



Introduction to Healthcare Ethics

Navy Medicine

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General Directions

The following materials contain content to be used for required continuing education in healthcare ethics for all Navy Medicine personnel. The core content is central for a general introduction to the subject area.

All personnel are responsible for knowing, understanding and incorporating the core content and its application into one's professional service, values and personal performance.

Healthcare ethics education and training in the core content must be provided via interactive, face-to-face experiences. It is not permitted to use these materials as an on-line training exercise of any type.

The core content that follows is to be used in one or more presentations. The content must be adapted/applied for local usage, taking into account participant levels and field contexts. For Section III.A, local communities are to add relevant case studies and current scenarios for discussion and learning.

Documentation for certifying ethics educational program completion is required in accordance with standard operating procedures and instructions as directed.

Objectives

By the end of the education experience, participants should be able to:

1. Describe the nature of human illness, healthcare, and the principles of healthcare leadership.
2. Define the basic principles of healthcare ethics and the stages of ethical decision-making.
3. Detail and provide core interpretation for the key elements of informed consent in healthcare as a process and a procedure.
4. Relate, compare and demonstrate knowledge of the principles and practice of healthcare ethics in terms of the Navy Ethos and the mission of Navy Medicine.

**The Experience of Human Illness,
Healthcare, and
Healthcare Leadership**

Reflective Definitions

Before proceeding, it is important to review briefly how experts & scholars are reflectively defining the following central terms:

Disease
Illness
Sickness
Health
Healing
Healthcare

The reflective comments/definitions that follow are collated from: Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Disease

- A pathological process or pathology deviating from human norm.
- Can be physical, mental, spiritual, or perhaps social.
- Requires some form of verification or endorsement whether it be scientific, medical, or otherwise.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Illness

- An experience of ill health particular to the human person. It is internal to the individual person or patient.
- Often accompanies disease but may be undeclared from a particular disease.
- Sometimes may even elude being verified by empirical evaluation etc.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Sickness

- Refers to the external, public expression of ill health.
- Social recognition of ill health: societal judgment and evaluation.
- Social evaluation can be problematic. For example: Some in society might stigmatize PTSD, yet look upon surgical amputation needed after battle as heroic. Important to keep this potential problem of societal evaluation in mind. Discrimination is always possible.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Health

- A state of well-being in the person and one's group – often relative.
- It is not limited to the physical. It involves the mental or psychological, the spiritual, and the social.
- It does not refer to the absence of disease or the absence of a negative experience of ill health. It is a “proactive” experience. It includes positive factors that increase existing well-being within the various life-stages.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Healing

- Refers specifically to the processes to counter the experiences of disease, illness, and sickness.
- It also occurs in the presence of the need to increase health or deal with natural human experiences such as advancing age. A total experience of filling up lacks and building upon existing health factors.
- The process meeting needs for personal life corrections, personal integration, synergy, or completion of life.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Reflective Definitions

Healthcare

- The organized pattern of professional and personal relationship that intervenes into, builds upon, or promotes the human condition for the sake of health, wellness, and healing.
- Its complete expression involves both “cure” and “care.”
- In contemporary society, becomes an organized pattern of social/cultural structures and operations that provide the services needed to facilitate and/or deliver healing.

cf. Professor Kenneth Boyd. *Disease, illness, sickness, health, healing, and wholeness: exploring some elusive concepts*; The Association of Faculties of Medicine of Canada. *Primer on Population Health*; Professor Alastair Campbell, ThD. *Health as Liberation*.

Transition

Having reviewed some of the definitions and reflections upon basic ideas that are central to healthcare itself, it is now possible to explore the following “experiences.”

Human Illness

Healthcare

Healthcare Leadership

The Experience of Human Illness

Human illness is a constant in the human experience.

In illness, the person experiences alienation and disruption from normal living.

Illness disrupts the individual's relationships to:

- The World
- Work
- Family & Friendships
- Self
- The Meaning of One's Life.

