

Strategies for Regulating and Improving the Conduct of Military Physicians Are Courts Martial the Answer?

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Introduction

Most doctors are conscientious and act in considerate manner towards their patients. They put the interests of their patients first and observe the ethics of the medical profession. Those ethics were championed by Hippocrates (1) and included respect for teachers of medicine, holding human life sacred and respecting the confidentiality of the patient. The archaic content of the Hippocratic Oath was modified to form the Geneva Declaration of 1948 and this was adopted by the World Medical Association. Most of the 21 undergraduate medical faculties in Australia and New Zealand nowadays administer some form of oath at graduation (2). That "profession" of an oath embracing ethical ideals is what distinguishes the disciplines of law, medicine and the clergy. Psychological research supports the notion that public commitment to a course of action strongly binds the swearer to that behaviour (3).

Occasionally doctors fail to uphold the highest ideals of the profession (code of ethics) and may even fall short of a minimally acceptable standard of professional behaviour (code of conduct). Traditionally the medical profession has jealously guarded its right to self regulation: a tribunal of peers being the usual way that such professional misconduct or unprofessional conduct is managed. Recent scandals such as the Shipman cases (4) in the United Kingdom, the Patel (5) and Reeve (6) cases in Australia have called into question the ability of the medical profession to competently self – regulate. In response to the UK scandals the power of the General Medical Council has been diminished. National Health Service regulators now have statutory authority to investigate and stand down UK doctors accused of wrongdoing.

Other means of regulating doctors include the familiar and somewhat foreboding civil professional negligence legal actions. Rarely are doctors in Australia prosecuted for criminal medical negligence however in the last 5 years there have been 3 notable exceptions: the Bundaberg manslaughter cases of Dr Patel (7), the genital mutilation by Dr Graeme Reeves in Bega (8) and a criminal abortion performed by Dr Sulman Sood in Sydney (9).

Military physicians are not only subject to civilian regulation but also military law. That provides a unique opportunity to utilise alternate disciplinary measures. In this paper I will describe the range of options available to discipline doctors in

the ADF and suggest that these are greater than those available to the civilian sector. The deterrent effect of such disciplinary measures in the ADF should result in better compliance with ethical standards of medical practice. I will argue that undergraduate medical training has only a small component of formal ethical training and propose that the current ADF program (Project Achilles) (10) which was developed to augment ethical training for members (11) should include health professionals. Finally, I will analyse selected cases of military courts martial involving ADF doctors and make some recommendations for newer methods of military discipline employing techniques developed from psychological research.

Examples of Courts Martial for International Military Medical Officers: disobedience, technical incompetence.

Captain Howard B Levy was a young dermatologist who was commissioned as a reserve officer US Army Medical Corps. Following his residency he was then posted to Fort Jackson in 1965. He refused an order to teach dermatology to aidmen in the Special Forces as part of his campaign against the Vietnam War. He was not a conscientious objector but vehemently opposed the Vietnam War. He was charged with disobeying a lawful order; attempting to promote disloyalty and disaffection amongst the troops and making intemperate, defamatory, provoking and disloyal statements to Special Forces personnel whilst in uniform. He was found guilty by a court martial and sentenced to three year's hard labour in 1965 (12). His attempt to claim conflict between his medical ethics and the Army order in defence was denied by the Presiding Officer, Colonel Brown, because 'the ethical precepts of a physician are not protected by existing law' (13).

