Editorials

The Quest for Ethical Leadership in Military Medicine

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At the level of senior leadership and command, the creation of an imaginative vision must include an awareness of ethical values and standards necessary to successfully execute those tasks inherent in any organization's mission. In the case of military medical facilities, this must also call for the provision of quality services. Without the implementation of a creative vision and goals consistent with military medicine's mission, the organization and its personnel may expect to perish. At the present time, military medicine itself is sorely in need of closer scrutiny and re-examination of its goals and values. Ideally, and with permission to allow free reign to my imagination, my vision would encompass a challenge to military medical ethics, which has been riddled by legitimate criticism during the recent decade. Somewhere underneath a multitude of media campaigns of sensationalism and the fall of military medical facilities into disrepute, lies the bona fide truth of abuses gone awry in the military medical community. It appears that those in the most senior ranks of the military have misplaced ethics, both personal and professional, and are responsible for morale meeting an untimely death in the face of gross negligence of the most basic ethical principles. Too often, serving the population of military service members, their families, and retirees has become the last priority, while self-interest and self-aggrandizement take on increasing importance as the overriding motivation.

In an even broader leadership context, one can certainly argue the point that justification of morally reprehensible actions by silence and the pleading of ignorance amounts to a violation of the oath of office that every officer is sworn to uphold. The military cannot possibly perform its functions and duties in accordance with the values, ideals, and principles embodied by our Constitution (from which the Oath of Office is derived) if these duties are performed with disloyalty, disobedience, and a lack of integrity. This would result in an ineffective military instrument of questionable virtue. Moral competence must be as urgent as technical and tactical expertise on the battlefield and in every leadership dimension. Orders and actions that violate ethical standards of both medical and psychological practice, as well as the laws of war, are illegal in either context. Both are in direct violation of those basic humanitarian principles of the four Geneva Conventions (1949), the Principles of Conduct set forth for professional soldiers by the United States Military, and those ethical standards to which all medical practitioners are bound by law. Every leader must persevere in developing the courage of conviction to stand up for and to abide by what is morally right. Situations, circumstances, and consequences of any actions must never allow for compromise. Our lives, our humanity, are otherwise at stake.

An organization can only be effective if conformity to the highest of ethical standards forms its backbone. There are risks involved for any leader in setting the tone for what he or she considers an acceptable set of ethics and standards of conduct, to which his or her organization is expected to subscribe. Ethics must govern over behavior. Ethics can only become group-centered if all parties are willing to adopt them and adapt to them. This can only occur if desirable behaviors are demonstrated by the leadership. This is not a revolutionary new concept, but actually formulates one of the most basic principles of human behavior. As infants, we learn behavior by observation and modeling of our care-givers' behavior. Standards of behavior cannot be dictated, demanded, or referred to in vague memorandums, disseminated for the lining of office trash cans. Leaders at all levels must clearly exhibit exemplary behavior as the expected and accepted standard for organizational behavior and functioning.

Authority must be utilized ethically in any leadership position, despite the temptation to use and abuse rank for other than the legitimate fulfillment of responsibilities. Anything less should be considered negligent and an exploitation of power, authority, and of subordinates who fall within the chain of command. Within the military hierarchy, this has oftentimes become a sanctioned practice, earned by virtue of ascension of the rank ladder. It becomes all too easy to forget how discouraging and demoralizing this becomes for those in one's charge. Senior leaders must never be permitted to grant silent immunity to those who move up into command positions, as this becomes a no-win situation in every respect. It cannot be forgotten that the visibility offered by positions of authority impacts upon the work lives of personnel at every level of organizational functioning.

The brotherhood/sisterhood of physicians and the medical community have frequently earned the reputation of overlooking infractions and violations of medical ethics. In many institutions, both civilian and military, this practice has become acceptable in order to protect the notion that physicians and other professionals are indispensable to any organization. Oral reprimands and transfers to other military facilities are insufficient punishment for falsification of licensure documents after revocation, for failure to report disciplinary actions by state