The level of alienation/disruption is proportional to the severity of the experience. Disease, illness and sickness affect the entire human community.

The Experience of Healthcare

Healthcare is a systems or holistic experience of “intervention into” the experience of a person’s illness.

Healthcare affects the whole person or persons. It affects family, friends, the patient’s community, and the provider.

While the word is used most often more specifically, all of healthcare generally is a “Palliative Experience.”

“Palliation”...from the Latin, *palliare*, meaning to cover.

Healthcare is the experience of “covering the patient with care.” Healthcare involves BOTH scientific curing and total human caring.

The Experience of Healthcare

Healthcare can be understood as having three constitutive elements.

Presence: Compassion and empathy toward the patient as person

Process: Assessment, Diagnosis, Evaluation, Treatment and Therapies

Progress: Measures to short and long range outcomes --- including assistance to help the patient deal with life long requirements or even one's death.

To provide effective “healthcare as healing” one must know and practice the principles of person-centered leadership.

The Experience of Healthcare Leadership

In history, leadership has been discussed as having two dimensions or types.

Hierarchical Leadership:

Leadership as a “top down” experience. Based upon the “hierarchy” of a society or group.
Needed for swift and immediate action.
Can be authoritarian, creating social power.
Not respected, only feared.

Historical Leadership:

Leadership as a “from within” experience. Based upon the “lived experience.”
Needed for creating community buy-in.
Can be compromising, creating confusion and lack of needed action. Can be disregarded.

cf. Robert C. Fisher, JD and Peter S. Adler, PhD. *Leading from Behind*; Adrianna Kesar, PhD et al. *Rethinking the “L” Word in Higher Education: The Revolution of Research on Leadership*.

The Experience of Healthcare Leadership

Contemporary scholars speak about: Servant Leadership

Servant Leadership makes use of both hierarchical and historical leaders depending on need.

Servant Leaders know how to balance both and how to avoid the potential for power or lack of needed action.

Servant Leaders in all fields but especially in healthcare maintain constant progress in three areas:

- Knowledge
- Professional Skills
- Ethical Formation

cf. Joseph Thomas, PhD. Leader Development in the US Department of Defense: A Brief Historical Review and Assessment for the Future. USNA Stockdale Center for Ethical Leadership; Carnegie Foundation. The Preparation for the Professions Program. 2005-Present.

The Experience of Healthcare Leadership

The Carnegie Foundation's Preparation for the Professions Program details the continual deepening of knowledge, professional skills, and ethical formation as central to healthcare leadership.

Ethical formation as “ethos formation” means the ongoing development of the character of a person and an institution.

Healthcare, while needing the best business practices, is fundamentally a human service. Its “character” requires ethical principles upon which care is given and upon which healthcare leaders provide that care.

Healthcare also requires ethical decision-making knowledge.

cf. Patricia Benner, PhD et al. *Educating Nurses: A Call for Radical Transformation*; Molly Cooke, MD. *Educating Physicians: A Call for Reform of Medical School and Residency*.

The Experience of Healthcare Leadership

The Ethos-Invitations of Contemporary Healthcare:

1. One must understand healthcare as the forum in which leaders remain true to the path of becoming “healers.”
2. The ethics commitment is a commitment to human healing in response to human suffering. This adds to our understanding of the meaning of human existence.
3. This involves presence to patient-suffering as well as maintaining the highest medical knowledge and technical performance.
4. The “connectedness” of the military ethos is a central gift for the future of healthcare itself in the nation and the world.

cf. Thomas Egnaw, EdD, LICSW. *Suffering, Meaning, and Healing: Challenges of Contemporary Medicine*.
Annals of Family Medicine.

The Principles of Healthcare Ethics and the Stages of Ethical Decision-Making

Principles and Decision-Making

Healthcare, in all of its diverse forms, is a human service. It touches the human person and human nature in the most vulnerable areas.