A notable US Navy court martial involved a cardiothoracic surgeon, CMDR Donal Billig, who was found guilty of manslaughter by a Navy court martial comprised of 9 members of whom 4 were health professionals including 3 doctors and one nursing officer. He was given a custodial sentence (14). Billig, the former head of cardiothoracic surgery at Bethesda Naval Hospital, had been dismissed from two previous appointments and had not performed open chest surgery in nearly six years before entering the Navy in 1982. Three retired servicemen, who had coronary artery grafts performed by Billig, died postoperatively in 1984. Dr Billig had vision impairment. Billig was charged on five counts of involuntary manslaughter resulting from surgical mistakes and poor judgment in the operating room (15). Five other Navy medical officers were disciplined including the Commander of Bethesda Naval Hospital and the commanding officer of the Naval Health Sciences, Education and Training Command at Bethesda at the time. These two senior officers were censured by the Navy Secretary 'because of their involvement in the improper credentialing of Dr Billig'. The previous Director of Surgical Services at Bethesda, who directly supervised Dr Billig, was also court martialled. The other two officers were charged with withholding professional information about the "physical and professional unsuitability" of Dr. Billig (16). These recriminations against five other officers including a general court martial were part of a new campaign to hold commanders responsible for doctors under their supervision (17). In 1988, a United States Navy-Marine Corps Court of

Military Review set aside Dr Billig's conviction because they were not 'convinced beyond a reasonable doubt that the deaths that formed the basis of the appellant's conviction were due to any negligence, simple or otherwise, on his part' (18).

In the United Kingdom on the 13 April 2006, Flight Lieutenant Malcolm Kendall-Smith, a 28-year-old Medical Officer with the Royal Air Force (RAF), was court-martialled and sentenced to 8 months in prison for a series of offences that resulted from his refusal to serve in Iraq. Defence counsel, Philip Sapsford QC, argued that the defendant believed there was no lawful reason for UK forces to enter Iraq, as Iraq had not attacked the United Kingdom. FLTLT Kendall was also ordered to pay £20 000 from his personal savings towards the defence costs, and dismissed from the service (19).

Courts Martial of ADF Doctors: disobedience, sexual misconduct, violence, substance abuse, absent without leave.

A study of such cases was undertaken using anecdotal information supported by information available through the National Archives. Whilst this list is unlikely to be complete (20) the details of those cases which could be identified have been tabulated. Basically they fall into six categories: inappropriate sexual conduct involving patients, substance abuse, assault, insubordination, absent without leave and failure to obey a lawful order. One RAN medical officer was removed from the medical register by the Medical Board after being found guilty of surgically treating sailors beyond his capabilities. Another Army medical officer who assaulted a fellow officer in 1966 was the subject of an internal Army investigation and lost 12 year's seniority but did not face court martial.

Recently the authority of the new Australian Military Court under the Australian Constitution was successfully challenged in the High Court (21). The Federal government responded quickly by reinstating the previous system of Service-based tribunals, namely Courts Martial (22). Under the previous ADF Court Martial system a member would be charged in relation to an alleged offence, say by his/her Commanding Officer and if of a minor nature, the matter could be heard by either a Subordinate Summary Authority (SUBSA) or a Summary Authority (SA) (usually either an Executive Officer (SUBSA) or Commanding Officer (SA) depending on such criteria as rank and the nature of the offence). If the charge was more serious or the member charged were Leading Seaman rank or above and so elected, then the matter could be heard by a Court Martial or Defence Force Magistrate depending upon the nature of the charges being brought.

When the AMC was established in October 2007, the intention was to simulate civilian legal process, especially in relation to more serious and complex offences. After investigation by the relevant Service Police, the matter would be referred to the Director of Military Prosecutions (DMP), an entity independent of the ADF and similar to the civilian equivalent, the Director of Public Prosecutions. The DMP would then, if in agreement, prosecute the ADF member and bring the matter before the AMC. The AMC was judicially independent from the Service chains of command and executive. It replaced and modernized the previous system of trial by either Courts Martial (military line officer presiding with panel members

