The essence of military service is the subordination of the desires and interests of the individual to the needs of the service.  

Military law and custom prohibit many acts that most civilians would categorize as normal human behavior under the catch-all justification “for the good order and discipline of the military.” Internal orders and the Uniform Code of Military Justice (UCMJ) alike impose restrictions on dress and personal appearance, speech, homosexual activity, and even everyday relationships. While military personnel maintain many of the same rights and burdens as members of the civilian community, there is simply not the same autonomy within the military as there is in the larger civilian community. However, should that fact hold true when it comes to one’s medical decisions and the relationships between patients and physicians in the military?

When the law enters the field of bioethics, it provides a rich language for exploring bioethical issues and provides the tools for action and the means for dialogue. As the environment surrounding the meeting of the physician and patient in the military changes, so does the dynamic of the relationship and the parties’ options for action. This article begins with an overview of the patient-physician relationship and how it functions in both the civilian and military world. Next, it discusses the military health care system and how members of the military are barred from initiating malpractice suits against the U.S. Government and individual military physicians, and the possible impact this restriction has on the patient-physician relationship. It then discusses how the patient-physician relationship changes due to the varying importance of the stakeholders and interests present under different specific circumstances.

Throughout this article, the phrase “military patient” is used as the generic term applying to a sick, injured, or wounded member of the military who receives medical care or treatment from medically-trained personnel who make medically substantiated decisions based on medical military occupational specialty (MOS) specific training. The term “physician” refers to the medically-trained personnel who administer treatment and make medical decisions based on their medical MOS training.

I. Introduction

Military law and custom prohibit many acts that most civilians would categorize as normal human behavior under the catch-all justification “for the good order and discipline of the military.” Internal orders and the Uniform Code of Military Justice (UCMJ) alike impose restrictions on dress and personal appearance, speech, homosexual activity, and even everyday relationships. While military personnel maintain many of the same rights and burdens as members of the civilian community, there is simply not the same autonomy within the military as there is in the larger civilian community.

II. The Patient-Physician Relationship in the Civilian and Military Worlds

A. The Patient-Physician Relationship in the Civilian World

Generally, a few main principles comprise the relationship between physicians and their patients – or patients and their physicians, depending on your perspective. These issues include veracity and disclosure of information, privacy, confidentiality, and fidelity. The first, veracity, is important in a patient-physician relationship because it is a part of the respect physicians owe to their patients. Consent is not informed unless it is based on truthful communication, and it invokes obligations of

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fidelity and promise-keeping, and the trust necessary for successful interaction and cooperation. Veracity is not absolute, however as nondisclosure, deception, and lying will occasionally be justified when veracity conflicts with other obligations.

The second principle, right to privacy, refers to protection against unauthorized access to and reports about a person. The rule of privacy can often conflict with concerns for the safety and welfare of others. For example, physicians are concerned with issues of privacy when an HIV-positive patient refuses to inform family members or lovers of his or her condition. The third principle, confidentiality, is related to privacy in that while patients lose some of their privacy when they grant physicians access to their bodies and personal histories, they maintain some degree of control of the information generated about them through the confidentiality of their physicians. When one person divulges information to another with the implicit promise that the receiver will not reveal that information to any other person, the receiver should respect that implicit promise. The difference between a breach of confidentiality and a breach of privacy in the medical setting is that an infringement of confidentiality occurs when a physician with the duty to protect information fails to protect that information or deliberately discloses it without the consent of the patient. A breach of privacy, on the other hand, would occur if someone merely broke into the hospital and stole the information.

Lastly, rules of fidelity or promise-keeping are rooted in respect for autonomy, and provide a strong warrant for an individual’s obligation to keep promises. Upon making a promise, one creates an expectation on the part of others who then rely on the promise and have a valid claim to its being kept. Promises, such as the promise to think of the patient’s welfare and the related promise that the physician will not abandon the patient, are important to the patient-physician relationship.

There is another extremely important aspect of the civilian patient-physician relationship: the tort. One of the law’s oldest aims is to resolve disputes. American law fulfills this aim partly through the law of torts, settling the dispute between the injured and the victim and restoring the victim to his or her prior well-being. Building on tort doctrines, courts have developed the principle of informed consent, which serves three bioethical goals: (1) to help resolve disputes over injuries caused by a doctor’s failure to inform a patient adequately; (2) to recompense – however crudely – the injured patient; and (3) – more ambitiously – to improve the way doctors treat patients. Tort law’s loftiest goal in the medical realm should be to improve the way doctors treat their patients. The possible consequences for neglectful or reckless acts give doctors an incentive to provide patients with the best care possible.

B. Military-Specific Challenges of Patients and Physicians

Even in the civilian world there is an inherent imbalance of power between the patient and the physician. Within the military, unique pressures only accentuate this imbalance of power, as the military is a hierarchical organization and its operation is based on the presumption of obedience. Because of this, both military physicians and patients face challenges different from their civilian counterparts.

i. Military Patients

The discipline and “order-centric” nature of the military inherently reduces a military patient’s autonomy in comparison to a civilian patient’s autonomy. Like the physician, a military patient must answer to the military command which has its own set of expectations for the cooperation of the soldiers on medical matters. A soldier on active duty will usually be required to accept medical care considered necessary to protect his own life or the life of those around him. Additionally, unlike their patient counterparts in a civilian setting, patients in a military setting may suffer from numerous psychological illnesses, which can occur from the stresses of combat or from the guilt associated with a medical evacuation from the combat zone. There is also a pre-existing reduced state of autonomy when it comes to medical decisions involving vaccinations, as the President of the United States may mandate vaccinations despite the patient’s refusal. The level with which the command and nation’s interests come before that of the patient varies depending on the stage of military life.