Due to its ultimate humanness, the providing of healthcare has always been situated by society within the context of ethical principles and systems of value. These place the “Greatest Good” for the human person as central.

The history of healthcare ethics is long and detailed. However over time, the practice of healthcare has come to rest upon an appreciation of what is termed the “Hippocratic Oath” and four major principles.

These principles are central to ethical decision-making in healthcare leadership.

Principles and Decision-Making

Hippocratic Oath

Revised Oath of Hippocrates adopted by the
World Medical Association

Includes:

- Dedicate life to serving humanity
- Perform duty with honor and dignity
- Health of a patient comes first
- Respect patient confidentiality
- Uphold your professional duties at all times

Principles and Decision-Making

Four Principles of Healthcare Ethics

- Respect for Persons/Autonomy
- Beneficence
- Non-maleficence
- Justice

Principles and Decision-Making

Respect for Persons/Autonomy

- Obligation: To respect the individual person and their autonomy. Also extended to their culture and heritage.
- An individual's decision making capacity must be respected
- Autonomy requires:
 - Intention
 - Understanding
 - Lack of controlling influences or coercion
- Despite possible bias, healthcare personnel go to extraordinary lengths to adhere to the concept of patient autonomy
 - Clear attention to diverse multicultural contexts is critical. This applies both within the US and overseas.

Principles and Decision-Making

Beneficence

- Primary Obligation:
 To benefit the person.
- Secondary obligation:
 To balance benefits against risks

Important healthcare setting notation. Healthcare leaders must be aware of the inner tension of balancing benefits with potential risks

Principles and Decision-Making

Non-maleficence

- Primary Obligation: To avoid causing harm
- Sometimes misinterpreted in history. Good current translation is: *“Benefit the patient; or at the least, do no harm.”*
- In healthcare, articulated as a stand alone principle: the principle to do no harm.
- In research, this is a component of beneficence due to risks inherent in experimental environment.
- Important Notation: Healthcare leaders often have an impulse is to “do something.” The impulse must be balanced with the promise to “do no harm.”

Principles and Decision-Making

Justice

- Obligation: To distribute benefits and expose to risks fairly.
- Applies broadly to both the institution (macro-justice) and also the patient (micro-justice).
- This principle pertains to the just distribution of medical assets. *(It is not to be confused with subjects such as “criminal justice.”)*
- This principle guides also the distribution of services and products based upon human need, degree of need, and available resources.
- Healthcare leaders provide the same standard of care to all individuals at all times. This must never be compromised.
- Helpful ancient principle: *Each according to one’s need.*

Principles and Decision-Making

Two important guiding lights:

The practice of these principles requires personal commitment to:

- The duty to protect life and health;
- Respecting autonomy and confidentiality;
- Acting on behalf of or “for the good of the patient;”
- Doing no harm;
- Acting in the best interest of others, even when what is healthy and in their best interest is not what they desire.

The practice of these principles requires keen and continual awareness of cognitive dissonance.

- The discomfort one experiences when one holds conflicting cognitions (beliefs, values, ideas, emotions) simultaneously.
- An ever present possibility whether in the medical treatment facility context or field contexts.

Principles and Decision-Making

Providing healthcare ethically necessarily involves ethical decision-making. The following are involved in that process.

Five Steps/Stages:

- Ethics Awareness: Situational realization
- Ethics Assessment: Exploration of all factors
- Ethics Formulation: Proposing various courses of action
- Ethics Decision: Choice
- Ethics Evaluation: Long & short range effects of choice

cf. Expanded from Sarah Hope Lincoln, PhD (cand) & Elizabeth Holmes, PhD, ABPP. (Stockdale Center at USNA). *The Psychology of Making Ethical Decisions: What Affects the Decision*. Psychological Services.

