WHOSE CHOICE? PSYCHOTROPIC MEDICATION AND THE ARMED FORCES

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> There was only one catch and that was Catch-22, which specified that a concern for one's own safety in the face of dangers that were real and immediate was the process of a rational mind. Orr was crazy and could be grounded. All he had to do was ask; and as soon as he did, he would no longer be crazy and would have to fly more missions. Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to. Yossarian was moved very deeply by the absolute simplicity of this clause of Catch-22 and let out a respectful whistle.
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> – Joseph Heller, *Catch-22*

I. INTRODUCTION

In military combat settings,[1] the use of psychotropic medications can be highly desirable for myriad reasons: for performance enhancement; to stay awake and alert for long periods of time; as a way to calm nerves in

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[1] In this paper, I will focus specifically on usage of psychotropic medications in the context of combat, as opposed to other operational usage. Operational usage refers to the usage of psychotropic medications in "military operations other than combat, during peacetime or war, and on land, at sea, or in the air." DEP'TS OF THE NAVY & U.S. MARINE CORPS, COMBAT AND OPERATIONAL STRESS CONTROL Glossary-4 (Dec. 2010), *available at* http://www.med.navy.mil/sites/nmcsd/nccosc/coscConference/Documents/COSC%20MRCP%20NTTP%20Doctrine.pdf.

highly stressful situations; to ease the symptoms of depression or anxiety disorders; or to preserve the mental health of the service members[2] in combat. Service members experience various coercive pressures in their relationships with mental health treatment and psychotropic medications. First, there are coercive pressures to hide mental health issues and to either ignore or deny them.[3] If mental health problems become impossible to ignore, there are pressures to quietly take psychotropic medications in lieu of any other mental health treatment, such as psychotherapy.[4] There are also coercive pressures to take medications like stimulants to perform missions lasting twenty-four hours or longer.[5]

Indeed, psychotropic medications are playing an increasingly larger role in the everyday lives of deployed service members, for problems ranging from depression to insomnia to anxiety:

> Walk into any of the larger-battalion-aide stations in Iraq or Afghanistan today, and you'll find Prozac, Paxil and Zoloft to fight depression, as well as Wellbutrin, Celexa, and Effexor. You'll see Valium to relax muscles (but also for sleep and combat stress) as well as Klonopin, Ativan, Restoril, and Xanax. There's Adderall and Ritalin for ADD and Haldol and Risperdal to treat psychosis; there's Seroquel, at subtherapeutic doses, for sleep, along with Ambien and Lunesta. Sleep, of course, is a huge issue in any war. But in this one, there are enough Red Bulls and Rip Its in the chow halls to light up the city of Kabul, and soldiers often line their pockets with them before missions, creating a cycle where they use caffeine to power up and sleep meds to power down.[6]

Although the reasons for taking psychotropic medications vary widely throughout each branch of the armed forces and among individual units and service members, psychotropic medication usage is demonstrably a daily reality for many.[7]

The military has acknowledged the problem and, as will be discussed, has made recommendations for dealing with the overmedication of its service members. Yet in practice, individual service members continue to

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[2] In the interest of clarity, the term "service member" is used to refer to any individual member of any branch of the U.S. armed forces.

[3] *See infra* Part VI.

[4] *See infra* Part V.C.

[5] *See infra* Part V.F.

[6] Jennifer Senior, *The Prozac, Paxil, Zoloft, Wellbutrin, Celexa, Effexor, Valium, Klonopin, Ativan, Restoril, Xanax, Adderall, Ritalin, Haldol, Risperdal, Seroquel, Ambien, Lunesta, Elavil, Trazodone War*, N.Y. MAG. (Feb. 06, 2011), http://nymag.com/news/ features/71277/.