ii. Military Physicians

The Manual for Courts-Martial defines the term “medical officer” as “an officer of the Medical Corps of the Army, an officer of the Medical Corps of the Navy, or an officer in the Air Force designated as a medical officer.” Health care professionals serving in the military play a variety of roles, including, for example, pathologists, primary care physicians and nurses, battlefield clinicians, and advisors to interrogators. However, what separates military from civilian physicians is that once he or she is a member of a military branch, the physician is subject to the same chains of command, rules, restrictions, and bodies of law as all other members of the military, including criminal consequences for failing to follow orders. These competing interests give rise to the issue of “dual loyalty,” which transpires when the physician feels
caught between the obligation to help another human being under his or her care and a demand (formal or informal, explicit or implicit) to act on behalf of some other entity.34 This dual loyalty conflict between the practice of medicine, the interests of the patient, and pressures from the military and command produces the majority of biomedical issues and highlights the inherent conflict between patients and their doctors throughout different stages of one’s military career.35

iii. Military Patient-Physician Interaction
Many challenges of the military patient-physician relationship present themselves differently as the military setting around the meeting of the patient and physician change. For example, on one hand, the military patient may not be as eager for the physician to release him as a civilian would be if it meant a swift return to the battlefield. On the other hand, a patient may be more inclined to lie about symptoms and pains if he is eager to perform his duties and wants to return to the battlefield. Depending on which interests the patient holds highest – either his own interests or those of the patient’s unit, mission, or nation – the patient may make medical decisions and requests that a civilian in the same situation would not make. These include decisions such as requesting release to return to battle before medically-ready or asking to remain in the hospital after fully healing to avoid the same result. In turn, the issues put pressure on the military physician that he would not face in the civilian world. It is not likely that a determination of whether to release a patient or not has such drastic consequences on the lay patient in a civilian hospital. Outside of certain medical conditions that require extra attention from the doctor after the patient leaves, the possibly extreme character of the location of the release has an impact on both the military patient and the military physician in their relationship and decision-making.

C. Bioethical Issues
In the study of bioethics there are a few recurring terms and, arguably, four main principles: Autonomy, beneficence, nonmaleficence, and justice.36 Autonomy is the principle usually assigned to the patient, indicating that independent actions and choices of the individual should not be constrained by others.37 To act autonomously, the patient must act intentionally, with understanding, and independently of controlling influences.38 Autonomy is the foundation for rules relating to disclosure of information on the side of the physician, and consent on the side of the patient.39 Paternalism on the part of the physician is in constant conflict with the autonomy of the patient, and may include actions such as withholding information from the patient or going forward with a procedure despite the wishes of the patient if the doctor believes it is in the patient’s “best interest.” Informed consent is important to the promotion of autonomy in medical decision-making.40 and requires the doctor to disclose material information to the patient such as risks, discomforts, benefits, side effects, alternatives, risks if left untreated, and personal interests unrelated to the patient’s health prior to treatment.41 Additional – and equally important – concepts are the related non-maleficence and beneficence. Non-maleficence is the principle that one has a duty not to inflict evil, harm, or risk of harm on others while beneficence is the principle that one has a duty to help others by doing what is best for them.42

D. Stakeholders and Competing Interest
Those who exercise command authority over military personnel have an obligation to protect the rights, dignity, and autonomy of their subordinates to the greatest extent possible without jeopardizing the military mission or the welfare of military personnel as a whole.43 That said, in addition to conflicting bioethical principles, a physician in the military will confront the simultaneously competing interests of multiple stakeholders throughout his career. First, the physician has a duty to the patient. Depending on the circumstances that bring the soldier into contact with the physician, the physician may experience varying relationships with the soldier. These can range from peace time to on the battlefield, and even in the courtroom.44 Additionally, not only does the military physician see the soldier as his patient, but also as his or her fellow soldier. Second, the physician has an obligation to the medical community’s general standards and practices. Despite the military physician’s – at times – special circumstances, the medical community has standards and practices that it does not feel are ever appropriate to compromise.45 Third, the physician has a duty to the military command and superior officers. Command is the authority that a commander exercises over his subordinates by virtue of his rank or assignment.46 One cannot become a military doctor unless he or she is in the military and accepts the obligations that come with it. This subjects the physician to the same rules and laws as any other soldier; physicians face the same consequences for failing to follow orders. Fourth, the physician has a responsibility for society, as a whole, and the state’s dependence on the proper functioning of the military for safety and order. Because of the special nature of the military and the importance of maintaining good order, the military has its rules, regulations, and disciplines to provide for a proper defense of the nation. By joining the military, the doctor makes a promise to put the needs of the command and society before his or her own.47
From the patient’s point of view, his or her autonomy is already compromised for the sake of the armed forces and national security. For example, “the [Department of Defense], through administrative, legislative, and executive action obtained its own exception to the consent requirement, which has been upheld despite constitutional challenge.” Under civilian standards, consent to a drug or treatment is of the utmost importance. A person of adult years of sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment. Patients in the military are bound to follow orders, and certain federal provisions make it lawful to put the needs of the nation before those of the patient.

III. Health Care in the Military

A major selling point for the military is its well-known and highly regarded health care system. Congress took steps to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services and their dependants. The health care program serving active duty service members, retirees, their families, survivors, and certain former spouses is called TRICARE. On its website, the TRICARE program states that it “brings together the health care resources of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.” The program covers a wide range of services, including medical, dental, vision, mental health and behavior, and life events using both military and civilian physicians.

A. Malpractice Suits Generally

As previously mentioned, the law of torts is an important aspect of resolving disputes which stem from claims of medical malpractice and negligence between patients and their physicians. The medical malpractice system has two primary goals: to compensate injured patients, and to deter physicians from careless behavior. Allowing patients to seek redress for the negligence of their physicians has forced changes in the attitudes and behaviors of physicians, and led them to become more accommodating to the needs of their patients. Knowing that their actions could produce a liability has even led some hospitals to manage risk by setting policies. Furthermore, while in traditional negligence cases, the duty not to act negligently applies among all persons regardless of their relationship to one another, the idea behind medical malpractice liability is that by undertaking the voluntary role of physician, the doctor creates a special relationship between him or herself and the patient. In the medical profession, the relevant standard of care is objective and looks to whether the practice conforms to the standard of care practiced by another member of the medical profession.

B. Relief Barred Against the United States: The Feres Doctrine

Military doctors are different from most civilian doctors in that they are not private individuals but employees of the federal government. In fact, perhaps no relation between the government and a citizen is more distinctively federal in character than that between the government and members of its armed forces. While the Federal Tort Claims Act mandates that the government shall be liable to the same extent as a private individual under similar circumstances, the statute also makes certain exceptions that take away this privilege from members of the armed forces. The Supreme Court in Feres v. United States held that the U.S. Government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or in the course of activity incident to service. This means that a soldier has no means for redress from the negligence of his or her military physician if the injury arises from activity incident to service. In Feres, the Court held that the service members fail the test for applicable federal claims against the government because: (1) the plaintiffs could not point to the liability of a “private individual” even remotely analogous to their claims; and (2) there is no liability “under like circumstances.” The Court’s analysis for the first reason said there was no analogous private individual because the Court “knew of no American law which ever has ever [sic] permitted a soldier to recover for negligence against either his superior officers or the Government he is serving.” As for the second reason, the Court said that there are no like circumstances because “no private individual has the power to conscript or mobilize a private army with such authorities as the Government vests in echelons of command.” It is important to note that in the Feres opinion, the Court did not mention the patient-physician relationship or the standard for a medical breach, two factors typically discussed in medical malpractice cases in civilian realm.

