while a doctor has the same degree of legal and ethical responsibility to his patients, these problems are often more complex and there may be circumstances that necessitate placing the military interest above the patient's interest (Benetar & Upshur, 2008). For example, to disclose medical information to another person to prevent an ill soldier from deploying on operational tour or within a battlefield may seem to be a reasonable action to a military doctor.

It is, therefore, clear that preserving patient confidentiality in the military is problematic. Rogers (2006) argues that preserving confidentiality in any situation is complex since sharing information to treat and protect the patient and others from harm, often results in the widespread disclosure of personal information. Maintaining confidentiality becomes more challenging in the military since a caveat of a soldier voluntarily joining this type of disciplined organisation is that are aware that they will lose some of their personal autonomy in doing so (Visser, 2003). Thus, achieving medical confidentiality can be flawed from the first time a patient seeks medical treatment since he or she has already made a conscious decision to reveal his or her problem to the physician (Kipnis, 2006). Accordingly, Major Smith's actions in disclosing Sergeant Smith's PTSD to his CO may seem to be a reasonable action and justifiable. This is because Sergeant Smith is planning to deploy on his forth-coming operational tour, which in itself could be problematic and may cause harm to his colleagues if his symptoms were exacerbated (The Royal College of Psychiatrists, 2010).

Therefore, with a military role-specific ethic, Major Smith would breach Sergeant's confidentiality and inform his CO of the medical reasons why this soldier cannot deploy. Contrarily, it is accepted that this position is in contrast to the principles of maintaining patient confidentiality and may be seen as morally repugnant to other civilian healthcare professionals (Crowe & Hardil, 1991). Professionally, such a disclosure may also be seen as an unjustified breach of confidentiality and would ordinarily in a civilian environment almost certainly lead to fitness to practise proceedings (GMC, 2009).

Option 3

It is perhaps obvious then that there is no clear-cut way to deal with the problem that Major Smith is faced with regarding patient confidentiality. Ethical dilemmas concerning patient confidentiality are complex (Beech, 2007). In contrast to the medical and military role-specific ethical approaches, it appears that the best approach would be for Major Smith to use a discretionary role-ethic. This role would allow Major Smith to carefully consider and determine when and whether the needs of the military are absolute (Howe, 2003 pp. 333-334). This role is unlikely to be appropriate in a combat situation because military doctors are not military tacticians and they lack the military skills and knowledge to make the best choice where these choices are more complicated and decisions have to be made quickly (Howe, 2003 pp. 333-334). However, during peacetime, ethical challenges are less pressing (Simmons & Rycraft, 2010). Major Smith would also be making a decision in an environment that is safer and more familiar to him than that of a combat situation (Simmons & Rycraft, 2010). Therefore, using a discretionary role-ethic, Major Smith would still not allow Sergeant Green to deploy. Unlike the military role-specific ethic, where Sergeant Green's clinical needs appear secondary to the military need not to allow an unfit soldier to deploy, Major Smith would however, still disclose Sergeant Green's PTSD to his CO. This however, would be for medical reasons in the interests of the patient and not military reasons.

Major Smith would still be following a universal principle in that professional responsibility overrides all other considerations (Benetar & Upshur, 2008).

While it might remain unacceptable to Sergeant Green for Major Smith to disclose his PTSD to his CO, using a discretionary role-ethic has three advantages:

First, while professional responsibility suggests that Major Smith is disclosing confidential information because he is accountable to the GMC and could face professional consequences if he did not disclose this information when it is in the public interest to do so (*Tarasoff v Regents of the University of California, 1976);* however, his actions appear to be reasonable as he is also being caring to Sergeant Green by making him his first concern (GMC, 2006, p. 2). Furthermore, his actions are allowing for the principles of patient and professional autonomy to be respected (Seedhouse, 2001). Moreover, he is being beneficent to his patient, which is the core of medical confidentiality (Plambeck, 2002) and non-maleficent to the CO as a third party (Williams, 2009). He is also placing accountability and responsibility to Sergeant Green's healthcare needs above all other considerations, which is more legitimate and ethical than following the orders of a powerful military individual such as a CO (Benatar & Upshur, 2008).

Thus, despite Sergeant Green refusing the offer of medical treatment from a clinical psychologist, Major Smith's actions are justified because it is unlikely that Sergeant Green's symptoms of PTSD will improve without treatment (NHS National Institute for Clinical Excellence, 2005). Furthermore, if deployed on an operational tour where his life and others could be at risk from enemy attacks, these symptoms may be exacerbated, which in turn could potentially be harmful to himself and others if put under added stress (Sayer, Friedmann-Sanchez, Spoont, Murdoch, Parker, Chiros, & Rosenheck,, 2009; Feczer & Bjorklund, 2009). Moreover, it is more difficult to remove a soldier suffering from psychological trauma symptoms once deployed on an operational tour because liaising with

the soldier's CO to have him sent back home becomes more challenging (Simmons & Rycraft, 2010). This is because a CO has many priorities and needs all the available manpower he can gather together in the field and the evacuation of a soldier from the frontline severely depletes manpower since it takes a fit soldier to remove an injured one (Gross, 2006). This, therefore, further emphasizes the need for MHCPs to disclose information before deployment when a patient's and other people's lives could be at risk from harm (Castledine, 2010). Thus, in reaching this decision, Major Smith would have balanced the advantages and disadvantages of divulging Sergeant Green's condition to his CO with the "level of risk at hand" (Gibson, 2006).

