

Chapter 7

ETHICAL ISSUES IN COMBAT PSYCHIATRY

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INTRODUCTION

Although some argue that combat itself is so highly unethical as to defy attempts to apply any ethical precepts, some cultures have had specific ethical principles for engaging in combat.^{1,2} When cultures with divergent ethical standards have engaged in war, controversies have arisen. This was seen, for example, when European settlers came into conflict with Native Americans. Some tribes felt that the ultimate honor one could accord an enemy was to torture him to death so that he could display his courage.³ Similarly, the Japanese outraged Americans by a “sneak attack” without a declaration of war on Pearl Harbor in 1941 with the Japanese position that this attack was a brilliant and ethical military maneuver, a position apparently endorsed by Israeli and Arab forces in some of their wars.^{4,5} In subsequent wars, surprise initiation has become commonplace. Another example of divergent ethical positions occurred when American forces surrendered to the Japanese in the Philippine Islands. The samurai ethics of Bushido held surrender to be a heinous crime placing the perpetrator beneath contempt.⁶ As a result, American prisoners of war were harshly treated and many perished.⁷

Starting with the medieval concept of chivalry, European ethics of combat were increasingly codified and formalized although there were many lapses.⁸ In the American Civil War, General Sherman’s slash-and-burn march through Georgia to isolate Confederate forces from supply support marked a major change in the American ethics of war because civilian populations became embroiled in what had been an occupation of professional military men.² In more modern times, one can see an extension of this concept in the fire bombing of

Dresden,⁹ the atomic bombing of Hiroshima and Nagasaki,¹⁰ and the forced relocation of villagers in Vietnam.¹¹ The Nuremberg trials after World War II have shown, however, that there are definite limits to waging war on civilians.¹² Following his Vietnam service, the defense argued that First Lieutenant William Calley of the infamous My Lai massacre was no more guilty than pilots who bombed North Vietnam, killing thousands, because both were attempting to destroy the support infrastructure of the enemy.¹³ The jury, composed almost entirely of combat veterans, did not agree, and Calley was convicted of over two dozen murders. In Calley’s case, specific U.S. Army regulations were violated, and he was convicted not of ethical but of criminal offenses.

Psychiatry is not alone among the professions in having this sort of ethical dilemma when serving in the military, nor is the military the only institution in which it arises for psychiatrists. It is unavoidable that problems arise regarding conflicting loyalties and contradictory goals. Whether or not these are experienced as problems by the individual psychiatrist, or if they are so experienced, whether they are acknowledged, are important correlative issues and of special interest.

Finally, it needs to be emphasized that questions of professional ethics are not the sole prerogative of psychiatrists but also must be considered by other mental health disciplines and their noncommissioned officer and enlisted counterparts. In addition, it must not be forgotten that combat psychiatry is also practiced by general medical officers and physician assistants and, to some extent, by platoon medics and all other U.S. Army Medical Department clinicians on the battlefield.

ETHICS OF PSYCHIATRY IN WARFARE

Before the Vietnam conflict, military psychiatrists seemed confident that their goals and methods conformed to the values of both the military and the American people. These earlier military psychiatrists perceived that the rationale for America’s military activities sufficiently satisfied the criteria for a “just” war and saw little role conflict or moral dilemma associated with encouraging the soldier-patient to return to combat re-

gardless of residual psychiatric symptomatology.¹⁴ However, in conjunction with the controversial Vietnam conflict, a frank and impassioned debate¹⁴ erupted within psychiatry concerning the proper role for psychiatrists in time of war, especially military psychiatrists. Underlying this debate was the critical moral or ethical question for whom does the military psychiatrist work—the individual patient or the military organization? Novelists such as

Rosten (*Captain Newman, MD*)¹⁵ and Heller (*Catch-22*)¹⁶ have also addressed this issue, setting their stories in the context of World War II.

A military psychiatrist as a physician subscribes to the Hippocratic Oath and as an officer in uniform is governed by the Uniform Code of Military Justice and the oath sworn when commissioned. Conceptually, the potential conflict between these oaths reaches its most extreme point when the military psychiatrist must decide whether to conform to his soldier-patient's wish to be medically exempted from further exposure to the high-risk, high-stress combat environment or to satisfy the military's contrary expectation that he be returned to that environment even if he is in some emotional distress.

It is not new to observe¹⁷ that psychiatric patients seen under combat conditions might themselves suffer with a conflict between self-protective motives and feelings of obligation to military comrades and goals. Likewise, psychiatrists who have not been sufficiently schooled in the goals and methods of military psychiatry have been noted¹⁸ in previous wars to fail to understand the competing sides of the soldier's struggle to overcome his fear, to overly empathize with the soldier's self-protective side, and to overdiagnose psychiatric disturbance. What was new from the Vietnam period were the expressions of doubt as to what constitutes the ethical practice of psychiatry within the military—expressions that were vocalized primarily in the latter half of the war coinciding with the influx of civilian-trained psychiatrists into the services and with the increasing divisiveness among Americans regarding the war.¹⁴

By way of a literary example, in chapter 10, "Gentlemen, it works" of Glasser's fictionalized account¹⁹(pp124-148) of his experiences as an U.S. Army doctor assigned to an army evacuation hospital in