A key aspect under the Feres doctrine is that the outcome of the case varies according to the status of the member of the military at the time of the alleged injury. For example, in Madsen v. U.S. ex rel. U.S. Army, Corps of Eng’rs, the plaintiff was a Captain in the regular Air Force who was on terminal leave expecting to retire in a month. He sustained injuries in a motorcycle accident and sued the United States for the negligent acts of Army medical personnel. The suit was barred under the Feres doctrine because the court concluded that the treatment was incident to military service and that the plaintiff was on active duty status. The court looked to the fact that during his terminal leave and while on military hold status, the plaintiff was, in fact, on active duty status because he received active duty pay, accrued annual leave, and accumulated credit for active duty time later used in computing his military retirement pay. It did not matter that the plaintiff was on terminal leave because, like other forms of military leave, it could have been cancelled at any time and the service member could have been ordered to return to duty. Correspondingly, the active duty service member under military care remains subject to the orders of the hospital commander and the Uniform Code of Military Justice. These are some of the factors considered by courts when determining the status of the plaintiff and whether a negligence suit should be barred under the Feres doctrine.

First, the relationship between the Government and members of its Armed Forces is ‘distinctively federal in character’; it would make little sense to have the Government’s liability to members of the Armed Services dependent on the fortuity of where the soldier happened to be stationed at the time of the injury. Second, the Veterans’ Benefits Act establishes, as a substitute for tort liability, a statutory ‘no fault’ compensation scheme which provides generous pensions to injured servicemen, without regard to any negligence attributable to the Government.
Of note is the third factor, “the peculiar and special relationship of the soldier to his superiors, the effects of the maintenance of such suits on discipline, and the extreme results that might obtain if suits under the Tort Claims Act were allowed for negligent orders given or negligent acts committed in the course of military duty . . . .”79 The third factor carries the most weight, as the Supreme Court specifically stated that the first two rationales are “no longer controlling.”80 This makes the strongest justification for the Feres doctrine consistent with the UCMJ’s rational for many of its laws – “for the good order and discipline of the military.”81

Congress and the military made their priorities clear by barring medical malpractice suits for the good order and discipline of the military. Essentially, the military holds barring suits on superior officers and good order and discipline above the two main reasons for allowing medical malpractice suits: redress for victims and maintaining proper standards for medical personnel. If one looks at the two rationales side by side, they do seem to conflict. On one hand, if the military wants efficient military functioning, it cannot allow soldiers to question, second guess, and bring suit against superior officers. On the other hand, if society wants the medical community to maintain the utmost standards of medical practice, it must allow patients to sue for negligence. Faced with these two rationales for and against malpractice suits, the Court in Feres chose the option that ensured the good order and discipline of the military.

C. Relief Barred Against the Individual Military Doctor Under 10 U.S.C. § 1089

In case there were any questions left regarding whether a member of the military could collect a remedy alleging medical malpractice in 1976 Congress enacted 10 U.S.C. §1089(a). The Act’s purpose is to fully protect military personnel from any potential personal financial liability that might arise from the performance of official medical duties.82 Its effect is to provide complete immunity for individual military doctors, even where it leaves servicemen without remedy.83 It protects against suits for personal injuries, including death caused by a negligent or wrongful act or omission, and protects the following persons: physicians, dentists, nurses, pharmacists, and paramedical or other supporting personnel, including medical and dental technicians, nursing assistants, and therapists if they are in the armed forces, National Guard (under specified times), the DOD, the Armed Forces Retirement Home, or the Central Intelligence Agency.84

The plaintiff in Howell v. United States, outlined the “Catch-22” situation in how 10 U.S.C. §1089, when combined with the Feres doctrine, left her without the possibility of a remedy.85 She made this argument on the basis that 10 U.S.C. §1089 makes the Federal Tort Claims Act action against the United States the exclusive remedy for negligence of military medical personnel, yet Feres bars suits by servicemen against the United States.86 While she argued that this contradiction indicated Congress could not have intended such a result and urged for an alternate interpretation of 10 U.S.C. §1089, the court ruled that the interpretation she sought was not persuasive when viewed in light of the case law developed prior to the enactment of the statute.87 Furthermore, aside from wanting to maintain the good order and discipline of the military by preventing military personnel from suing for medical malpractice, there was also a more practical reason why Congress enacted 10 U.S.C. §1089, which was to eliminate the need for personal malpractice insurance for all government medical personnel.88

IV. The Fluctuating Patient-Physician Relationship

A. Peacetime

Peacetime is when the nation is not at war89 and the soldier and physicians have no notice of an impending deployment. Times of peace are the instances when a military patient-physician relationship most closely mimics that of the patient-physician relationship in the civilian world. While the military physician still has duties to the command and nation, those interests are lower than what they might be during a time of war which, in turn, means peacetime indicates the heightened interests and autonomy of the patient. Some of the situations that may cause a military physician to compromise principles for the good of the nation, such as confidentiality or privacy in disclosing medical information to superiors, are not present, and forced vaccinations or treatment are not as necessary as they might be if a soldier were preparing for war. The environment is more stable and the soldier likely goes to the medical officer on the base or near vicinity to where he or she is stationed. While the nature of the military requires military personnel to travel and move often, during peacetime it is possible for the patient and the physician to maintain a relationship that extends beyond a passing check-up, and it is more likely that they can build a long-lasting, trusting relationship.