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boards prior to application for military service, and for sexual improprieties (such as assault) against patients. The latter charge is a clear incidence of unethical behavior in accordance with principles set forth by the American Psychiatric Association and the American Psychological Association, as well as most state medical boards. It is also strictly forbidden by the Hippocratic Oath. Sexual assault is considered a felony in all 50 states and is a criminal violation of both state and local laws, as well as the Uniformed Code of Military Justice. Allegations of improperly prescribed drugs and prescription of controlled substances for other than valid and reasonable purposes, as in the case of at least two Army psychiatrists, have regularly been labeled as quality control slip-ups, rather than criminal actions. Competence in clinical practice has been frequently used as an excuse for discounting criminal actions. These behaviors must be condemned at all costs. Allowing medical officers to resign from their commissions or honorably discharging them with glowing recommendations in order to escape and evade disciplinary action is hardly getting rid of the problem. Instead, it empowers its perpetrators to continue their commission of crimes. This was certainly true in the case of a Fort Belvoir pediatrician convicted of sexual assault crimes against a minor. Two years prior to this conviction, the Army had sufficient evidence to court-martial this physician for forcible sodomy of a minor, but he was simply permitted to resign from his commission. This left 25 victims remaining, to suffer from severe psychological trauma, while their rapist remained free from just punishment for these additional crimes, with total disregard for their ongoing mental anguish and suffering.

Culpable negligence and dereliction of duty in the performance of surgery amount to far more than physician indiscretion when patients die, as in the case of Commander Donal Billig. Commander Billig, a cardiothoracic surgeon, was assigned to Bethesda Naval Hospital from January 1983 to November 1984, when his competence was first questioned. His pattern of performance problems at civilian hospitals was established long before his Naval commission in 1982. His near-blindness in his right eye, first documented in 1980, and falsification of documents regarding his blemished career, resulted in the deaths of five unsuspecting victims. Intimidation of testifying physicians by their commanding officers permitted this surgeon with bad eyesight, poor judgment, inadequate performance of surgical techniques, and failure to be cognizant of his own limitations, to take the lives of innocent human beings. No hospital can afford to disregard the misreading of electrocardiograms and misdiagnoses of gastrointestinal problems, which later leave victims dead from heart attacks in emergency room parking lots.

In 1983, the Chief of Anesthesiology at Walter Reed Army Medical Center (WRAMC) pleaded guilty to supplementation of income by illegal receipt of funds from drug manufacturers in order to carry out testing of approved and unapproved products on uninformed WRAMC patients. He also owned 50,000 shares of a corporation that produced defective respiratory equipment, claiming that it was completely safe for use. Additionally, he recommended high-volume purchase of this equipment. This anesthesiologist attempted to discredit and destroy the career of the young physician who reported him by falsely accusing him of narcotics addition. Blatant instances of corruption, flagrant violations of the law, and investigations that are twisted into whitewashes, have become accepted practice in many segments of military medicine; hence, the mess in it.

Tolerance of indiscretions, inappropriate behavior, and criminal actions must be rendered unacceptable and prevented at all costs in military medicine. It becomes quite simple to divert attention and to excuse misuse and abuse of power and authority. These injustices enable further deception and breaches of ethics at every level of organizational structure, as selflessness gives way to selfishness. Leadership must establish a reputation for fairness and enhancement of the highest standards of conduct, competence, and ethics by setting the example. In order to teach ethics and to hold each individual accountable for their own behavior, the system cannot afford to reward ethical violations or to remain neutral by ignoring them. Although no simple task, the system of rewards and punishments must be alert to personnel who will stop at nothing to climb over subordinates, peers, and patients on their way to the top. Denial of this reality contributes further to organizational downfall and failure. Neither can there be room for "retired on active duty" officers and NCOs who can be found sleeping at their desks long before the conclusion of the duty day.

In order to perpetuate success in any organization, the leadership impact must constitute a positive force that mobilizes a working toward the common good of both personnel and populations served. It is not always as easy to teach ethics as it is to effect changes in a system that rewards unethical behaviors. In the inevitable battle between good and evil, the primary motivation remains survival, an instinctual human drive. A system of reward and punishment is therefore the most likely means of successful enforcement of acceptable standards of conduct. There can be no exceptions based upon rank, professional standing, or withholding of promotions until compliance is achieved. The addition of peers and subordinates to officer and enlisted rating schemes may offer a means of instituting appropriate checks and balances. If a leader has reason to be concerned about such ratings, he or she should also be questioning his or her own leadership capabilities. Leaders who fear staff input have cause to worry about more than their next Officer Efficiency Report.

Senior leadership must be held accountable for the encouragement of productivity. In order to build an unshakable morale and create a healthy organizational climate, every member of a medical center staff must be perceived for their value and potential to succeed. Respect and dignity are essential for both staff and the patients they serve. Leadership must be educational in its approach by coaching at all levels of rank and responsibility, demonstrating its genuine interest in the welfare and well-being of the organization. It is a human trait to rise to the level of expectations held by one's superiors. In order to build a successful organization of personnel who strive for excellence, leadership must invest in the success of each member, contributing to the sum of high-functioning organizational parts. This premise must not fail to include leadership's assumption of responsibility and blame when events do not go as planned, as well as for their own personal conduct. Leaders must live what they expect from others.