Japan during the middle phase of the Vietnam conflict, he vividly portrays both sides by presenting an ersatz official stateside briefing on combat psychiatry's development, logic, and field methods (eg, brief, simple treatments provided near the soldier's unit and followed by rapid return to combat duty). The briefing was periodically interrupted by reflections of drafted psychiatrist Kohler regarding his own clinical experiences in Vietnam. Although initially skeptical of "the military machine with its emphasis on interpersonal rather than intrapersonal psychopathology,"¹⁹(p140) Kohler came gradually to appreciate the pragmatic value of the approaches used by military psychiatry to stem the psychological breakdown of stressed combat soldiers (and his patients expressed their appreciation). However, the piece ends with Kohler returning to his original worry that he could have been sending vulnerable soldiers back to face the risks of combat (echoing Livingston's 1969²⁰ concern): "It works. The men are not lost to the fight, and the terrifying stupidity of war is not allowed to go on crippling forever. At least, that's the official belief. But there is no medical or psychiatric follow-up on the boys after they've returned to duty. No one knows if they are the ones who die in the very next fire fight, who miss the wire stretched out across the tract, or gun down unarmed civilians. Apparently, the Army doesn't seem to want to find out."¹⁹(p148)

This chapter will examine the arguments that serve as justification for the policies, field principles, and techniques that compose the doctrine of combat psychiatric treatment. It also will examine a number of associated ethical questions surrounding military medicine and military service. The chapter will review challenges to the doctrine and provide an analysis of the effects of the competing value systems on military psychiatrists.

TREATMENT AND PREVENTION ISSUES

The Ethics of Military Medical Triage

The principles of medical triage²¹(p182) developed in disaster (mass casualty) situations for medical personnel were limited so that not all can be treated. In ordinary emergency situations, the most seriously ill would be treated first to save life and limb, but in military triage situations, the most seriously ill might be allowed to die so that limited medical resources can be devoted to salvaging the lives and limbs of the less seriously injured. In combat set-

tings, this might be carried a step further in rendering care first to those most likely to carry out the combat mission, that is, the lightly wounded and combat stress casualties.

The military triage situation is "mission driven" and "resource scarce" and thus creates serious ethical dilemmas in terms of individual survival. Differing perspectives on impairment result in a conflict between putting the mission first versus the risk of increased morbidity. The principle of military medical triage²¹ holds that individual soldiers'

interests can be sacrificed when necessary either for the medical welfare of other soldiers or to further military goals. In practice, the need for such sacrifices may be rare. During the Vietnam conflict, for example, no efforts were spared to assist critically injured soldiers, and after evaluation, only those with the most severe head wounds were considered unsalvageable.^{22(p156)}

The application of the military medical triage principle for the purpose of benefiting the military objective was exemplified during World War II in North Africa when penicillin was scarce in supply, but soldiers needed it. Some soldiers had been wounded in battle, and others had venereal disease. The available penicillin was given to the latter group because they could return to the front.^{23,24,25(pp209–210)}

An application of the military medical triage principle being applied for the sake of other soldiers is reported by Hinds,²⁶ a British physician and medical historian. This situation occurred after an airplane on which he was traveling crashed in the desert. Eight men were badly injured and needed pain medication to survive the 120-mile journey to obtain care. Yet, there were but four doses of morphine. Hines gave the limited morphine to those who had the best chance of survival.

Analogously, during combat, military physicians may have to decide which service persons' treatment should be given priority. More specifically, they may have to decide whether to give priority to treating soldiers so that they can return to the front or to saving the maximum number of lives. A relatively different emphasis between these two goals occurred, for example, during World War II. The German army placed greater priority on returning injured soldiers to the front, the United States, on sending injured soldiers to the rear for rehabilitation.²⁷

Yet, triage and different degrees of risk-taking by certain groups is less than fully analogous. When triage takes place, no group is singled out on the basis of some preexisting characteristic that subjects some to a greater risk of morbidity or death.

The Right To Refuse Treatment

Many civil rights are lost or abridged when one joins the military, including the right to refuse legal orders even if they may result in one's death. Often decried^{28,29} in medical circles is the loss of medical confidentiality although regulations^{28,30,31,32} limit access to medical records to those with a need to know. Paradoxically, while this pillar of medical

practice is pushed aside, the right to refuse medical treatment is preserved except in emergency situations in which the patient may lose life or limb.

The military has occasionally been subjected to the same difficult situation encountered in civilian jurisdictions when an involuntarily detained patient meets detention or commitment criteria but has the right to refuse treatment. A military member may be ordered into a psychiatric facility for evaluation by his commander; however, this situation does not give physicians the right to treat involuntarily. With psychotic mental patients, this situation may result in lengthy hospitalization until spontaneous improvement allows nonhospital disposition or persuasion or deterioration to the point of danger to life or limb allows hospital treatment. Such a case described by Beighley and Brown³³ resulted in 5 weeks' delay in treating a psychotic manic-depressive patient.

The military does have a procedure by which a member who refuses treatment may be eliminated from the military. This lengthy procedure involves review by the applicable surgeon general. In 1973, the second author, in his capacity as chief of psychiatric services at a major army medical center, encountered a case in which the procedure took one-half a year and was still unsatisfactory because the military member did not get appropriate care after being discharged.

Military Physicians Treating Combat Fatigue

The handling of psychiatric breakdown during the stress of combat was generally considered to be a command issue until the introduction of psychiatrists into the Russian medical support structure during the Russo-Japanese War.³⁴ Previously, such combat breakdown was attributed to physical causes (such as "soldier's heart" in the U.S. Civil War) or moral weakness (cowardice).³⁵ Management tended to be medical (rest and medications) or coercive (court martial or death). Russian psychiatrists³⁴ offered an alternative by labeling such stress casualties as "insane," "neurasthenic," or otherwise not responsible. As recently as World War II, America's General Patton³⁶ frankly considered combat stress casualties to be cowards.

Gradually, the medical view held sway because this approach appeared more humane and pragmatically resulted in a greater salvaging of casualties who could return to combat or combat support duties. The battalion surgeon and the psychiatrist shared some of the commander's responsibility for

sending men back into combat where they might die. Because of inherent ethical dilemmas, this situation can become an uncomfortable role for physicians.