and a Judge Advocate) or Defence Force Magistrates (an experienced Legal Officer appointed pursuant to the *Defence Force Discipline Act 1982* (C'th) (DFDA). The AMC was presided over by a Military Judge with provision for trial by a Military Judge and Military Jury or Military Judge alone (23). The general principles and laws of criminal responsibility as provided for within the *Criminal Code* (C'th) applied in respect of Service offences prosecuted before the AMC. The onus and standard of proof in disciplinary proceedings before the AMC were generally the same as in proceedings before a civilian court. Trials with a Military Jury were akin to a civilian jury trial (24). Following the successful challenge to the authority in the High Court in 2009, the system of military justice has reverted to the Service-based courts martial. However the independent DMP still has the responsibility of assessing each charge and then prosecuting the matter before either a Restricted Court Martial or a General Court Martial (the difference between the two being the number of members on the Board and the nature of the charges being tried). The advantage of the DFDA is that it has extraterritorial jurisdiction thus allowing prosecution and punishment of defence members or defence civilians in relation to offences committed overseas (25).

Table 1. ADF medical officers court martialled

Year	Service	Charge	Conviction	Penalty
1963	Navy	Failure to obey a lawful order	Yes but overturned on appeal	Nil
1967	Navy	Intoxicated on duty	Yes	Dismissal from Service
1975	Navy	Absent from duty without leave	Yes	Reprimand
1981	Navy	Substance abuse & theft of a controlled substance	Yes	Dishonourably discharged
	Navy	Sexual misconduct	Yes	Dishonourably discharged
1965	Army	Failure to obey a lawful order	Yes	Imprisonment & Fine (ROSO)
1966	Army	Failure to obey a lawful order	Yes	Imprisonment & Fine (ROSO)
1985	RAN	Absent from Duty	Yes	Dismissed from Service
2011	Army	Insubordination	In progress	No result

Where ADF doctors have breached standards of professional conduct towards patients, the tendency is for those cases to be referred to civil regulators. An example of that involved the recent case of the Medical Board of West Australia v Dr Doug McKenzie (26). In that case the alleged breach of patient confidentiality had occurred on Commonwealth territory at a Navy establishment. A finding of "gross carelessness and improper conduct" was made against the medical officer who had, according to the Board, "improperly referred [a senior

officer] to a psychiatrist in the absence of any symptoms" and "acted against [the officer's] trust and confidence" when he conveyed his concern about the officer's mental state to her Commanding Officer. McKenzie was reprimanded and fined \$10,000 (27).

Even if, for example, an ADF doctor were charged with breaching a Commonwealth criminal statute such as complicity in torture then it is likely that this matter would be heard in a civil criminal court.

The utility of Courts martial for disciplining military doctors

But is court martial the best means of dealing with military physicians serious misbehaviour? A court martial is triggered when the alleged offence occurred on military land during the performance of the member's military duties. The penalties which can be imposed are fourfold: incarceration, fines, loss of seniority and dismissal from the ADF. One of the trenchant criticisms of court martial processes has been the lack of adequate legal knowledge and expertise enjoyed by some of the panel of adjudicators. For example military commanders who frequently sit in judgement have little legal training. If a medical officer were to be court martialled then justice would only be served if the court empanelled officers with a medical training and experience. Decisions may be based more on deeming the misbehaviour dishonourable to the parent Service than finding objective evidence of fault. Attempts have been made to address those concerns by appointing civilian judges to preside at courts martial (28), establishing a civil court of appeal (29) or bypassing the military justice system completely (30).

However the view of the Joint Health Commander (31) is that a court martial should be only the last resort in a range of attempts to regulate medical behaviour. He favours alternative means which rely on reward for good behaviour rather than punishment for poor behaviour. This view is shared by Ayers and Braithwaite: in *Responsive Regulation* they assert that: 'the trick of successful regulation is to establish a synergy between punishment and persuasion' (32). It may be that this ADF system of awards and commendations has been hitherto underutilised as a means of encouragement.

Shaming as a Disciplinary Measure

Assertions that doctors are very fearful of loss of reputation amongst their colleagues are convincing (33). Witness the many examples where doctors have applied to medical tribunals to have their name suppressed. The use of shaming as a means of deterrence for medical misbehaviour has been explored in the United Kingdom (34). The arguments against deliberate 'shaming' as a punishment include that shaming involving adverse publicity is automatic as a consequence of civil medical negligence litigation; that shaming removes a doctor's right to privacy and that the exposure resulting from public shaming cannot be controlled. There are also doubts that defiant recalcitrant doctors would regret their misbehaviour and could actually ignore any adverse publicity and loss of peer esteem.