[7] *See id.*

bear the full weight of choosing to take care of their individual health while risking stigma and their careers, or choosing to hide their mental health concerns while risking their long-term health, their safety, and the safety of their fellow service members. In this paper, I will examine the historical and present usages of psychotropic medication in the armed forces, as well as the justifications and choices behind them. I will also explore the longstanding stigmatization of mental health issues that continues to pervade the armed forces. I will then examine the role of coercion in the military in general, and explore what effect—if any—coercion has on influencing service members to take psychotropic medications. Finally, I will consider the unique position in which military physicians find themselves in choosing whether to prescribe psychotropic medications.

II. HISTORICAL USAGE OF PSYCHOTROPIC MEDICATIONS IN THE ARMED FORCES

Service members have long self-medicated to relieve the anxiety and insomnia that result from the stresses of war, "from chloral hydrate and bromides in World War I to barbiturates in World War II and self-prescribed alcohol, cannabis, and heroin in Vietnam."[8] Since World War II, stimulants have been in widespread use to heighten preparedness and enhance the abilities of service members in combat.[9] During World War II, German, Japanese, and English soldiers used amphetamines as performance enhancers to increase alertness, "but also to improve memory, concentration, physical strength, and endurance."[10] American service members used performance-enhancing drugs with frequency during the Vietnam War. For service members involved in long-range reconnaissance patrol, Ritalin and Dexedrine "were standard-issue drugs" used to combat fatigue. Sedatives were used to relieve anxiety and tension for "paratroopers making low-altitude jumps" and "young soldiers when guns were fired."[11]

The Vietnam War was the first armed conflict in which the United States was involved after the advent of modern psychopharmacology. Consequently, researchers took the opportunity to investigate the

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[8] Brett J. Schneider et al., *Psychiatric Medications in Military Operations*, *in* COMBAT AND OPERATIONAL BEHAVIORAL HEALTH 151–52, 154 (Elspeth Cameron Ritchie ed., 2011).

[9] *Id.*

[10] *Id.*

[11] *Id.*

prevalence of prescribing psychotropic medications during the Vietnam War, recognizing that "combat is ordinarily regarded as one of the most stressful of human activities."[12] The data was supplied by physicians deployed in Vietnam in the summer of 1967.[13] The physicians detailed the mental health justifications behind their prescriptions—most commonly, anxiety, insomnia, and combat fatigue ("shell shock")—as well as the frequency with which they prescribed certain medications—about 12.5% of troops received prescriptions per year.[14] The physicians prescribed major tranquilizers, minor tranquilizers, antidepressants, stimulants, sedatives, and hypnotics with regularity, and reported that they found the drugs to be efficacious.[15]

Despite the acceptance of prescribing psychotropic medication for deployed service members since the Vietnam War, it was not until the mid-1990s—when psychotropic medications with less deleterious side effects were introduced into the pharmaceutical landscape—that psychotropic medications began to be used with more frequency in treating ongoing psychiatric conditions like depression and anxiety in combat settings.[16] Indeed, the evolution of psychotropic medication usage in the armed forces has "mirror[ed] changes in psychiatric practice and use of these medications in the military garrison environment and the civilian sector."[17]

Prior to the Iraq War, service members were barred from deploying if they were taking psychotropic medications.[18] Yet despite the growing usage of psychotropic medications while deployed since then, the military has been hesitant to issue directives regarding their recommended usage in combat settings.[19] It was not until 2006 that the Department of Defense

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[12] WILLIAM E. DATEL & ARNOLD W. JOHNSON, JR., WALTER REED ARMY INST. OF RESEARCH & THE DIRECTORATE OF HEALTH CARE OPERATIONS, DEP'T OF THE ARMY, PSYCHOTROPIC MEDICATION IN VIETNAM 1 (1978), *available at* http://www.dtic.mil/cgi-bin /GetTRDoc?AD=ADA097610.

[13] *Id.*

[14] *Id.* at 5, 7.

[15] *Id.* at 4, 9.

[16] Schneider et al., *supra* note 8, at 152.

[17] *Id.* at 160.

