Introduction

Military ethical considerations are now relevant to all dermatologists as the National Defense Authorization Act for Fiscal Year 2017 has decreased the number of future military dermatologists. Consequently, more active-duty service members (ADSMs) will be referred to community dermatologists for their care. Therefore, all dermatologists should be familiar with how skin disease and the subsequent treatment may affect an ADSM's military occupation (U.S. Defense Health Agency, 2017). In addition, although men and women are both concerned about scar formation from medically indicated and elective procedures, the increasing number of women in the military may also increase the number of cosmetic procedures for scar revision and treatment resulting from both routine dermatologic procedures and treatment of battlefield-related injuries (Frederick et al., 2007; Young and Hutchinson, 2009).

Civilian dermatologists also need to be aware of the fact that military personnel with certain chronic medical issues are required to be evaluated by a Medical Evaluation Board (MEB; Young and Hutchinson, 2009). This evaluation is meant to determine whether the service member's long-term medical condition enables him or her to continue to meet "medical retention standards, in accordance with military service regulations" (Military Health System, 2020).

Each branch of service has a different standard for entrance and retention in the military. For example, common skin conditions (e.g., atopic dermatitis and psoriasis) may be a disqualifying condition for entrance into the military or may require an MEB evaluation for continued service in the military, depending on the severity of involvement and prescribed treatments. As future civilian dermatologists of ADSMs, we may have to interact with MEBS. Care of ADSMs also involves understanding whether the patient's skin condition, and its potential treatments, affect the patient's ability to deploy or if the skin condition may flare in a deployed environment. During Operation Iraqi Freedom, 20% of outpatient visits recorded in Afghanistan during a 6-month period were for skin issues. The most common dermatologic issues documented during recent warfare included eczema (17.1%), benign skin neoplasms (13.9%), acne (9.2%), skin cancer (7.6%), and bacterial infections (5.9%; Gelman et al., 2015; Henning and Bahar, 2010a,b). Although skin conditions were common issues in previous wars, such as the Vietnam War, the number of skin cancers diagnosed in a deployed setting was much higher during more recent conflicts in Iraq and Afghanistan (Gelman et al., 2015).

Case scenario

The following case is based on a real patient scenario involving an ADSM that occurred at a military dermatology clinic.

You are a dermatologist in the U.S. Air Force at the rank of lieutenant colonel. A 36-year-old female master sergeant presents to you for follow up on 12 recently biopsy proven, untreated basal cell carcinomas (BCCs) on the head and neck area. As a teenager, the patient was diagnosed with and treated for odontogenic keratocysts. She later enlisted in the U.S. Air Force with a medical waiver for her treated odontogenic keratocysts, allowing for medical clearance into the military. In her early thirties, the patient started developing numerous BCCs and met the diagnostic criteria for the basal cell nevus syndrome. Initially, she underwent Mohs surgery, electrodessication and curettage, and topical 5-fluorouracil for treatment of BCCs. However, after multiple procedures resulting in scarring in cosmetically sensitive areas, she began refusing treatment for BCCs. During the office visit today, she refuses proposed treatment options for her BCCs and requests to have her medical profile preventing deployability revoked to allow for promotion and career advancement.

DR. DUTY SHOULD:

A) Remove the patient's medical profile and allow her to deploy.
B) Use authority as senior-ranking military medical officer to make the patient undergo standard treatment with surgery and hedgehog pathway inhibitor.
C) Respect the patient’s autonomy and allow her to refuse treatment.
D) Discuss potential treatment options for untreated BCCs and coordinate a reasonable treatment plan.

Discussion

The ethical dilemmas of military physicians in the treatment of detainees during times of war are well-described (Annas et al., 2013). However, military physicians are also faced with many
ethical considerations for the treatment of their own military members. When a patient desires treatment that deviates from the standard of care, patient care can turn into a figurative tug-of-war battle, with a dermatologist's recommendations for the optimal treatment opposed to patient's ideal treatment regimen and with a resultant power struggle for balance of patient autonomy.

Respect for those in authority is inherent in the rank structure of the military. This dynamic results in ADSMs being at high risk to receive paternalistic care by a person of authority, such as a dermatologist (Sidel and Levy, 2004). Paternalistic care may cause a physician to employ rank to influence a patient to comply with recommended surgical treatment or hedgehog inhibitor use or to not undertake a discussion of all potential treatment options. Although the inherent rank structure and the dermatologist should be respected, patient autonomy is critical to ethical medical care (Williams and Quill, 2004). Civilian dermatologists may not need to worry about infringing on patient autonomy as a result of superior rank, but there is still the concern that civilian dermatologists' findings may need to be presented to an MEB, whose findings could affect the patient's career.