Shaming however in a military environment has the potential to be a powerful weapon against professional misbehaviour. For example demotion as a punishment is immediately obvious

as a change in worn rank insignia. Equally loss of seniority is a serious blow to the career of a military doctor be they Permanent or Reservist. There is strong competition for promotion and loss of seniority would in most cases impair the career of any doctor so disciplined.

Nudging as a means of controlling medical behaviour.

Cass Sunstein, a Chicago law professor, outlined his theory of "nudging" or "liberal paternalism" (35) whereby 'good' choices could be encouraged. For example, healthier choices for students' lunches at the school canteen are enhanced by making those items more visible and accessible on the shelves. Similarly, software purchasers can be encouraged to download the 'best' version of software by making that version the default. There may be aspects of nudge theory which could be adapted to encouraging moral and ethical choices by ADF doctors. By substantially increasing the volume of ethical training, military doctors would be more likely to choose an ingrained ethical decision over any lesser alternative. This would also fit in with the notion of automatism (36) whereby there is a shift from controlled decision making to automatic processing.

Because the learner can no longer verbalize intended behaviors or processes, automatization enables task accomplishment without conscious monitoring and enables concurrent performance on additional tasks (37).

Ethics Training for Doctors

Formal ethics training for medical undergraduates in Australia is short and variable (38). For example at Sydney University there is a compulsory 2 day module in Year 1 whose intent is for students 'to be able to demonstrate commitment to compassionate, ethical professional behaviour and the ability to work cooperatively as a member of a team accepting and providing leadership as appropriate. (39). Ethics training for medical undergraduates is obviously no better in the US.

'Doctors who have Hippocratic ethics have them in spite of medical education, not as a result of it' (40).

There is evidence that an individual's ethical and moral viewpoints can be changed in adult life (41): Socrates (42) was of that opinion 2,500 years ago (43). In the 1980's the Harvard psychologist Lawrence Kohlberg identified moral development

beyond the conventional level whereby individuals adopt the ethical and moral norms of their peers. He showed that a higher level of moral development ('post-conventional') was possible. That involved reasoning which took account of the universal principles of human rights, justice and welfare. Kohlberg discovered that when his subjects took courses in ethics and these courses challenged them to look at issues from a universal point of view; they tended to move upward through the levels (43). That strategy is currently being developed in the ADF through Project Achilles.

Given that medical undergraduate ethical teaching is brief and lacks any specific military component, it is recommended that Permanent and Reservist medical officers are exposed to this moral and ethical teaching at several points in their career. There are anecdotal reports of ethical dilemmas involving medical management of prisoners during deployments. These support the notion that doctors and other health professionals should receive military-specific ethics training in addition to pre-deployment training in International Humanitarian Law.

Making correct ethical decisions under stress.

Stress can be defined as a condition occurring when environmental demands are in excess of available resources and lead to undesirable physiological, psychological, behavioural and social consequences (44). There is controversial evidence that under stressful conditions, decision making may be impaired (45, 46). Salas cites the case of an Iranian Airbus shot down by the USS *Vincennes* in July 1989. Two hundred and ninety passengers and crew including 60 children perished in the Strait of Hormuz (47). The U.S. government believed the incident may have been caused by a psychological condition amongst bridge crew of the guided missile cruiser who were under extreme stress at the time. So-called 'scenario fulfilment' is a mind-set which encourages personnel to carry out a training scenario, believing it to be reality while ignoring sensory information that contradicts the scenario. In this case the scenario was an attack by a F14 Tomcat military aircraft (48). This tragedy prompted a seven year research program called Tactical Decision Making under Stress (TADMUS). An analysis of the decisions made by USN *Vincennes* watch-keeping officers, who were working at a high tempo in very stressful conditions, led to the conclusion that combat stress was the core reason for a poor targeting decision in that case. The goal of TADMUS was to develop training, simulation, decision



OPERATION CATALYST

Photo by: CPL Michael Davis Major Christopher Cunneen, the Overwatch Battle Group (West)-4 Doctor, treats an Iraqi man at the Al Islah medical centre during the Medical Civil Action Program.
TITLE: Medics assist at Al Islah Gallery Number 2008-S0485

support, and display principles that would help to mitigate the impact of stress on decision making (49).