The Feres doctrine and 10 U.S.C. §1089 still bar medical malpractice suits for soldiers, even during peacetime, so long as the soldier is acting in the course of duty. However, the lack of a hectic situation may reduce the need for such suits in the peacetime environment. During peacetime there are less immediate needs, fewer
battlefield injuries, and fewer excuses for proceeding with treatment without informed consent or for acting with negligence. Yet, these same reduced stressors may also be the reason that lifting the bar on malpractice suits may be more appropriate at this stage. The lack of hectic situation, the reduced interests of the command and nation, and the raised autonomy of the military patient make it less necessary to hold the physicians to a different standard than their civilian counterparts. It is more reasonable that a military physician working in a hospital, while still subject to chains of command and orders, could be held to the same objective standard of care to which civilian doctors are held. Granted, allowing malpractice suits in this peacetime setting could result in a snowball effect of suits. Even in peacetime, it is not in the nation’s best interests to allow soldiers to sue superiors because of orders. However, it is worth considering that many of the factors that justify overriding a military patient’s autonomy in a battlefield or pre-deployment stage are not present during peacetime, so a suit may be more justified. While these reasons to lift the bar make sense in the civilian world because of the goals of malpractice law (i.e. redress and upholding proper medical standards), it still would not override the interests of the military and the rationale behind the Feres doctrine and 10 U.S.C. § 1089’s enactment – avoiding suits against superiors for negligent orders.

B. Pre-Deployment
The pre-deployment setting lasts from when the soldier is alerted that he or she will deploy to the date of deployment. As a nation moves closer to war, the interests of the command and nation begin to rise and, as a result, the interests of individuals fall. One example of this is the Military Selective Service Act, which signs certain qualified individuals up for military service and possibly war whether or not they consent; it is the means by which the United States administers military conscription. These actions on the part of the government are constitutional, and the government sees service in the Army as duty owed to the state. At these times a soldier can undergo treatment he or she does not desire, be given vaccinations he or she does not consent to, or receive unapproved drugs that he or she did not know about nor give consent to receive. The ever-conflicting paternalism of the military physician rises and the autonomy of the soldier-patient falls.

Informed consent for vaccinations and treatments is one clear principle of autonomy that the government will compromise to achieve military success. For example, prior to commencing Operation Desert Storm, the combat phase of the Persian Gulf War, the DOD sought and obtained a one-time waiver of informed consent requirements, known as Rule 23(d), to permit the use of investigational drugs and vaccines on American Forces serving in the Persian Gulf. In persuading the Food and Drug Administration (FDA) to waive their requirements on the use of investigational agents without obtaining consent from the soldiers, the DOD argued that obtaining soldiers’ informed consent was “not feasible” in the exigencies of war. By following the orders of the command and administering these vaccinations without the informed consent of the soldiers, the physicians showed increased paternalism, and the military patients were subject to decreased autonomy.

Additionally, it is arguable whether the physicians were upholding or contradicting the important principles of beneficence and nonmaleficence. On one hand, if the vaccination saved a soldier’s life, then the physician may feel that he acted for the good of the patient while simultaneously feeling that he harmed the patient by administering the vaccine without the soldier’s consent. This is likely in contradiction with the Hippocratic Oath, which every doctor must take, and is another pressure exerted onto the military physician. If the situation arose where the patient was demanding that the physician not administer the vaccine, but the physician received orders to administer the vaccine – adding in the fact that it is a lawful order due to the waiver obtained by the DOD – the physician would likely have to administer the vaccine. This would tarnish the autonomy of the soldier and, depending on how much the military authorized the physician to reveal about the vaccination, it may diminish the truth and veracity principles for the physician.

In the civilian world, if a doctor performs a surgery without the informed consent of a patient, it is considered an assault, an unlawful touching, and the patient would be able to seek redress through the court system. In the military setting, however, there are two issues that run contrary to the interests of the patient. First, it is not always unlawful for a military physician to administer treatment to a patient without his or her informed consent as seen through the directives, orders, and statutes enacted by Congress and the Executive Branch. The military allows and sometimes orders its physicians to administer vaccines, treatments, and experimental drugs without the informed consent of the patient or any consent at all from the soldier-patient under certain narrow circumstances, in effect making it a lawful touching. In the pre-deployment stage, many of the environmental factors discussed in the next section about the battlefield are not present, decreasing the military necessity for such actions. However, since the interests of the military and society are still in heightened state and because the soldier is likely deploying to a battlefield environment, the command
could still argue that it was militarily necessary to administer the compulsory treatment.

Second, even if the touching was considered unlawful, the military patient would still be barred from bringing suit because of the Feres doctrine and 10 U.S.C § 1089. While the soldier is in a pre-deployment position there is little room to argue that the soldier is not on active duty or acting within the course of military duty while receiving compulsory treatment. Therefore, the courts and Congress have effectively barred all personal injury suits in order to maintain the discipline the military so heavily relies upon to achieve the success of the mission. The knowledge that a doctor is safe from a tort action may further make it easier for him to administer non-consensual treatment or vaccinations, which further keeps the physician and patient from achieving a well-balanced relationship.

C. Battlefield
On the battlefield, it is common for the greatest medical ethical dilemmas to arise.

Indeed, it is impossible to imagine a more challenging environment in which to practice medicine than on a battlefield. It is the antithesis of the ideal medical setting. It is violent. It is noisy. It is chaotic. It is in a constant flux. And it is unpredictable. Lack of creature comforts is the least of the problems faced. Noise levels prevent normal aspects of patient care. Rapid movement, often on little or no advanced notice, requires treatment facilities to be set up and taken down very quickly. Patients can arrive before preparations are completed. Medical personnel, as well as patients, suffer from the fatigue and filth. In addition to the challenging physical environment surrounding physicians and patients, the physician has the legal obligation to place the interests of society (and the military mission of protecting and defending that society) above those of the military patient. In situations of military necessity, such as on a battlefield, military physicians must give absolute priority to military needs, and therefore, will also give priority to protecting and defending society when not doing so would greatly sacrifice society’s interests. In fact, the Secretary of the Army may direct the medical care of any individual on active duty and may determine that the needs of the Army are so significant that they must override those of the soldier-patient. At this point, it is likely that the strength of the autonomy of the patient is at its lowest and the paternalism of the physician is at its highest. This reduction in patient autonomy is in direct correlation to the heightened interests of the command and society during this time of war.