One justification is expounded by Jones³⁷ who cites numerous examples that illustrate that when military psychiatrists treat combat stress casualties on the basis of principles such as proximity and expectancy, not only the military but also, over the long-run, these service persons also benefit. That is, if they are returned to the front after a few days, they have appeared to experience no subsequent psychological morbidity greater than their untreated fellow soldiers.

Thus, in this situation, the conflict cannot be fairly characterized as the military's interests versus soldiers' interests. Rather, to some extent, the military and service persons' interests are in agreement. If the combatant dies after returning to duty, this may not be the case; but, this outcome may be justified on other grounds. Further, if military psychiatrists actively tried to protect combatants with combat fatigue from reentering combat, they would violate the soldiers' prior expectations and break an implicit promise to them. Furthermore, some other, less-experienced and presumably less-skilled individual would have to assume the risks from which the combat stress casualty had been removed.

Combat stress casualties seek medical handling and rarely overtly ask to be removed from combat. If they should ask to be removed from combat and if the ethical principle of respect for their autonomy were prioritized, this would require military physicians to permit their request, even though they might at that time be psychologically impaired. The consequence of granting their request might be subsequent morbidity from feelings of guilt and low self-esteem, and furthermore, they might be subject to court martial. Desertion in the face of the enemy is a capital offense. Even if a combatant showed manifestations of combat fatigue, this is not usually sufficient to justify medical evacuation beyond first or second echelon levels. Ethically, it may be that the stressed soldier should retain decision-making capacity because he is still competent to decide what he wants. For comparison, in civilian settings, physicians may not be justified in overriding their patients' desire to refuse a life-saving operation even when the patient is depressed.

Even if such patients are considered to retain competence, however, military psychiatrists would have some justification, when unsure, to err by treating them as if they primarily had combat fa-

tigue and, once recovered, would want to return to duty. This usually is the case,^{38,39} and psychiatrists lack the means of determining when it is not. Moreover, treating most combatants with combat fatigue so that they can return to duty is necessary for the welfare of the unit and the military combat mission. The soldier's return to duty also, in at least a majority of instances,³⁸ is necessary to prevent numerous others who also feel afraid during combat from following suit. Just as they may have to sacrifice their lives, if necessary, for the combat effort, those who show symptoms of combat fatigue, to some degree, may have to sacrifice their autonomy. To this extent, the benefit to the military is opposed to the interests of the soldier with combat fatigue.

The incident regarding combat fatigue often cited in the ethical literature^{40-42,43(pp261-262)} is a press report of an air force sergeant who had flown many combat missions in Vietnam and subsequently asked to be relieved from further combat duty. Air force psychiatrists assessed his condition, diagnosed it as a stress reaction, treated him for combat stress with psychotropic medication and psychotherapy, and returned him to duty.⁴²

Veatch reports that Newman, a physician, argued, however, that the psychiatrists who treated this sergeant created an "iatrogenic psychosis."^{42(p246)} Newman was asserting, of course, that this soldier's request to be removed from combat was "genuine," and therefore, he should not have been treated for combat fatigue. As just discussed, however, there is sufficient justification for military physicians to treat service persons for combat fatigue even when their request to be removed from duty is in part genuine. Namely, military psychiatrists lack the means of distinguishing combat fatigue from "genuine" requests, the military will benefit, and to the degree combat fatigue exists, the service person will benefit if he survives combat. Service persons also have agreed implicitly, even when conscripted because they could refuse conscription and face penalties, when entering the military to give their lives, if necessary, much less their autonomy, for the combat mission. They also expect the military to do what they can to protect them.

It could be asserted, in agreement with Newman's⁴² claim, that any soldier entering combat willingly is irrational. Lifton⁴⁴ contends, for example, that service persons sometimes initially seek out combat experience enthusiastically because of "male bravado." Lifton gained this impression from the not unbiased comments of "rap groups" of antiwar veterans, and his description of their at-

tempts to understand their earlier motivation for entering combat is noteworthy: "They probed unsparingly the source and fears beneath their male bravado in enthusiastically (in many cases) 'joining up' and even seeking out the war."^{44(p807)}

Lifton's observations, although involving only one small group of disaffected veterans, might be generalizable to others. That is, surely most Americans would prefer not to risk their lives in combat, although there have been societies in which this was the standard for males. For this reason, practices such as those that follow are designed to enhance service persons' "willingness" to take this risk. For example, a historical principle illustrated by Frederick the Great, and reaffirmed by army senior commanders often as late as World War I, is that the common soldier must fear his officer more than the enemy. General Wolfe in 1755 exemplified this practice. Wolfe informed his troops that "A soldier that quits his rank or offers to flag, is instantly to be put to death by the officer or Sergeant in the rear of that platoon: a soldier does not deserve to live who will not fight for his king and country."^{45(p69)} A second example would be the threatened use of courts-martial.

It must be reiterated that combat fatigue casualties rarely claim that they wish to escape combat. In fact, they are more likely to evince a desire to return to combat but cannot do so due to their symptoms. Thus, their initial psychiatric symptoms temporarily speak for them; that is, requesting an honorable exit from combat.

As noted, Newman⁴² states that when military psychiatrists "treat" soldiers so that they again become willing to enter combat, they create "iatrogenic psychosis." This assertion is stated in another way by Lifton. Referring to military chaplains and psychiatrists, Lifton states "We can . . . speak of the existence of a 'counterfeit universe' in which pervasive spiritually reinforced inner corruption becomes the price of survival."^{44(p808)}

The answer to Newman and Lifton's claim, however, is suggested by the last part of General Wolfe's statement, just quoted. That is, although few persons would *want* to risk their lives for their country, the vast majority would choose to do so despite their fear of death because they are willing to fight for their country. In suppressing this fear, however, they are exceptionally subject to combat fatigue, but they are better able to overcome this fear if their commanders, fellow service persons, and military psychiatrists, among others, exert pressure on them to do so. Such soldiers' decisions to reenter battle,

fundamentally, however, are autonomous because they can refuse to give up their symptoms or can refuse combat and take the consequences.