Principles and Decision-Making

Criteria for Personal Ethical Choices: *Within ethical decision-making, key questions are important for healthcare leaders and patients to face.*

- Are you being responsible? Making a responsible choice?
- What are the probable consequences of your choice?
- If you were on the receiving end, would these consequences be acceptable?
- Is this a special situation? Or are you pretending it is?
- Can you discuss the problem with the affected parties or chain of command before you make your decision?
- Would you want your employees to make the same decision?
- Would your family and loved ones approve of your choice?
- Would you be proud of your kids making the same choice?
- Would you have any difficulty explaining it on 60 Minutes?
- Would it be okay if others did the same to you?
- Did you do what you said you would do?
- Are you being honest with yourself about the real issue?
- How do your decisions reflect who you are, what you are doing, and who you are becoming by what you are choosing?

Principles and Decision-Making

One of the guiding practices that underscores the practice of the previous ethical principles and the process of ethical decision-making has been the requirement for informed consent in healthcare.

Informed consent in healthcare is related to but different from the practice of informed consent in the research context. However both have much to give to one another.

The following materials highlight the basics of informed consent as found in healthcare delivery.

**Informed Consent:
At the Center of Healthcare Ethics**

Informed Consent

Informed consent is central to the ethical nature of healthcare.

As Dr. Mark Kuczewski of Loyola University Chicago Stritch School of Medicine comments: *“Informed consent is the cornerstone of medical ethics in the United States and much of the world.”* (2012).

Informed consent is both a **process** and a **procedure**. It is, at its roots, based upon a ***foundation of trust*** between patients and healthcare leaders.

The **process** of informed consent takes place in the professional interaction between clinical staff and patients. Where decision-capacity is diminished. Informed consent also may involve those to whom decision-capacity is entrusted.

The **procedure** of informed consent includes the signing of an informed consent document. It is critical that all parties understand completely the information provided as well as the short and long range implications for the decision or decisions to be made.

Informed Consent

Key Elements of Informed Consent

The information necessary for the patient to make a knowledgeable decision includes:

- Diagnosis
- Purpose of proposed treatment or procedure
- Possible risks and benefits of proposed treatment or procedure
- Possible alternatives to proposed treatment or procedure
- Risks and benefits of alternatives
- Possible risks of not receiving treatment.

Informed Consent

Both the process and procedures of informed consent always include key characteristics. The following characteristics are taken from The Belmont Report that addresses informed in research. The Belmont Report does not affect informed consent in healthcare but its contents have applicability for healthcare delivery.

Information

Comprehension

Voluntariness

cf. The Belmont Report.

Informed Consent

Information: Informed consent must provide clear individual's information regarding all factors such as: the patient's healthcare situation, diagnosis, proposed treatments and standards of care, potential risks, all benefits, duration of the time, alternatives, confidentiality provisions, contact information, and assurance of freedom to refuse treatment (in ordinary non-judicially prescribed situations).

Informed Consent

Comprehension: Informed consent must be obtained in a way that is intelligent, rational and respectful of the maturity of enrollees. Consent documents should be in the native language of enrollees, and in a way that is understandable. Terms and content need to be explained during the course of the process of informed consent. The trust between patient and provider must be ensured.

Informed Consent

Voluntariness: Informed consent must preclude any element or even the appearance of coercion or undue influence.

Informed Consent

The question often arises as to how physicians, nurses, other clinicians and healthcare providers experience the complex nature of informed consent.

Of particular value is the perspective that members of the military healthcare leadership have to share.

The following are four key reflections of one military physician on the approach healthcare leaders must take to the informed consent process/procedures.

Informed Consent

Four Reflective Considerations

“1. The patient must understand their current medical condition, their prognosis, and the medical treatment options available to them (including their consequences). The degree to which they must demonstrate insight into these things varies with the gravity of the situation. In the gravest of situations where the consequences include the possibility of death or serious disability, there must be a commensurate level of depth to their understanding of the above (in contrast to consenting for something like an IV or lab draw).