Training for stressful events.

Unless sound decisions are learnt so comprehensively that they become automatic (50) then immediate responses in conditions of extreme stress may be ill considered and lack a full consideration of all the relevant factors. There are five consequences of stress on cognitive thinking (51):

1. The absorption of newly presented information is patchy or selective and certainly not comprehensive
2. Short term memory is impaired
3. Automatic responses, regardless of their previous success, are likely because of pressures of time (52)
4. Natural tendencies to 'revert to type' and employ traditional solutions operate
5. The ability to use simulation thought processes is lost (53)

These impairments in learning and memory are probably caused by the action of high stress-related glucocorticoid levels on the hippocampus (54).

At its best, decision making occurs when all relevant information is processed and assimilated in an objective manner and all alternatives are canvassed before reaching a decision. That is termed 'vigilant' decision making. In 'hypervigilant' decision making, typically under stressful conditions, information is processed in a selective non-systematic manner; data is rapidly evaluated; alternative decisions are not fully explored and decisions are reached rapidly without sufficient review or reappraisal (55).

Stress induced impairments in learning and memory are just as likely to affect doctors who need to make rapid decisions in combat. One solution is for those medical staff is to receive ethical teaching which is so comprehensive and frequent that it becomes 'second nature' to make sound decisions which conform with ADF standards. That ethical training should include theoretical teaching in the classroom as well as simulation training in stressful scenarios. There may be value in introducing a form of 'stress inoculation training' (56) (SIT) whereby anxiety is reduced by lowering heightened arousal and altering anxiety-laden thoughts and images. Coping strategies taught using this SIT strategy include recognizing negative anxious self-dialogue and replacing those with positive self-statements, images and behaviours (57). However stress inoculation training needs to be specific to the anticipated stress.

Conclusions.

Regulating ADF doctors is best achieved by a reward system for exemplary behaviour. Persuasion is the preferred method of regulation: punishment should be reserved for those who are unmoved by persuasion (58). Probably insufficient attention has been paid to the use of awards, commendations and promotion as tools to reward high achievement in ethical conduct. Courts martial have been rarely used to discipline ADF medical officers and there are strong arguments why that method of control is inappropriate for clinicians. Where the errors are administrative rather than in clinical care, then court martial may be appropriate. This might involve situations

where senior medical executives fail to adequately supervise clinicians.

ADF medical officers, like other service personnel, are at times subject to stressful situations where clear judgement and decisive actions are required. Nowhere is that more likely than when medical officers are in combat. Recognising and planning for those contingencies should include pre-deployment training not only in International Humanitarian Law but also military ethics. That ethical training needs to be so substantial that correct ethical choices become the default option for our medical officers on deployment. They should be made aware of the potential for poor judgement and decision making under stress. Stress inoculation training does seem to have value but it needs to be specific to the anticipated stressors.

Edmund Pellegrino, Emeritus Professor of Medicine and Medical Ethics at Georgetown University, Washington, DC identifies a key difference between military physicians and other military personnel:

'The military physician...is distinguished.... by his engagement in a special kind of human relationship that ...demands a certain level of moral commitment. That commitment must be the determinant of the physician's conduct even in the extraordinary circumstances of national defense and war.... The good of the patient is, as always, the gold standard of moral propriety (59).

Acknowledgments

LCDR Steve Rayner (Navy psychologist) and LCDR Stuart Lowe (Navy legal officer) provided technical assistance for this paper.

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