On the battlefield, the military physician faces issues such as battlefield triage, limited supplies, injured enemies, questions of whether to administer euthanasia, and return-to-duty considerations. For almost all of these issues, the doctor must make decisions with the interests of the military command and society in mind first, and the individual soldier second. This is not to say that the physician is not without any guidance. On the battlefield, the physician applies the following rules, listed in order of precedence, when priorities are in conflict: (1) maintain medical presence with the soldier; (2) maintain the health of the command; (3) save lives; (4) clear the battlefield; (5) provide state-of-the-art care; and (6) return soldiers to duty as soon as possible. Military physicians have the duty to be as concerned with the success of the military mission as they are with their patients, and although returning soldiers to duty as soon as possible is the lowest priority, there are likely times when national interest may allow the military to require soldiers to undergo life-saving or other medical care to return to the front lines.

It does not always follow that it will hurt the military patient if the military physicians obey their orders. Oftentimes, due to the extreme nature of the battlefield setting and the injuries brought to the attention of the military physician, the physician may make risky decisions to help save the soldier’s life without his or her first thought turning towards the military mission or society as a whole. For example, in Iraq, Army surgeons have become aggressive users of a controversial drug called Factor VII, which promotes clotting in cases of severe bleeding. Like in the pre-deployment stage where soldiers may have to take vaccines that the FDA has not yet approved, Factor VII is still in a trial stage. However, the urgency of saving a soldier’s life in Iraq takes priority over possible ethical conflicts. Furthermore, to improve the trauma care which is a leading cause of death in war zones and is the third leading cause of death in the United States, top trauma surgeons strongly advocate conducting clinical trials to improve trauma. These trials can be ethically tricky “because trauma research can involve trying novel treatments on severely injured patients who cannot give informed consent.” However, the dire situation in which many of the physicians find themselves often justifies the use of risky, potentially life-saving treatment.

Military physicians in a battlefield setting can also go the opposite route with their paternalism and send soldiers home using medical reasons as an excuse if they feel that they can save a soldier’s life by getting him or her out of harm’s way. This is most common with combat stress disorder and was often experienced during the latter stages of Vietnam. A physician’s willingness to
send soldiers home early could result in the physician diagnosing a soldier with a more serious psychological disorder, and further leave the soldier with a sense of guilt for leaving his comrades because of the questionable diagnosis. Furthermore, knowing of the existence of this less-than-truthful option may leave the physician with a sense of guilt if he chooses not to exercise that option.

The battlefield stage is also where the Feres doctrine and 10 U.S.C. § 1089 likely affect the patient-physician relationship most. Due to the loud and hectic nature of the administration of medical care on the battlefield and in clinics near the front lines, there is already a compromised relationship between the military patient and the physician. It is possible to see how an injured military patient would desperately look to the physician to save his life or ease his pain with any means available. However, without the time and opportunity to become familiar with one another, it is more likely that the physician will also have to make snap decisions without consulting as carefully with the military patient or the medical community as would be expected in the civilian world. As a result, issues such as the administration of treatment with less than perfect trial results, without informed consent, or with a reduced standard of care could occur more easily. Congress has already barred the ability of soldiers to seek redress from the government and individual health care administrators for medical malpractice for the good-order and discipline of the military. It has also made clear that if a physician has orders to act a certain way in certain situations that may impede the autonomy of the military patient, he or she must do so to avoid violating orders and may do so without the fear of a medical malpractice suit.

At the same time, in this setting, the Feres doctrine and 10 U.S.C. § 1089 restrictions may make the most sense from the physician’s standpoint. After all, it seems unfair to hold the same objective standard of care to military physicians with conflicting orders in a hectic, dangerous, and often dirty battlefield environment as is held to civilian doctors in hospitals and office buildings. In this situation, it may be more appropriate to hold the doctors to a “reasonable-under-the-circumstances” standard. It is also in this situation when it is the most important for military personnel, both soldiers and physicians, to follow orders immediately and without question. Therefore, it is more likely that a physician on the battlefield will need to follow standing orders to perform a certain operation or administer a certain drug without receiving the informed consent of the military patient. Here, the physician should feel the most secure that her actions are for the good of society and the command, and further, that she does not have to face a possible malpractice suit in the future. The thought that following an order under these circumstances may eventually cause the physician to face a malpractice suit would likely dampen the resolve of the physician to follow that order and may compromise the success of the mission. This would produce negative consequences for the physician, the command, and society.

D. Post-Deployment

The fourth setting is in a post-deployment stage, which is arguably very similar to the peacetime setting in terms of the levels of autonomy and the importance of the interests of varying stakeholders. In comparison to the battlefield setting, in post-deployment, there is likely an increased level of autonomy of the military patient due to the diminished immediate concerns of the command and nation. There is also a reduced opportunity for paternalism on the part of the doctor as compared to the battlefield because the post-deployment setting lacks the immediate and stressful nature that was present on the battlefield. Unless the physician is working in an emergency room setting, many of the hectic theater-of-war elements are not present. For instance, the physician does not have to make immediate decisions regarding whether the soldier can and should return to the front lines. There is more time to sit and discuss options with the military patient, and at this stage, the doctor has the opportunity to listen more closely to the needs and desires of the soldier who has just returned from the battlefield. There are many resources available to post-deployed soldiers, and the military and medical communities are sensitive to the issues that a returned soldier may face.

In this stage, however, there are also additional needs and concerns that are not present in the previous settings because the soldier has just returned from a high stress and dangerous situation. There is a substantial possibility that the soldier is dealing with injuries in this quiet and not-urgent setting—both physical and mental injuries—that the physician did not have to deal with in the previous stages except when on the battlefield. One example is post-traumatic stress disorder (PTSD) that, by definition, occurs after a stressful event. PTSD is a unique diagnosis in that use of the term requires determination of an external gatekeeping condition: exposure to an event through “direct encounter or witness that involves actual or threatened death or serious injury combined with a response involving intense fear, helplessness, or horror.” At this stage, the relationship between the patient and his physician would likely depend on trust, veracity, privacy, and open communication.

There is also the possibility of the issue arising that the soldier returns from the front lines to be treated by a physician who had never deployed. In this case, a soldier may not have the same trust in the physician that he might have if the physician had been at battle and experienced the same stresses and injuries as the military patient. It is possible that the military patient feels he has more answers and experience than the physician, which may make it more difficult for the soldier to accept the advice of the physician, resulting in a conflict in their relationship. This is especially likely in the cases of PTSD where the soldier may feel more comfortable with the person administering his mental health plan if he or she has experienced the same issues that the military patient is currently feeling.