2. The patient must be able to demonstrate how the decision they are choosing to pursue is in line with their life narrative and value structure. If a decision seems to be a departure from a previous value structure, it is cause for pause and an investigation of why the patient is pursuing their current course should be undertaken. This is not to say that such a departure is uncommon (or not acceptable), but it must be explained/justified and placed in the context of their overall narrative.

With thanks to Robert Walter, MD, DHCE. *Reflections on Informed Consent*. Chair, WRNMMC Healthcare Ethics Committee and NCA Regional Consortium Director.

Informed Consent

Four Reflective Considerations ***(cont'd)***

3. The patient must be free from undue influences. This can take several forms (serious psychiatric illness, family coercion [well-intentioned or otherwise], manipulation/coercion/pressure by the physician/team member, etc.). While it is unrealistic to suggest that as humans we are ever free of all influences, the key phrase is really undue influences.

4. The patient must be able to communicate their decision. This may seem self-evident, but in the ICU it can often be an issue. For example, when a patient is intubated and sedated while on the ventilator.”

Informed Consent

A Final Reflection: Trust versus Mistrust

Healthcare is steeped in the moral imperative of medicine to do no harm and to bring health and healing to the sick. Patients bring their “trust” to the healthcare table in a moment that is nothing short of vulnerable.

One of the central points to remember about informed consent is that its ultimate purpose is to protect the “Agenda of Trust” that must be the foundation of the interaction between patient and provider.

Ethos & Ethics in Healthcare: The Navy Medicine Commitment



United States Navy Ethos

We are the United States Navy, our Nation's sea power – ready guardians of peace, victorious in war.

We are professional Sailors and Civilians – a diverse and agile force exemplifying the highest standards of service to our Nation, at home and abroad, at sea and ashore.

Integrity is the foundation of our conduct; respect for others is fundamental to our character; decisive leadership is crucial to our success.

We are a team, disciplined and well-prepared, committed to mission accomplishment. We do not waver in our dedication and accountability to our Shipmates and families.

We are patriots, forged by the Navy's core values of Honor, Courage and Commitment. In times of war and peace, our actions reflect our proud heritage and tradition.

We defend our Nation and prevail in the face of adversity with strength, determination, and dignity.

We are the United States Navy.

Article 3 of the Geneva Convention

Article 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat (out of the fight) by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, color, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- (a) Violence to life and person. in particular murder of all kinds, mutilation, cruel treatment and torture;
- (b) Taking of hostages;
- (c) **Outrages upon personal dignity, in particular humiliating and degrading treatment;**
- (d) The passing of sentences and the carrying out of executions without previous judgment pronounced by a regularly constituted court, affording all the judicial guarantees which are recognized as indispensable by civilized peoples.

2. The wounded and sick shall be collected and cared for.

An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

The Parties to the conflict should further endeavor to bring into force, by means of special agreements, all or part of the other provisions of the present Convention.

The application of the preceding provisions shall not affect the legal status of the Parties to the conflict.

The Navy Medicine Commitment

- Our Navy Ethos rests upon core ethical principles of great importance.
- Navy Medicine members always must reflect continually and carefully on five principles of ethical empowerment:
 1. Purpose
 2. Pride
 3. Patience
 4. Persistence
 5. Perspective

The Navy Medicine Commitment

Leadership & Accountability

Our healthcare leaders are always accountable for their role and for exemplifying our Navy Ethos and the Navy Medicine Commitment to patient-centered care.

Accountability is about setting the expectation, clearly communicating it, and then holding yourself and everyone within your sphere of influence responsible for consistently meeting the established expectations. Hold yourself and your staff accountable always to ethics in healthcare.

The Navy Medicine Commitment

Ethics Continuing Education

It is the responsibility of all Navy Medicine personnel. It must be a continual experience of personal and professional growth and development.