Newman⁴² questioned military psychiatrists' ability to assess combat fatigue accurately. He stated, "It is virtually impossible to refute a psychiatric diagnosis and the harder one tries, the more the attempt is viewed as additional confirmation of the severity of the 'mental illness.'"^{42(p246)} Newman argued that military psychiatrists lack objectivity. However, all physicians—like military physicians—are at risk of having their objectivity distorted by the conditions under which they practice. Before the Civil War, for instance, when slaves ran away, they were sometimes given the diagnosis of drapetomania.⁴⁰ In the former Soviet Union, the mere expression of dissidence could raise the suspicion of schizophrenia.⁴⁶ Daniels,⁴⁷ a sociologist, has cited an example she considered particularly illustrative of military physicians' institutional bias. She asked a military physician his response to sending soldiers to possible death. This doctor corrected her and told her that he was returning them only to "arduous duty."^{47(p4)}

Bok⁴⁸ argued more generally that professional groups such as physicians and military personnel become increasingly insensitive because of the frequent crises occurring in their work. Insensitivity is not the same as bias but would be conducive to it. If Bok's assertion is correct, military psychiatrists, as other military physicians, would be doubly susceptible to acquiring bias. Jones'⁴⁹ argument that soldiers suffering combat fatigue should be given the message that they are "just tired" and "will recover when rested" is consistent with this possibility. This assumption, pragmatically, is true. Yet, the phrase "just tired" can be construed as carrying within it the presupposition that if service persons were not just tired, they would want to return to duty. As discussed, this may not be the case. To the degree, then, that military physicians using this phrase have lost sight of the fact that it is not normal to want to risk being killed, they may appear biased. In fact, military psychiatrists are well aware of the nuances of these phrases. The phrase *just tired* saves the soldier from the self-doubt and self-guilt that he is a coward.

The possibility of clinical bias would superficially seem to be supported by Jones'⁴⁹ report that military personnel were willing during World War I to consciously delay service persons' diagnosis for the sake of military needs. Military aidmen were instructed to "tag" casualties of combat fatigue as

“not yet diagnosed.”⁴⁹ This was necessary because poorly trained, nonphysician personnel had been tagging patients as “war neurosis” or “gas neurosis.” By the time physicians saw them later and noted the transient nature of the problem, soldiers had latched onto the incorrect diagnosis as a ticket out of combat. This practice, thus, does not represent deception, which ethically may be seen as a greater wrong than coercion and pragmatically, if discovered by service persons, could have significant adverse consequences on military physician-patient trust. Rather than being deceptive, this measure postponed the diagnostic labeling until specialists could render it and prevent unfortunate labeling from adversely affecting treatment. In World War II, better trained personnel tagged such soldiers correctly as “combat fatigue,” a transient disorder.³⁸

Observing French and British treatment of combat stress reactions before U.S. entry into World War I, Salmon⁵⁰ abjured aversive techniques used by French and German physicians, such as the application of faradic current to ostensibly “paralyzed” muscles. In a report to the Austrian military after World War I, Freud⁵¹ noted that coercive electrical procedures were ineffective, usually producing only temporary results. Salmon⁵⁰ relied on persuasion, which on the surface may appear to be a less dramatic and weaker approach. In a situation of strained resources, persuasion may appear to be a luxury that takes time and resources; however, when policies were well-established toward the end of World War II and after the first few months in the Korean conflict, most soldiers could be returned to combat after a few nights’ rest.⁴⁹ The system became quite efficient. Ethically, of course, it is much easier to justify persuasion than coercion in treatment.

The Use of Drugs to Prevent and Treat Combat Fatigue

Different kinds of ethical problems are raised by the ways in which military psychiatrists could attempt to prevent or treat combat fatigue. Military psychiatrists could, for example, give drugs to reduce fear,⁵² and drugs have been given to those who have experienced combat fatigue to help them return to battle.

While few psychiatrists would contend that psychological treatments of combat stress disorders are unethical, Holloway⁵³ has argued that pharmacological interventions to treat or prevent such disorders may be unethical. From ancient times, soldiers

have utilized pharmacological agents to enhance combat motivation. The most utilized drug has been alcohol, an effective and readily available anxiolytic that unfortunately impairs motor performance. Vikings of the first millennium often fought after being intoxicated on mead (beer made from honey), and during the middle ages, armies often went into battle intoxicated. As late as World War II, Japanese troops sometimes prepared themselves for final, desperate banzai charges with saki. A medieval Moslem sect gave the word “assassin” to the English language because of its members’ use of hashish (they were called “hashishim”) before they were sent to kill their leader’s critics. Like alcohol, cannabis can seriously impair combat performance, and it is unclear whether the hashishim were still “stoned” as they committed the assassinations or just convinced that they had experienced, briefly, the paradise that was to be their eternal reward.⁵²

During World War II, using a newly discovered technique in which psychiatric casualties were sedated with barbiturates given intravenously and then were asked to recall traumatic battle scenes (abreaction), Grinker and Spiegel⁵⁴ were able to return some otherwise unreachable cases to effective service. This technique may still have some applicability in treatment resistant chronic post-traumatic stress disorder cases. It was quickly learned that this procedure was rarely necessary when casualties were given early forward treatment with rest and expectation. In Italy during World War II, Glass^{38,55} found that the traditional treatment principles were adequate, and when he became Pacific consultant during the Korean conflict, he emphasized them and discouraged pharmacological interventions.