Secondly, confidentiality is not an absolute right and disclosure of confidential information without consent in the public interest is lawful in certain circumstances such as misconduct, illegality and gross immorality (Nurse Midwifery Council, 2009). This was explained in *W v Egdell* (1990), where the court determined that confidentiality could be breached when it is justifiable to do so as if there is the threat of serious harm to others. However, such a disclosure must only be made to the person it was intended for and not to anyone else. Thus, Major Smith should only inform Sergeant Green's CO and no one else that Sergeant Green is unfit to deploy due to PTSD. In addition, Major Smith should inform Sergeant Green that he is disclosing the information to his CO in relation to a public interest and that his reasons for disclosure will be documented in his notes (GMC, 2009).

The duty of confidence is thus a qualified right meaning that in certain circumstances, the law may permit Major Smith to disclose personal information about Sergeant Green if it is in the public interest to do so (McHale, 2009). For example, the GMC states personal information of a patient can be disclosed to a third party if the "benefits to an individual or to society of the disclosure outweigh both the public and the patient's interest in keeping the information confidential" (GMC, 2009, p. 16). Thus, it may be reasonable to Major Smith

that disclosing Sergeant Green's confidentiality to his CO to prevent his deployment is justifiable. This is because it would be illegal for him as a doctor to knowingly allow a soldier to deploy on a dangerous operational tour when he is medically unfit to do so *(Tarasoff v Regents of the University of California*, 1976*).*

Thirdly, by Major Smith explaining to the CO the reasons why Sergeant Green cannot deploy, it minimises further potential harm to Sergeant Green if his symptoms exacerbate in a harsh environment where medical expertise from a clinical psychologist is less likely to be available (Simmons & Rycraft, 2010). While this may be unacceptable to Sergeant Green, healthcare professionals should do everything they can to protect their patients from further harm (Williams, 2009a). In addition, by Major Smith being open and transparent to the CO in giving him the medical reasons why Sergeant Green cannot deploy, it makes the ethical dilemma seem less problematic for Major Smith. This is because it also manages the dual loyalty conflict between either following military orders or professional codes of practice more smoothly rather than creating further tension in not giving any explanation to the CO (Annas, 2008). Additionally, although Sergeant Green will not deploy and the CO's manpower will be depleted, the CO's interests will be met since it will prevent a psychologically unfit soldier to embark on a dangerous operational tour (Benetar & Upshur, 2008). Further, at the same time as advocating Sergeant Green's medical needs, Major Smith is also effectively communicating to the CO to avoid any negative interaction between the parties that dual loyalty can sometimes create without dialogue (Williams, 2009a). It thus prevents any undue influence from the CO as a more senior officer possibly ordering Major Smith to divulge personal information about Sergeant Green (Wynia, 2007). Moreover, Major Smith's actions will take into account the common interests that the CO and the Major share in allowing only fit soldiers to deploy. A view shared by Pettrey (2003) who suggests

that identification of needs and recognising common interests will minimise potential conflict between parties where there is a dual loyalty conflict.

Conclusion

In conclusion, the duty of confidentiality is grounded in law and medical ethics (Plambeck, 2002). This paper has highlighted the complex nature of maintaining patient confidentiality in a military environment especially where a patient refuses to consent to medical treatment and where his personal information is divulged to a third person. This paper has also highlighted the difficulties for military doctors when they have a dual loyalty conflict between obeying military orders and following professional codes of practice (Benetar & Upshur, 2008). When having to follow professional codes of conduct and military orders, this role is problematic as they can be acting ethically and legally in one sense but unethically and illegally in another (Yeo, 1989). Thus, the management of military dual loyalty is challenging and can be contradictory to the values and beliefs of normal civilian ethical principles (Griffiths & Jasper, 2007).

Using Howe's (2003) three-dimensional role-specific model, this paper has concluded that managing patient-soldier confidential information when the soldier is suffering from Post Traumatic Stress Disorder is complex and demanding. It has also concluded that to avoid further harm to a patient and an exacerbation of dual loyalty conflict in a non-operational environment (Coleman, 2009), the most appropriate method is to make the patient the first concern of the military doctor. Also, the doctor should have an awareness and appreciation that takes into consideration the interests of the third party (Williams, 2009a). For military soldiers, although they subvert some of their rights and freedoms when they join the military (Howe, 2003), they are still entitled to be treated with respect and have their private medical information kept confidential when appropriate. However, this paper has concluded that in the context of the vignette, disclosure of confidential information about a soldier without his

consent to his CO to prevent the soldier from deploying on an operational tour is both lawful and ethical when in the interests of the public (Visser, 2003).

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