It is to be adapted and integrated into all education and training venues including Pre-Deployment courses, Officer training and Enlisted training courses, PCO/PXO courses etc.

Ethics education, adapted for local needs and levels, should be provided during various command and training orientations.

The Navy Medicine Commitment

Living Out the Ethos

Complex Challenges: Working in a War Zone

- Hostile mortal enemies
- Limited resources and triage
- Command structure
- Patient rights
- Mission paradigm
- Disparate rules of engagement
- Doctors with guns
- Your corpsman was just killed beside you.



The Navy Medicine Commitment

Living Out the Ethos

Complex Challenges: Varied Missions

- Combat Operations
 - Battalion Surgeon, Fleet Surgical Team
 - Treating your friends **and** those who were captured fighting against your friends
- Humanitarian Operations
 - Are you benefiting or are you doing more harm than good?
 - “Operationalizing” medical care? Some of the pitfalls
- Detainee Operations
 - In-country detainee camps
 - Guantanamo Bay
 - Indefinite detention of Law of War combatants in what was once termed a “Legal Black Hole” ...**or is it?**

The Navy Medicine Commitment

Living Out the Ethos

Complex Challenges: Dual Agency

- Are you a healthcare person first, or a military person first?
- Are there situations when this could be in conflict?
- Some say there are.

The Navy Medicine Commitment

Living Out the Ethos

Complex Challenges: Transparency

- We are an ethical country and our military goes to great lengths to conduct itself in an ethical manner.
 - “Moral high ground” is an important concept.
 - Mistakes in ethical conduct have major importance.
- Our enemy is media savvy and will use this to advantage
 - Claims of mistreatment and torture are frequent
 - Directed via the Manchester Document
 - Intentional self-harm for the purpose of claiming medical malpractice is common... You are the target
- Reporting of mistakes is swift.

How do we handle complex situations?

Case Studies & Scenarios

Scenario 1: International Surgery

Case: Afghan Female

You are serving in the Role 3 hospital.

An Imminent arrival occurs: 3 helos from an explosion.

12 patients are brought in: Afghan women and children.

Eventually, a male family member ("uncle") arrives.

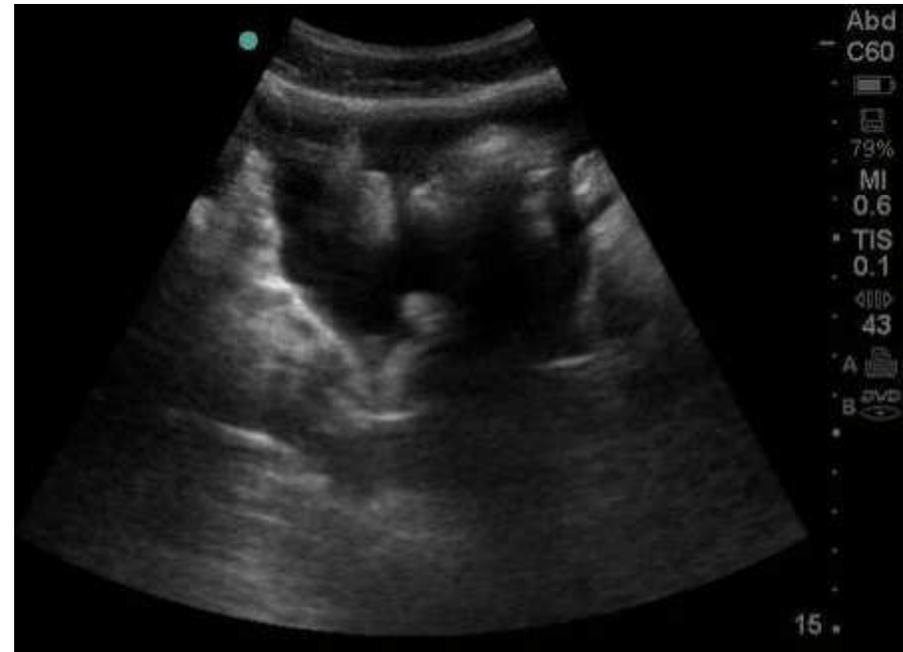
This situation is complicated by Afghan tribal Muslim cultural and religious practices.