The Vietnam conflict was the first time U.S. forces had true anxiolytic and neuroleptic drugs.⁵⁶ Most widely used were the major tranquilizers chlorpromazine (Thorazine) and prochlorperazine (Compazine), medications that also decrease neurological ability to respond to threat. They slow troops down, decrease motor skills, and result in greater risk of injury from clumsy behavior and decreased alertness. Anxiolytics, primarily chlordiazepoxide (Librium) and diazepam (Valium), were also used in Vietnam to treat less severe psychiatric casualties and for alcohol detoxification.

A sometimes unintentional treatment of psychiatric symptoms occurred in Vietnam when soldiers would complain to battalion surgeons of the physiological components of anxiety (such as diarrhea) and would be given prochlorperazine (Compazine),

a standard but powerful antiemetic, antidiarrheal drug that is also a major tranquilizer. Because such medicated soldiers were typically returned to their units, ethical issues can be raised. By impairing motor skills, these drugs may have increased the soldiers' risks in combat. Should the physician inform troops of the consequences of the medications they are taking, and should the soldier be involved in the decision?

Following the disastrous results of a "medical" (inhospital sedation on a medical ward) approach to psychiatric casualties in the 1973 Arab-Israeli War, the Israelis banned hypnosis and medications, having read the U.S. literature and consulted with Walter Reed Army Institute of Research personnel.⁵⁷ In the 1982 Lebanon War, however, a few depressed patients were treated with antidepressants.

If drugs are used to render soldiers less fearful before combat, Gabriel⁵⁸ has expressed concern that these drugs also could render service persons less emotionally able to appreciate the consequences of their actions. As a result, they might be willing to carry out otherwise unacceptable acts. Whether or

not this speculation has a basis in fact is unknown. Yet, persons using alcohol clearly become less inhibited and show more aggressive behavior. Whether drugs such as buspirone would have a similar disinhibiting effect during combat is unknown; however, most persons given buspirone become less aggressive. Other, as yet unknown, drugs might be used in the future to prevent combat fatigue in a beneficial manner. However, they might also increase the soldier's tendency to carry out overly aggressive acts during combat as suggested by Gabriel.⁵⁸

Holloway⁵³ has speculated that the use of chlorpromazine (Thorazine) and similar medications in Vietnam rendered some soldiers more susceptible to subsequent psychological morbidity, that is, chronic post-traumatic stress disorder. He further speculated that these drugs (and possibly illegal drugs such as heroin) prevented service persons from having the capacity to "process" what they were feeling so that neither then nor later could they have the same capacity to express or "abreact" their emotional responses. There are no studies to confirm or deny this hypothesis.

DIAGNOSTIC ISSUES

Combat Refusal as a Form of Combat Stress Casualty

Although some military psychology writers⁵⁹ are inclined to lump combat stress casualties with genuine combat refusal cases (conscientious objectors), one must be careful to distinguish them to avoid the misuse of psychiatry as exemplified by the former Soviet treatment of dissidents.

Handling those who refuse combat while evidencing combat stress symptoms as stress casualties is beneficial because the soldier avoids being prosecuted for a capital offense, and after appropriate treatment, the military retains a soldier who is capable of further service.

At the other end of the spectrum are soldiers refusing to leave combat when impaired. An Israeli physician served with an infantry commander who became increasingly reckless of his own safety and was finally killed on a combat mission. In retrospect, the physician felt that the commander was suffering from increasing anxiety and degradation of performance ("old sergeant syndrome") but chose death rather than admit to a psychiatric breakdown. The Israeli physician felt that he might have

erred in not medically evacuating the commander, but the grounds for doing so would have been difficult to establish.⁶⁰

Conscientious Objectors

The U.S. military has recognized that certain religious creeds forbid aspects of military service. Army Regulation 600-43, *Conscientious Objection*,⁶¹ recognizes two kinds: (1) 1-0, which precludes any military involvement, and (2) 1-A-0, which allows one to serve in uniform but not to engage in combat. The military has generally held that an individual's scruples against combat must be based on religious affiliation to qualify for conscientious objector status. Furthermore, if the objection is to a particular war because one believes it to be illegal or unjust, this is not considered justification for conscientious objector status.

The military has been disinclined to grant conscientious objector status to service members who declare conscientious objector convictions after entry to active duty, particularly if their conversion occurred after receiving orders to a combat zone or if it followed lengthy education or training and the

service member is scheduled to put that training into action. Such a person may be viewed as using conscientious objector status as a ruse to evade obligated duty.

Case Study

About 1 year after completing a military psychiatric residency, Captain MC stationed in the United States declared himself a conscientious objector who could not wear the military uniform. Captain MC had been an exemplary psychiatrist in his military-affiliated residency and, during his senior year, had been selected as chief resident. Background information revealed that his decision to enter psychiatry had been influenced by his mother's chronic mental illness. After completing residency, he had attended meetings with the Society of Friends (Quakers) and had gradually identified with their creed of nonviolence. He was in no danger of being assigned to the combat zone (South Vietnam), but he became convinced that he could not contribute to the war effort. After lengthy administrative evaluations, his conversion was accepted as genuine, and he was separated a few months earlier than he would have been had he served out his obligation.

Comment: While one could speculate on the identity crisis faced by one reared in this psychiatrist's circumstances, those who knew him well could not doubt the genuineness of his convictions or the validity of his conversion as a Quaker. It is military policy to obtain evaluations by chaplains, psychiatrists, and commanders to validate the genuineness of the alleged conscientious objector status and to ensure that this religious conviction is not secondary to a mental illness.