My organizational vision is a simple one. Integrity and a clear sense of professional ethics and values are the critical ingredients that must lie at the foundation of any successful

hospital mission. Have a mentor and be a mentor. Be outraged at personnel who seek to do damage to their colleagues, their subordinates, and their patients. Believe in the extraordinary, without sacrificing staff to perform the impossible. Believe totally in the value of every single individual within your charge, from housekeeping and maintenance to department chiefs. Affirm their value in their presence—often. Be sufficiently enthusiastic and ambitious to commit to the fulfillment of organizational goals, without being intoxicated by the prestige and power of rank. Be liberal in awarding of well-deserved praise and inspirational in fostering enterprise and empowering people to promote the development of new ideas and new worlds, personally, professionally, and for the good of the organization. Avoid the conspiracy of silence and the denial of wrongdoing. Be intense in challenging systems that are dysfunctional. Dare all personnel to be better. Anything less amounts to a gross breach of medical ethics and a miscarriage of the truth about patient mismanagement.

WESTPAC, AIDS, and the Navy

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Times have changed. For several generations, sex and the Far East have been synonymous. Many a battle group visited Olongapo or Pattaya for liberty. The women were as available as hot and cold running water. Many a man remembers these liberty ports as sexual playgrounds. Whatever their tastes were, they could find fulfillment in Thailand or the Philippines.

In the old days, men had only to worry about the clap. There was nothing that could not be cured with a bit of antibiotics and a few weeks of abstinence as the ship headed home. Conscience checks were done, the soul was cleansed, and many a wife never knew that her husband had a different woman every night on liberty for a week. The "docs could cure anything."

As the seventies ended and the eighties rolled around, the clap continued and herpes became the key word. The course of events changed slightly as no longer could medical cure the problem before homecoming. But given about 3 weeks, the husbands and boyfriends were no longer infective, business carried on as usual. Only if new lesions arose did the husband have to say anything. The clap had been left behind and herpes came home. It was the gift that kept on giving. This did not shut down the sexual palaces of the Far East. Ships continued to call in the affected ports, conscience checks were done on the way home, and husbands knew what they had before they got home.

By 1982, the problem began to change. The sexual industry and American sexual practices brought AIDS to the United States. The problem has continued to grow in the U.S., as reflected in the press. Little has been done to stem the tide of the disease, to control its spread, short of using condoms. The fleet has continued to believe in the Far East as a sexual playground.

The easy availability of young prostitutes has historically made ports like Subic and Pattaya favorite liberty ports. The women enter the profession young, some pushed into it by their families for money. They are friendly, arousing, and have learned the tricks of the trade. Where in America are 5,000 sailors greeted by a scantly clad amazon on the beach with a squeeze of the groin and a cold beer? The young and old sailors are bowled over by the assault and are quickly involved. Many a married sailor and officer remember the good old days when they could have anything with legs, and medical could cure them before they got home.

As the heyday of Olongapo wound down, AIDS was beginning to be seen among the prostitutes in Subic. It was 3–4% in the prostitute population. Mangsaysay Street continued to flourish to the end. Less than 20 dollars bought a bed full of pleasure for the night.

GONZO station was serviced by Mombasa Kenya. But Africa has a higher indigenous AIDS population than the United States. As the HIV rate among the prostitutes peaked at 90%, Mombasa was taken off the list of approved ports for liberty. No longer could carriers go there for port calls.

Pattaya remained a single bastion of the old practices, and the industry thrived. Prostitutes are shipped in when the fleet arrives. They are willing and able to take care of the sailors' yearnings. Anything goes. But with the flourishing sex industry has come a wildfire of HIV spread. Thailand, while not "allowing" prostitution, tolerates it. There are many sex tours from Europe, which travel to Thailand, due to the availability of cheap, easy sex. This lack of control has led to a tremendous spread in HIV, with EPMU reporting a 20–70% HIV rate in selected groups of prostitutes. Those who are affiliated with bars have a 20% HIV rate, while those who are "free lance" have a 70% rate. This leads to exposure of the fleet to a much higher rate of AIDS than the average population in the United States.

In Thailand, and in other countries in the Far East, some of the prostitutes suppress sexually transmitted diseases with prophylactic antibiotics. Public health departments and

Ships Surgeon, USS NIMITZ CVN-68, FPO AP 96697-2820.

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