Your patient – 13 yo girl

The girl is in shock –
ultrasound.

Requires immediate
surgery.

Discussions happen
with the uncle after
the surgery.



An hour goes by...

The patient exits the Operating Theater.
Blue drapes.

The Uncle asks: "Was she exposed?!!!" It is forbidden for men to see the girl exposed. Such exposure can result in death/tribal execution.

You know that, of course, she was.

What do you do? How do you answer?

What to tell her Uncle

You must chose either to lie to him or tell him the truth.

“No, she was not exposed.”

Is it right to lie (especially in this culture)?

Does the Uncle have a “right” to know?

Is it acceptable to withhold the truth in this scenario?

What if the Uncle discovers that you lied to him?

What conflicts does this raise within you?

Scenario 2:
**Use of Personally Owned Imaging
& Recording in Healthcare Contexts**

Ethics Policies and Guidance Governing Personally Owned Imaging & Recording

1. BUMED Instruction 3104.2 that specifically addresses: “USE OF PERSONALLY OWNED IMAGING AND RECORDING DEVICES”.
2. United States Central Command-General Order Number 1B.

BUMED INSTRUCTION

“USE OF PERSONALLY OWNED IMAGING AND RECORDING DEVICES”

- Per BUMED Instruction 3104.2, the use of personally owned imaging and recording devices is prohibited for any Navy Medicine personnel (military, civil service, contract or volunteer) to utilize personally owned imaging and recording devices to make recording of patients, patients’ families, or human remains in a health care setting.



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 3104.2
BUMED-M3
15 May 2012

BUMED INSTRUCTION 3104.2

From: Chief, Bureau of Medicine and Surgery

Subj: USE OF PERSONALLY-OWNED IMAGING AND RECORDING DEVICES

Ref: (a) SECNAVINST 5720.44C
(b) BUMEDINST 3104.1
(c) DODI 6025.18-R

Encl: (1) Definitions

1. Purpose. This instruction provides guidance and establishes Navy Medicine policy and responsibilities for the use of personally-owned imaging and recording devices for all Navy Medicine personnel.

2. Scope. This policy extends to all Navy Medicine personnel, without regard to duty station or status. Navy Medicine commanders, commanding officers (COs), and officers in charge (OICs) may develop local instructions and regulations based upon the policies established herein to mitigate the potential for privacy and ethical violations that may arise from the use of such devices. The definitions provided in enclosure (1) are to be used in the development of any subordinate instruction or policy. Navy Medicine public affairs officers, combat cameramen,

USCENTCOM General Order Number 1B of 13 Mar 2006

- Governs conduct for forces in CENTCOM AOR.
- Goal is to preserve U.S//host nation relations and ensure success of combined operations between the U.S. and friendly forces.



UNITED STATES CENTRAL COMMAND
OFFICE OF THE COMMANDER
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

place signature on a

MAR 13 2006

CCJA

GENERAL ORDER NUMBER 1B (GO-1B)*

TITLE: Prohibited Activities for U.S. Department of Defense Personnel Present within the United States Central Command (USCENTCOM) Area of Responsibility (AOR).

PURPOSE: To identify and regulate conduct that is prejudicial to the maintenance of good order and discipline of forces in the USCENTCOM AOR.

AUTHORITY: Title 10, United States Code, Section 164(c) and the Uniform Code of Military Justice (UCMJ), Title 10, United States Code, Sections 801-940.