Individual Service Persons Taking Exceptional Risks

War is replete with examples of individual gallantry and heroism. We honor such valor with medals, memorials, and national holidays, and their sacrifices have become an enduring aspect of our national heritage. However, equity may be violated if individual service persons are permitted repeatedly to take exceptional risks. During his tour as a division psychiatrist during the Vietnam conflict, the second author saw one man who volunteered initially to be a "tunnel rat." If he had continued to volunteer for this unusually hazardous duty, the risk he would have been taking would have become increasingly disproportionate to the risks taken by others. At some point, this risk might become unjust. This soldier, however, subsequently declined this role and allowed others to volunteer for this particularly dangerous mission.

Service persons might, of course, volunteer to take exceptional risks for several reasons. Some

may enjoy engaging in highly risky behavior. Others may volunteer for altruistic reasons, but in some cases, this altruism may reflect hidden guilt and an unconscious need to be punished.

Those who can repeatedly carry out dangerous missions may have exceptional capacities for withstanding this stress, and the military's utilizing their strengths may enhance the combat mission. Helicopter pilots, for example, may carry out risky missions because of physiological or psychological characteristics.⁶² Yet, if service persons take disproportionate risks, equity is violated, and their repeatedly taking these risks at some point could be forbidden.

The principle of respecting service persons' autonomy may be opposed to the principle of equity. That is, the service person who enjoys high risks or has exceptional capacity to function under stress might, like the service person volunteering to be a tunnel rat, freely volunteer. The assumption that a person's freedom to take risks should sometimes be limited so that he does not take on an unfair burden is commonplace. In civilian settings, for instance, a limitation is placed on the kinds of research for which subjects can volunteer.¹² Even if researchers themselves volunteer, a human use committee may disapprove the research on the ground that it is unduly dangerous. For a similar rationale, some limit should exist when service persons repeatedly volunteer for dangerous duty even if their motivation seems genuinely altruistic.

The service person in combat differs considerably from the subject of research. Potentially, a service person's bravery could save his unit and, using the example of World War II, conceivably thousands of lives. This, theoretically, could also be the case with research, as, for example, in research that could provide a cure for acquired immunodeficiency syndrome (AIDS). It is more likely, however, that allowing a service person to take exorbitant risks will be justified because of the great number of lives saved. At the very least, then, a service person should be permitted to take repeated dangerous risks only when attempts to enlist other volunteers (capable of performing the duty) for the same hazardous duty have been unsuccessful.

The military recognizes the need to share the risks of hazardous duty and, in the past, has initiated limited tours of combat duty and fixed numbers of combat aviation missions. In addition to serving the principle of equity, this policy enhances morale.⁶²

COMMAND ISSUES

Practices After Nuclear Attack

Fatally irradiated troops pose pragmatic and ethical issues. Such troops cannot always be readily identified and require enormous medical expenditures in personnel and other costs to treat. For example, a few might be saved by bone marrow transplants. On the other hand, many of these troops are not debilitated in the early stages after exposure. In a combat setting, the most rational approach might be to consider them fatalities, consider euthanasia for the most debilitated, and utilize the nondebilitated for high-risk missions. If euthanasia is not available, mere palliative procedures could consume medical resources needed elsewhere.

Exceptional circumstances obviously could exist after nuclear attack. Jones⁶³ raised several questions such as whether service persons fatally exposed to radiation should be sacrificed for the “greater good” by having them carry out high-risk delaying actions, kamikaze attacks, or operations in contaminated areas. Further, closely related questions are whether service persons should be sent back to irradiated areas when their degree of previous exposure is unknown, and whether if they are sent back, they should be told beforehand that their additional exposure may be fatal.

The last question is particularly complex because service persons who know that they could be exposed to fatal doses of radiation might refuse to return to the front. Under normal circumstances, as previously stated, it would be ethically permissible to ask service persons to make sacrifices to benefit their unit. The question Jones⁶³ raised involves primarily this issue: Is there any reason after nuclear attack that an exception to the usual ethical priorities should be made?

The answer is possibly yes. Although it is ethically permissible in most instances to withhold specific information from service persons so that they can carry out combat duties more effectively, after nuclear attack, the consequences may be so devastating to service persons that the priority should shift to truth telling to preserve what dignity remains.

Soldiers’ dignity could be furthered, for example, by their commanders’ choosing not to “use” them primarily as “means” to the units’ end by sending them to certain death as would be the case if sending them on kamikaze attacks. Alternatively, be-

cause the use of weaponry had “progressed” to the point of nuclear attack, it might be argued that more than ever, all-out attempts to win the conflict would be justified, and permitting service persons under these conditions to give their lives for their country would enhance their dignity.

After nuclear attack, then, combat actions that are carried on might best be construed as falling into either of two categories, noncritical versus critical means to achieve victory. In the former instance, to preserve service persons’ dignity, they might not be sent back to the front because it could be anticipated that this would probably mean their dying. At the very least, they should be told the truth regarding this likely consequence of their returning to battle.

When further engagement by irradiated soldiers is critical on the other hand, the usual justification for permitting soldiers to sacrifice their lives will remain—despite the assault to human dignity likely to result after nuclear attack. In this circumstance, respecting service persons’ dignity maximally might require allowing them to give their lives in, for example, any of the three ways Jones has described.⁶³ Further, it may be that respecting soldiers’ dignity in this situation also might mean *not* telling them that their reentering irradiated areas would or could mean their deaths. Withholding this knowledge could be justified in this instance if this were necessary to enable these service persons to continue to fight effectively.

Ethically, the justification for giving priority to the combat mission—like allowing service persons who have been fatally injured to die—would be based on the principle of equity. That is, all soldiers risk death during combat. Soldiers who happen to have been injured should not necessarily be protected from this risk. As with soldiers who are healthy, they, too, may be required to sacrifice their lives so that the combat mission can be accomplished.