It is in this post-deployment stage that the most mental harm could result from a barred medical malpractice suit. After all, if a physician is negligent in the treatment of an injured military patient who just returned from a battlefield, the resulting injury may compound the stresses already experienced by the military patient. She may feel that she did her part by following orders, doing her job, and returning safely from enemy lines. It would likely be mentally devastating for a soldier to have an injury with no chance of recovery occur due to the negligence of her physician once she made a safe return. In post-deployment, the soldier, in most cases, remains on active duty, so the same concerns and desires for good order and discipline still override the needs of the individual soldier and enforcement of medical standards when in reference to the Feres doctrine and 10 U.S.C. § 1089’s bar against medical malpractice suit.

In this stage, the physician should take the care and time to understand the difficulties experienced by the military patient. There is a high chance
that the soldier just returned from the hectic situation described in the “battlefield” section where her autonomy was at its lowest ebb. While it is in the nature of the military for personnel to rotate duty stations every so often, physicians and patients in this stage should do everything in their power to maintain a stable atmosphere, as post-deployment is likely a “healing” stage which requires consistency. In the post-deployment phase it is important for the physician to understand the desires and concerns of the patient to best meet those needs and develop a trusting and truthful relationship.

V. Conclusion

This article outlines the bioethical issues facing the patients-physician relationship in the military. Both parties have challenges and pressures that are foreign to those in the civilian world. While military physicians must be as equally qualified to practice medicine as their civilian counterparts, they are subject to different standards and have loyalties not only to the patient, but also to the military command, society, and the medical community. Military physicians should be cognizant of the fact that military patients’ level of autonomy rises and falls depending on the state of the military and nation, and adjust his or her treatment behavior accordingly. In the cases where the interests of the military override the wishes of the individual soldier, the physician should do everything in his or her power to, at the minimum, fully explain the treatment the soldier is about to receive. Barring the ability of members of the military to collect damages from instances of medical malpractice lowers the autonomy of the military patient even further, and could possibly compromise the patient-physician relationship. While the brunt of the responsibility falls on the physician to ensure the welfare of the patient, the military physician is not the only party here that should take extra precautions. Military patients should remember that, while limited at times, they still have a say in their medical future. It should be the goal of both the military patient and physician to discuss issues of autonomy, paternalism, and conflicting loyalties, and to promote an open dialogue about these sensitive issues.

2. 10 U.S.C. § 934. The Uniform Code of Military Justice (UCMJ) Art. 134. (“Though not specifically mentioned in this chapter, all disorders and neglects to the prejudice of good order and discipline in the armed forces... shall be punished at the discretion of that court.”).
5. 10 U.S.C. § 654; see Able v. United States, 155 F.3d 628, 636 (2d Cir. 1998) (reversing the district court and holding that 10 U.S.C. § 654, the prohibition on servicemen engaging in homosexual conduct, does not violate the Equal Protection Clause of the United States Constitution).
7. See Parker v. Levy, 417 U.S. 733, 751 (1974) (upholding a service member’s conviction for making public statements criticizing the Vietnam War and Special Forces personnel, and for refusing to train Special Forces aide men).
9. FIELD MANUAL 8-55, Planning for Health Service Support (U.S. Dep’t of the Army 1994).
10. See id. (using a variation of the same definition that defined ‘patient’).
12. Id. at 308.
13. Id. at 309.
14. Id. at 321.
15. Id. at 317.
16. Id.
17. Beauchamp, supra note 11, at 329; see Trammel v. United States, 445 U.S. 40, 51 (1980), (stating that the. The physician and patient privilege is rooted in the imperative need for confidence and trust, and that the physician must know all that a patient can articulate in order to identify and to treat disease because barriers to full disclosure would impair diagnosis and treatment).
20. Id. at 329.
21. Id. at 341.
22. See Henry Sidickowick, THE METHODS OF ETHICS 304, (7th ed. 1907) (“The essential element of the Duty of Good Faith seems to be not conformity to my own statement [i.e. veracity], but to expectations that I have intentionally raised in others.”).
23. CODE OF MEDICAL ETHICS §§ 8.11-8.115 (Am. Med. Ass’n Council on Ethical and Judicial Affairs 2001) (“Once having undertaken a case, the physician should not neglect the patient, nor withdraw from the case without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured.”).
26. See, e.g., Beauchamp, supra note 11, at 311 (stating that an increased level of disclosure is another example of improvement, and one documented reason for an increase in the level of disclosure to cancer patients is fear of malpractice suits).
28. ARMY REGULATION 600-20, Army Command Policy § 5-4(g) (U.S. Dep’t of the Army 2006) (“A Soldier on active duty or active duty for training will usually be required to submit to medical care considered necessary to preserve his or her life, alleviate undue suffering, or protect or maintain the health of others.”).
29. FIELD MANUAL 8-55, Planning for Health Service Support (U.S. Dep’t of the Army 1994) (stating that combat stress behavior is the generic term which covers the full range of behaviors in combat, from highly positive to totally negative).
30. ARMY REGULATION 40-562, Immunizations and Chemoprophylaxis § 8-3 (U.S. Dep’t of the Army 2006) (“The FDA may decide that potential recipients of a drug under an Emergency Use Authorization should have the option to refuse it. The President may waive this option for military personnel.”).
31. R.C.M. 103(20) (2005 ed.)
34. Solomon, supra note 32.
35. See Peter A. Clark, Medical Ethics at Guantanamo Bay: Abu Ghraib: The Problem of Dual Loyalty, 34 J.L. & MED. ETHICS 570, 571 (2006). (“Military medical personnel, especially in a time of war, are faced with the most ethically difficult dual loyalty of doing what is in the best interest of their patient and doing what is in the best interest of their government and fellow soldiers.”).
37. Furrow, supra note 18, at 4.
38. Beauchamp, supra note 11, at 69.
39. Beauchamp, supra note 11, at 308.
Atlin Meisler & Mark Kuezewski, Legal and Ethical Myths About Informed Consent, 156 ARCH. INTERNAL MED. 2521, 2521 (1996).

See Moore v. Regents of Univ. of Cal., 51 Cal. 3d 120, 129 (1990) (holding that in soliciting the patient's consent, the research physician had the obligation to reveal to the patient his financial interests in materials harvested from the patient).

Moore, 51 Cal. 3d at 129.

Michael E. Frisina, Medical Ethics in Military Biomedical Research, 2 MILITARY MED. ETHICS 533, 551 (2003) [hereinafter Military Biomedical Research].