Paternalism, similar to beneficence, may be necessary to protect one from self. It is natural to desire career advancement regardless of profession. In the military, deployments and medical readiness weigh heavily on career progression and rank promotion. The care of ADSMs includes understanding whether a skin condition and its treatment may affect the ability to deploy. For the patient, the medical profile preventing deployment is an appropriate use of paternalism to prevent additional morbidity associated with untreated BCCs or the development of new BCCs in a combat setting with potentially limited medical or dermatologic resources. A medical profile preventing deployment would then trigger an MEB assessment now that the patient has met the diagnostic criteria for basal cell nevus syndrome. This patient could be found fit for duty after appropriate treatment of BCCs depending on her job, or she could be forced to reclassify into a different job. Her genetic condition may permanently prevent her from deploying in the future to prevent further ultraviolet exposure and damage in a combat zone and the development of more BCCs.

Denial of deployment opportunities for female military personnel like our patient may have even greater long-term implications. Currently, women make up 16.5% of ADSMs (Office of the Under Secretary for Personnel and Readiness, 2017). Although there has been an increase in the number of women in the military in the last several decades, recent data have demonstrated that only 15% of women serve in combat compared with 35% of men. Serving in combat is inherent to the promotion and advancement process in the military (Patten and Parker, 2011). Why fewer women serve in combat is very complex, but may in part be due to the fact that more than a third of servicewomen interviewed recently stated that they experienced bureaucratic harassment, including superior officers delaying their promotions or being denied desired deployment assignments (Bonnes, 2017). Therefore, female military personnel with a medical issue that prevents deployment may have even greater difficulty and another hurdle to advancing their career.

ADSMs, like any other patient, may refuse treatment. However, refusing treatment for a BCC is a medically disqualifying condition for military service and would also initiate an MEB review (Army Publishing Directorate, 2017). An MEB evaluation for refusal of treatment would almost certainly result in separation from the military. This places emphasis on the autonomy of the informed consent process to ensure that all reasonable treatment options and their potential consequences are reviewed, including the risks, both medically and legally, and potential career implications associated with no treatment.

The patient in this case scenario also has appropriate esthetic concerns given poor cosmetic surgical outcomes in the past causing her to decline therapy. Nonetheless, it is critical to mutually agree on a treatment plan, knowing all the consequences and appropriately maintaining patient autonomy. Systemic therapies, such as vismodegib, offer alternatives to surgery and topical chemotherapy, but they would also affect ADSMs' ability to deploy. It is imperative that community dermatologists understand that they soon may be providing health care to ADSMs and may be required to deal with military bureaucracy, as well as the importance of how a dermatologic diagnosis and its associated treatments may uniquely affect active-duty service patients' current job and military career. It is equally important for the caring dermatologist to be able to effectively communicate in the medical record ADSMs' condition for coordination of care and a potential MEB evaluation. With the military's renewed emphasis on deployment readiness, this process is important not only for the individual service member, but also to preserve the fighting strength of the U.S. military.

Analysis of case scenario

Choice D is the preferred answer. Dr. Duty should understand why the ADSM is not interested in the recommended treatment options and, as part of the consenting process, give all potential treatment options for BCCs. Subsequently, an alternative treatment plan can be agreed upon to treat existing BCCs. Choice A is incorrect because a dermatologist also has a duty to prevent harm. In a combat zone, there may not be appropriate dermatologic care, which could allow for increased morbidity associated with untreated BCCs or the development of new lesions.

Performing proper counseling on BCCs and Gorlin's syndrome is correct and allows for patient autonomy, but choice C is not the best answer because the ADSM would be allowed to refuse treatment. Refusal of treatment would also result in separation from the military and prevent future career advancement. Conversely, using authority as a dermatologist or senior ranking officer to force medical or surgical treatment is also not appropriate, which makes choice B incorrect.

Bottom line

It is important for all dermatologists to understand the ethical, therapeutic, and bureaucratic considerations for ADSMs because they may be seeking care in your office soon. To learn more about branch-specific medical standards please follow these links:

- U.S. Air Force Medical Standards Directory: https://www.meddxs.af.mil/public/docs/MSD-29May2017.pdf?attach=true
- U.S. Army Regulation 40-501 Medical Services; Standard of Medical Fitness: https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN8673_AR40_501_FINAL_WEB.pdf
- U.S. Navy Manual of the Medical Department: https://www.med.navy.mil/directives/Documents/NAVMED%20-%20117%20MANMED%29/Chapter%2015%20Medical%20Examinations%20%20incorporates%20Changes%20126%20C%20128%20C%20135%20%2C%20140%20%2C%20144%20%2C%20145%20%2C%20150%20%2C%20151%20%2C%20154%20%2C%20156%20%2C%20159%20%2C%20160%20%20%20and%20164%20%29.pdf
- U.S. Department of Defense Medical Standards for Appointment, Enlistment, or Induction Into the Military Services: https://www.esd.whs.mil/Portals/54/Documents/DD/is-suances/dodi/613003p.pdf?ver=2018-05-04-113917-883
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Disclaimer

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