Sacrifices During Combat

It is sometimes necessary for commanders to allow some soldiers to lose their lives knowingly for the greater interest of other soldiers and the mission. Jones⁴⁹ referred to such a possible instance in the first case he discussed involving a soldier who was pinned down by enemy fire. Jones notes that in

this instance that the soldiers felt that there may have been a need to sacrifice some troops for the sake of the mission.⁴⁹ Jones described this same necessity, implicitly, when he stated that during the U.S. Civil War, commanders sometimes felt that it was desirable to “blood” the troops (expose them to wounded and dead fellow soldiers) to increase their effectiveness in later battles.⁶⁴ In addition, risky training exercises sometimes result in deaths, for example in parachute jumps.

The principle underlying commanders’ practices in these anecdotes is the same as the principle underlying military medical triage. Namely, as stated, it is sometimes necessary to sacrifice some service persons’ lives to achieve victory, if this sacrifice is necessary or seems necessary. Again, there is little question regarding the ultimate justification of this principle. The significant ethical questions involve the limits that should exist on allowing such sacrifices.

Impaired Commanders

When a physician becomes aware that a commander is obviously impaired, he can and should request that the commander be relieved. In neuropsychiatric conditions, however, the impairment may be subtle. General George Patton’s belief⁶⁶ that he was the reincarnation of great warriors of the past, while possibly pathological, did not apparently impair him as a commander. One of the authors became aware that one of his high-ranking commanders suffered from amyotrophic lateral sclerosis, a degenerative disease of motor neurons. The author did not see evidence that this impaired the commander’s judgment. It is not the prerogative of the physician to rule on incompetent (as opposed to impaired) commanders.

Improper or Illegal Commands

Illegal orders come in many guises and may be far from dramatic. When he was a division psychiatrist during the Vietnam conflict, the second author observed a high-ranking commander of limited combat experience (he had been a transportation officer) who ordered physicians to take sick call outside during the rainy season. The commander reportedly believed that soldiers going on sick call were largely malingering. Fortunately, the physicians simply ignored the order rather than challenging it. Another example occurred when a commander ordered his battalion surgeon to read openly

excerpts from the medical records of a troubled, mentally ill soldier who was related to a World War II military hero. The second author in his position as division psychiatrist objected; however, his objection was ignored by higher medical personnel.

A dilemma exists when military physicians believe that the probable sacrifice of soldiers’ lives lacks sufficient justification. The question that then arises is what action, if any, should military physicians take to protect soldiers from what physicians see as unnecessary or exorbitant risks. Military physicians who believe that they should follow orders unquestioningly in all circumstances follow what is often referred to as a “role-specific” ethic.³⁹ According to this ethic, military physicians would obey the orders of their superiors as long as they are legal and would delegate all decision-making authority to their superiors.

Alternatively, military physicians could believe that ethically they may assess independently the situations in which sacrifices are called for to see if they are reasonable. Military physicians who took this position might conclude that there are some occasions in which they should take action on service persons’ behalf. Hopkins and colleagues⁶⁵ expressed this latter view, for example, during World War II when the U.S. Army was sending many soldiers with malaria and dysentery back to the front in Southeast Asia. Hopkins et al stated that he considered it a “disgrace upon the Army Medical Department that ranking medical officers had not insisted upon the total evacuation of the 2nd and 3rd Battalions of 5307 after Nphum Ga”^{65(p371)} and added:

If pressure from high ranking field officers can be applied to Army Generals and Evacuation Hospitals as well as to medical officers in general to such an extent (regarding their) prerogative of protecting the health of the fighting men and guaranteeing that men unfit for combat are kept out of combat, then those hospitals as well as the medical officers are robbed of sacred duties and rights to which their medical knowledge and service entitles them.^{65(pp379–380)}

Physicians in the military are unlikely, however, to have knowledge comparable with that of their superiors regarding the overall strategy of command decisions. Therefore, when a military physician independently assesses command policy, he risks being short-sighted in determining his ethical obligations. Hopkins and coworkers,^{65(p372)} for ex-

ample, in the instance just described, may have been unaware of several important factors.

A similar question regarding the obligation of military physicians to take action also may occur in situations that do not involve risks to their own troops but to "innocent" civilians. The option of speaking out or refusing to carry out orders is available to line officers and all other service persons, of course, as well as military physicians. In the case of line officers, however, the argument that they should not act because they lack information would tend to be weaker.

Jones⁶⁶ cited the example of Colonel Eli Geva who refused to lead his troops into Beirut because he objected to the killing of civilians and felt that the military objectives did not justify the losses of his soldiers. Jones indicated also that Geva was criticized for showing too much concern for civilians. Military physicians refusing to obey orders for the sake of either their troops or civilians might be subject to the same complaint.

Yet, Jones⁶⁶ also commented in speaking of Geva's refusal that the decision subsequently was made to launch a "more discriminating attack" designed to reduce these casualties. It would seem plausible that Geva's refusal may have had some effect on saving civilians' lives. Even if it did not, however, his or military physicians' refusal to obey an order may be justified on so-called deontological grounds alone; that is, that "some actions are right (or wrong) for reasons beyond their consequences."^{67(p36)} During World War II, for example, Nazi physicians' protesting may have accomplished no consequential benefit; they may even have lost their lives as a result of refusing some orders. Yet, because they would have been respecting another human being's dignity, their refusal would have been justified. Similarly, Geva's refusing to carry out an order he considered immoral might be justified solely on the ground that by his refusal, he was avoiding implicitly sanctioning an act he considered immoral. This would be true regardless of the consequences.