See Stephen A. Saltzberg, MIL. R.EVID. MANUAL § 313.04 (2003) (quoting Analysis, Mil. R. Evid. 313(b)) ("Compulsory urinalysis, whether random or not, made for appropriate medical purposes, see Rule 312(f), which and the product of such a procedure if otherwise admissible may be used at a court-martial.")

See Navy Medical Corps Recruiting Brochure (The military is not inclined to have its physicians stray from accepted medical practices either. For example, in order to join the Navy Medical Corps an applicant must: (1) have graduated from an eligible medical school accredited by the American Medical Association (AMA) or the American Osteopathic Association (AOA); (2) have completed one year of graduate school in a program approved by the AMA or AOA; (3) have a current state medical license within one year of entering the Navy Medical Corps; and (4) be able to complete 20 years of active service prior to age 60.)

Field Manual 8-55, Planning for Health Service Support (U.S. Dep't of the Army 1994). Command also includes the authority and responsibility for effectively using available resources and for planning, organizing, directing, coordinating, and controlling military forces for the accomplishment of assigned missions. It includes responsibility for health, welfare, training, and discipline of assigned and attached personnel.

Orloff v. Willoughby, 345 U.S. 83, 92 (1953) (subsequently overruled on other grounds); ["The very essence of compulsory service is the subordination of the desires and interests of the individual to the needs of the service" referring to how a conscripted doctor may have to perform services other than his first choice depending on the needs of the Army.] see also Stephen A. Saltzberg, MIL. R.EVID. MANUAL § 313.04 (2003) (quoting Analysis, Mil. R. Evid. 313(b)) ("It may be appropriate to test – by compulsory production of urine – persons whose duties entail highly dangerous or sensitive duties. The primary purpose of such tests is to ensure that the mission will be performed safely and properly. Preserving the health of the individual is an incident – albeit a very important one – of that purpose.").

See 21 C.F.R. § 50.23(d) (2006), ("Under 10 U.S.C. § 1107(f) the President may waive the prior consent requirement for the administration of an investigational new drug to a member of the armed forces in connection with the member's participation in a particular military operation. The statute specifies that only the President may waive informed consent in this connection and the President may grant such a waiver only if the President determines in writing that obtaining consent: Is not feasible; is contrary to the best interests of the military member; or is not in the interests of national security.").

See 10 U.S.C. § 1107(1)(A) (2000) ("In the case of the administration of an investigational new drug or a drug unapproved for its applied use to a member of the armed forces in connection with the member's participation in a particular military operation, the requirement that the member provide prior consent to receive the drug in accordance with the prior consent requirement imposed under section 505(i)(4) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 355(i)(4)) may be waived only by the President. The President may grant such a waiver only if the President determines, in writing, that obtaining consent is not in the interests of national security.")

See Exec. Order No. 13,139, 64 Fed. Reg. 54,175 (Sept. 30, 1999) ("Before administering an investigational drug to members of the Armed Forces, the Department of Defense (DoD) must obtain informed consent from each individual unless the Secretary can justify to the President a need for a waiver of informed consent in accordance with 10 U.S.C. § 1107(f). Waivers of informed consent will be granted only when absolutely necessary.").


Marine Corps Website, http://www.marines.com/page/usmc.jsp?FlashRedirect=true (last visited Feb. 24, 2008) ("As long as you remain in the service of the U.S. government, you and your family are covered by medical insurance. If you remain in the Marine Corps through retirement age, your medical benefits will extend throughout your lifetime and that of your spouse.").

See 10 U.S.C. § 1071 (discussing the purpose of chapter 10 U.S.C. §§1071 et seq.).


Id.


See 61 AM. JUR. 2d Physicians, Surgeons, and Other Healers § 287 (2004) ("An action for injuries or wrongful death sustained while under the care and control of a medical practitioner may proceed on a medical malpractice theory, based on three component duties which a physician owes a patient: (1) a duty to possess the requisite knowledge and skill such as is possessed by the average member of the medical profession; (2) a duty to exercise ordinary and reasonable care in the application of such knowledge and skill; and (3) a duty to use best judgment in such application.").


Beauchamp, supra note 11, at 234.

Kyle Miller, Putting the Caps on Caps: Reconciling the Goal of Medical Malpractice Reform with the Twin Objectives of Tort Law, 59 VAND. L. REV. 1457, 1459 (2006).

See Adkins v. Ropp, 105 Ind. App. 331, 334 (Ind. Ct. App. 1938) (stating "[w]hen a physician and surgeon assumes to treat and care for a patient, in the absence of a special agreement, he is held in law to have impliedly contracted that he possesses the reasonable and ordinary qualifications of his profession and that he will exercise at least reasonable skill, diligence and care in his treatment of him.").