APPLICABILITY: This General Order is applicable to all United States military personnel, and to all civilians, including contingency contractor personnel (as defined in DOD Instruction 3020.41, dated October 3, 2005), serving with, employed by, or accompanying the Armed Forces of the United States, while present in the USCENTCOM AOR *except for* personnel assigned to: Defense Attaché Offices; United States Marine Corps Security Detachments; sensitive intelligence and counterintelligence activities that are conducted under the direction and control of the Chief of Mission/Chief of Station; or other United States

Photography

USCENTCOM General Order Number 1B of 13 Mar 2006

Paragraph 2. f. prohibits:

- “Photographing or filming detainees or human casualties, as well as the possession, distribution, transfer, or posting whether electronically or physically, of visual images depicting detainees or human casualties, except as required for official duties. “Human Casualties” are defined as dead, wounded or injured human beings, to include separated body parts, organs and biological material, resulting from either combat or non-combat activities.” and
- “...with their express consent, the photographing and possession of images of wounded personnel while within medical facilities and during periods of recovery is ... not prohibited.”

Reflections on Professional and Personal Impact

Impact: Professional

"Doctors can't prevent rule number one..."

"Practicing medicine... in opposite land."

"Deploying as medical staff to is like traveling down the rabbit hole in Alice in Wonderland."



With thanks to Darin Dinelli, MD, Heidi Kraft, PhD, & James Ritchie, MD. *Healthcare Ethics Education for Deploying Personnel*. Navy Medicine Ethics Education Course. January 2012.

Impact: Professional

Preserving your ethics and integrity in a world of moral ambiguity:

- Focus on what is healthcare;
- Find the balance between risk/benefit, autonomy/life;
- Give yourself permission to make the most difficult decisions;
- Give your comrades the same permission – and realize they may need *grace* most of all.



With thanks to Darin Dinelli, MD, Heidi Kraft, PhD, & James Ritchie, MD. *Healthcare Ethics Education for Deploying Personnel*. Navy Medicine Ethics Education Course. January 2012.

Impact: Personal

The things we carry with us, in military medicine:

- Intense relationships: positive and negative;
- Feelings of trust and value;
- Guilt;
- Loss;
- Growth;
- The need to forgive, and to be forgiven;
- Human “Spirituality:” Seeking the Meaning of My Experiences; *(NB. Not tied to a religion)*
- Personal Formation in my Life Experiences.

Impact: Personal

Things that might surprise you:

- As trying as some days can be, the goal of our mission deployments is a rich experience.
- You will be tested and might falter.
- You will also be strengthened.
- You will need to forgive yourself and others, including leaders.



With thanks to Darin Dinelli, MD, Heidi Kraft, PhD, & James Ritchie, MD. *Healthcare Ethics Education for Deploying Personnel*. Navy Medicine Ethics Education Course. January 2012.

Impact: Personal

- You will never be the same.
- Don't expect to be.
- Always be prepared. Prepare *proactively* so as not to be blindsided and need to act *reactively*.
- The question is: Will you be *better* because you have been a Navy Medicine Healer?



With thanks to Darin Dinelli, MD, Heidi Kraft, PhD, & James Ritchie, MD. *Healthcare Ethics Education for Deploying Personnel*. Navy Medicine Ethics Education Course. January 2012.

Final Consideration.....

- It is not a question of *if*; it is a question of *when* you will be confronted with an ethical dilemma.
- The consequences of poor decisions can be life changing. Learn from those who have been there before.
- How you develop will depend upon your ability to recognize and respect the patients with whom you are interacting. It will also depend upon your thought process in finding appropriate ethical balance for your actions and living with your decisions.
- Your knowledge of the ethical principles and your ability to apply them will help you to arrive at the best decision possible for your patients, for yourself, and for the Navy Medicine mission that you serve.
- Remember: Your call is to defend those who cannot defend themselves.

How well will you do that?

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Navy Medicine Professional Development Center

Senior Scholars of the Stockdale Center for Ethical Leadership at the
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Diverse national ethicists, scholars and experts