Thus, although some soldiers' lives must be sacrificed for the benefit of other service persons and/or for military goals, military physicians may be justified ethically in refusing to carry out orders that they consider immoral. Ideally, of course, mechanisms should exist within the military to prevent the need for disobeying an order from ever arising, and physicians or other service persons should never find themselves in a situation of having to decide whether to protest. Field Marshall Carver⁴⁵ reported

that during World War II, between the Normandy invasion and the end of the war, as an armored brigade commander, he had to remove many officers for the sake of their units and themselves. He pointed out that all of these officers had been highly decorated and respected men with more battle experience than himself and that none of their subordinates gave him a clue that he should act as he did because they were too loyal.

Despite attempts by the military, such as the inspector general system, adequate checks may not exist, particularly because of the hierarchical ranking in the military. Although the indications that a military physician should refuse an order or should act to protect service persons or civilians are likely to be unclear, nonetheless, they may exist.

Atrocities

Every significant war has witnessed atrocities against civilians or enemy soldiers. Most militaries attempt to prevent or punish such atrocities either from moral precepts or because they recognize that atrocities impair the morale of the perpetrators and may inadvertently spur greater resistance by the enemy. The 1990 to 1991 atrocities imputed to Iraqi forces in Kuwait earned United Nations condemnation and strengthened a multinational coalition to intervene against Iraq.⁶⁸ During the My Lai atrocity in Vietnam, at least one U.S. soldier became a casualty when he shot himself in the leg rather than participate.⁶⁹

Military psychiatrists during combat may witness or suspect acts that are illegal or whose legal status is uncertain. Jones⁶⁶ suggested that atrocities are particularly likely, for example, in low-intensity guerrilla warfare in which terrorism tends to brutalize both sides.

Several examples can be cited from the past. Gault⁷⁰ refers, for example, to enemy prisoners in Vietnam who were thrown out of helicopters if they refused to provide information. This atrocity apparently was intended as a lesson to other prisoners indicating what would happen to them if they also failed to give information. Other more equivocal examples include captured enemies being given less than optimal care before being interrogated,⁷¹ women being interrogated while they were breast feeding,^{72(p455)} children being asked to incriminate their parents,^{72(p456)} and prisoners being turned over to other parties when it was anticipated that the other parties would mistreat them.^{73(p402)}

Military physicians, like all service persons, have obligations under international agreements to treat enemy prisoners of war with decency. Military physicians not only have additional obligations to actively intervene to prevent atrocities as a result of their implicit promise made when they became physicians to not harm patients, but also they have the legal obligation of all service members to try to prevent such atrocities and to report any that have occurred. A military physician's medical role should give him a stronger obligation to speak out against or oppose atrocities than other service persons. The obligation arguably exists even when speaking out might pose some danger to the physician. Implicitly, when becoming a physician, one accepts a degree of self-sacrifice. The American Medical Association⁷⁴ has taken the position that all physicians, for example, should be willing to treat patients with AIDS despite the risk that they could give themselves a fatal needlestick. The example given about Nazi physicians further supports these assertions. Rosebury stated that "It is a matter of record that the majority of [German] physicians practiced ethically during the Holocaust except for not protesting."^{75(p517)}

Reasonable ethical arguments support two limitations to military physicians' obligation to oppose atrocities: (1) instances in which mistreatment of enemy service persons could produce information that would save a unit or even the nation and (2) instances in which physicians' or their families' lives would be endangered. The first limitation is based on utilitarian values. It assumes that harm to one is outweighed by harm to multiple others. Yet, it is usually, if not always, uncertain that atrocities

will be the only means of avoiding harm to others, and the use of atrocities to prevent such harm might contradict the ends for which the war is fought. As Supreme Court Justice Douglas stated, in another context, "It would indeed be ironic if, in the name of national defense, we would sanction the subversion of . . . those liberties . . . which [make] the defense of the nation worthwhile. . . ." ^{76(p264)}

As already stated, physicians made an implicit promise when entering the medical profession to work for the good of others even when this involves some degree of self-sacrifice, and they agreed when joining the military to uphold the U.S. constitution, which through treaties supports international law. If, then, military physicians' or their families' lives would not be endangered, at least when their opposing an atrocity would be beneficial, they have a *prima facie* obligation to act. Thus, if they do not act immediately, they would have a strong obligation to do so at the first opportunity that presents itself at which this degree of sacrifice would not be necessary.

A potential risk of this position—that military physicians need not act when their own or their families' lives are at stake—is that physicians could acquire justification for never acting and show the same kind of inaction shown by Nazi physicians. It hardly seems possible, however, that military physicians would *never* acquire an opportunity to be sufficiently protected from repercussions against themselves and their families to act against atrocities. Thus, as opposed to holding military physicians, or others for that matter, to an heroic standard implausible to achieve, this standard might justifiably be lowered.

SUMMARY AND CONCLUSION

Ethical issues abound in military psychiatry as in military medicine in general, but few issues are specifically limited to psychiatry. Those limited to psychiatry generally relate to the psychiatrist's unique role in treating combat stress casualties and in ruling out mental illness as a cause of proscribed behavior (for example, homosexuality, criminal behavior, alleged conscientious objector status, and so forth).

Despite its reputation for rigidity and conservatism, the military has generally reflected the prevailing American ethos and has sometimes led the way in reforms. This was demonstrated when the

military was the first large governmental organization to be desegregated and when it pioneered in developing drug and alcohol rehabilitation programs around the concepts of amnesty and confidentiality. Nevertheless, psychiatrists, who have their own reputation for strong individualism, will always find a substantial number of individuals who will not feel at ease in an organization that sometimes views individuals as replaceable parts in a large machine. Their struggles with ethical issues will invariably reflect not only the issues themselves but also the individual biases of the psychiatrist in conformity and confrontation.

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