See United States v. Standard Oil Co., 332 U.S. 301,
305-6 (1947) (superseded by statute on other grounds) (“To whatever extent state law may apply to govern the relations between soldiers or others in the armed forces and persons outside them or nonfederal governmental agencies, the scope, nature, legal incidents and consequences of the relation between persons in service and the Government are fundamentally derived from federal sources and governed by federal authority.”); see also Tarble’s Case, 80 U.S. 397 (1871); Kurtz v. Moffitt, 115 U.S. 487 (1885). 64 28 U.S.C. § 2674. (“The United States shall be liable, respecting the provisions of this title relating to tort claims, in the same manner and to the same extent as a private individual under like circumstances . . . .”) 65 Ferex v. United States, 340 U.S. 135, 146 (1950). 66 Id. at 136-137 (dismissing two of the claims which were medical in nature: in the first one, the Jefferson Case, the plaintiff underwent an abdominal operation, and eight months later, in the course of another surgery, a towel thirty inches long by eighteen wide, marked “Medical Department U.S. Army;” was discovered and removed from his stomach; in the second case, the Griggs case, Griggs’ executrix alleged that Griggs died while on duty because of the negligent and unskilful medical treatment by Army surgeons.). 67 Id. at 141. 68 Id. 69 Id. at 141-42. 70 841 F.2d 1011 (10th Cir. 1987). 71 Id. at 1012. 72 Id. 73 Id. at 1014. 74 Id. at 1013. 75 See U.S. Department of the Air Force, 7 August 1981, Reg. 35-9, para. 1-32. 76 See U.S. Department of the Army, Army Medical Treatment Facilities General Administration, Washington DC: DA, Army Reg. 40-2, para. 2-1(a) (change 1, 15 July 1981). 77 United States v. Johnson, 481 U.S. 681 (1987). 78 Id. at 684 n.2. 79 Id. (citing Stencel Aero Engineering Corp. v. United States, 431 U.S. 666, 671-672 (1977)). 80 United States v. Shearer, 473 U.S. 52, 58 n.4 (1985)); c.f. United States v. Atkinson, 825 F.2d 202, 206 (9th Cir. 1987) (barring the claim of a female service member who gave birth to a still-born baby due to the negligence of her military doctor and stating, “[a]lthough we believe that the military discipline rationale does not support application of the Ferex doctrine in this case, the first two rationales support its application”). 81 See 10 U.S.C. § 934 UCMJ Art. 134. 82 Hernandez v. Koch, 443 F. Supp. 347, 349 (D.D.C. 1978) (citing S. Rep. No. 94-1264, 94th Cong., 2d Sess. at 9 (1976), reprinted in 1976 U.S.C.C.A.N. 4443, which states: “The bill is intended to provide, through application of the Federal Tort Claims Act, protection from individual liability to certain medical personnel while acting within the scope of their official duties. In short, defense medical personnel would be immunized from malpractice suits. The bill would eliminate the need of malpractice insurance for all such medical personnel, including physicians, dentists, nurses and other medical support personnel.”) 83 Howell v. United States, 489 F. Supp. 147, 149 (D. Tenn. 1980). 84 10 U.S.C. § 1089(a). 85 Howell, 489 F. Supp. at 147 (discussing how the plaintiff alleged that as a result of the negligence of the Navy physicians that treated her back, her Navy career was irreparably damaged and she was forced to be discharged for health reasons, receiving only 10 percent temporary disability award or severance pay and not medical retirement). 86 Id. at 149. 87 Id. 88 Id. 89 Hall v. United States, 528 F. Supp. 963, 965 (D.N.J. 1981) aff’d without op. 688 F.2d 821 (3d Cir. N.J. 1982) (citing S. Rep. No. 94-1264, 94th Cong., 2d Sess. at 9 (1976), reprinted in 1976 U.S.C.C.A.N. 4443. 90 MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY (2005). 91 50 U.S.C. Appx 451. 92 United States v. Murray, 452 F.2d 503, 504 (8th Cir. 1971) cert. denied, 405 U.S. 935 (1972). 93 See Butler v. Perry, 240 U.S. 328, 333 (1916) (upholding a Florida statute requiring able-bodied men to do work on a road and declaring that it did not violate the Thirteenth Amendment’s restriction against slavery or involuntary servitude. The Court stated that “[i]t was not intended to interfere with the enforcement of those duties which individuals owe to the State, such as services in the army, militia, on the jury, etc.”). 94 Military Biomedical Research, supra note 43, at 549. 95 See id. (quoting a letter, sent from Assistant Secretary of Defense for Health Affairs to the Assistant Secretary for Health of the Department of Health and Human Services, 30 October 1990). 96 Thomas E. Bearn, Medical Ethics on the Battlefield: The Crucible of Military Medical Ethics, 2 MILITARY MED. ETHICS 369, 371 (Dave E. Lounsbury ed., Office of the Surgeon General, Department of the Army, United States of America, 2003) [hereinafter Medical Ethics on the Battlefield]. 97 Id. 98 A Proposed Ethic, supra note 27, at 853. 99 Id. (citing 10 U.S.C. § 3723) (“The Secretary of the Army may order the hospitalization, medical and surgical treatment, and domiciliary care, for as long as necessary, of any member of the Army on active duty . . . .”) 100 MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY, Springfield, Mass: Merriam-Webster (10th ed. 1999) (“Triage is the screening and classification of wounded, sick, or injured patients during war or another disaster to determine the priority needs and thereby ensure the most efficient use of medical and surgical manpower, equipment and facilities. It could also be a system to allocate a scarce commodity such as food, only to those capable of deriving greatest benefit from it.”) 101 Medical Ethics on the Battlefield, supra note 95, at 372 (describing the tension that is faced by nearly all deployed physicians, which is the issue of returning a minimally injured patient or one suffering from combat stress disorder, to combat). 102 U.S. Department of the Army, Planning for Health Service Support, Washington DC: DA, 9 September 1994, Field Manual 8-55. 103 Alex Berenson, Army’s Aggressive Surgeon is too Aggressive for Some, N.Y. TIMES, Nov. 6, 2007, available at http://www.nytimes.com/2007/11/06/health/06prof.html?em=et1 (last visited Feb. 24, 2008). 104 Id. 105 Id. (“With soldiers severely injured every day in Iraq, the military cannot afford to wait for a definitive answer [from the trials].”) 106 Id. (discussing what is behind heart disease and cancer). 107 Id. (describing top surgeons such as Col. John Holcomb, head of the Army’s Institute of Surgical Research and Dr. John R. Hess, a professor of pathology and medicine at the University of Maryland and a physician at the Shock Trauma Center in Baltimore). 108 Medical Ethics on the Battlefield, supra note 95, at 373-74. 109 Id. at 374. 110 At the same time there still may be the possibility of a future deployment. 111 Dept’ of Defense Post-Deployment Health Reassessment Program, available at http://fhp.osd.mil/pdhealthinfo/sm_fam/faq_sm.jsp (last visited Feb. 24, 2008) (making resources available through the Post Deployment Health Reassessment provided by the Department of Defense where a primary health care provider will review the soldier’s health concerns and discuss and deployment-related health questions the soldier may have). 112 One can still differentiate the battlefield and this post-deployment stage by the fact that the physician may give the patient more say and time with the lack of environmental stressors and with the diminished interests of the command and society. 113 Karl Kirkland, Post-Traumatic Stress Disorder vs. Pseudo Post-Traumatic Stress Disorder: A Critical Distinction for Attorneys, 56 ALA. LAW, 90, 91 (1995) (citing American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (Washington, DC: 1994)). 114 See, e.g., National Institute of Mental Health, http://www.nimh.nih.gov/health/publications/anxiety-disorders/how-to-get-help-for-anxiety-disorders.shtml (last visited Nov. 30, 2007) (“You should feel comfortable talking with the mental health professional you choose. If you do not, you should seek help elsewhere. Once you find a mental health professional with whom you are comfortable, the two of you should work as a team and make a plan to treat your anxiety disorder together.”)