[18] Kim Murphy, *A Medicated Military Faces Side Effects; As More Active-Duty Troops Take Stimulants, Antidepressants and Other Drugs, Experts Suspect a Link to Aberrant Behavior*, L.A. TIMES, Apr. 8, 2012, at A1. However, beginning with the Vietnam War, service members could be prescribed psychotropic medications while deployed. *See* DATEL & JOHNSON, *supra* note 12, at 5–6.

[19] Schneider et al., *supra* note 8, at 154–56.

released *Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications*, which specified certain guidelines for when service members on psychiatric medications may be certified for deployment.[20] It stated that service members taking psychotropic medications must be stable for three months on the medications before being cleared for deployment.[21] Commanders were directed to determine fitness for deployment on a case-by-case basis; service members who can "perform their assigned duties, are medically stable, and are not a danger to themselves or others should be considered fit and suitable for worldwide deployment regardless of their psychiatric diagnoses."[22]

III. PRESENT USAGE OF PSYCHOTROPIC MEDICATIONS IN THE ARMED FORCES

In the present day,[23] "a sizable and growing number of U.S. combat troops are taking daily doses of antidepressants," due to the repeated and lengthy tours in Iraq and Afghanistan.[24] According to a 2007 anonymous survey of U.S. troops taken by the Army's Fifth Mental Health Advisory Team,[25] "about 12% of combat troops in Iraq and 17% of those in Afghanistan are taking prescription antidepressants or sleeping pills to help them cope,"[26] which adds up to approximately 20,000 troops total. The *Los Angeles Times* reported that "more than 110,000 active-duty Army troops [in 2011] were taking prescribed antidepressants, narcotics, sedatives, antipsychotics and anti-anxiety drugs . . . . Nearly 8% of the active-duty Army is now on sedatives and more than 6% is on

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[20] Non-deployable service members include those who are being treated for psychosis or bipolar disorder, those taking medications (such as lithium) that require laboratory monitoring, and those taking antipsychotic medications. Waivers for certain disqualifying conditions may be requested. Memorandum from William Winkenwerder, Jr., MD, Assistant Sec'y of Def., to Sec'y of the Army, Sec'y of the Navy, Sec'y of the Air Force, & Chairman of the Joint Chiefs of Staff 4.2.4, 4.2.3 (Nov. 7, 2006), *available at* http://www.health.mil/Libraries/HA_Policies_and_Guidelines/Guidance_20061107_deplo_limiting_psyc_cond.pdf [hereinafter Winkenwerder Memorandum].

[21] *Id.* at 4.1.4.4.

[22] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 5-4.

[23] *See infra* text accompanying notes 128–30.

[24] Mark Thompson, *America's Medicated Army*, TIME (Jun. 05, 2008), http://www.time.com/time/magazine/article/0,9171,1812055-1,00.html.

[25] MENTAL HEALTH ADVISORY TEAM V, OPERATION IRAQI FREEDOM 06–08: IRAQ, OPERATION ENDURING FREEDOM 8: AFGHANISTAN 144, 203 (2008), *available at* http://www.armymedicine.army.mil/reports/mhat/mhat_v/MHAT_V_OIFandOEF-Redacted.pdf.

[26] Thompson, *America's Medicated Army*, *supra* note 24.

antidepressants—an eightfold increase since 2005."[27]

Due to the stigma[28] attached to mental health needs and service members' probable reluctance to report their intake, these statistics likely underestimate the use of psychotropic medications in the Army.[29] Usage of antidepressants like Prozac and Zoloft and sleeping pills like Ambien is widespread not only to ease the anxieties and pressures straining the mental health of individual service members, "but also to enable the already strapped Army to preserve its most precious resource: soldiers on the front lines."[30] Before enlisting, service members are prescreened for mental illnesses,[31] but there is continuing debate over the need to screen more effectively for mental health concerns before service members are deployed.[32] Indeed, whereas previously taking psychotropic medications while in combat was prohibited,[33] now service members are prescribed, and perhaps even encouraged, to take them while deployed so as to help conserve the limited number of trained service members available for

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[27] Murphy, *supra* note 18. However, the military asserts that "[e]ven given the increased trend, there does not appear to be an inappropriate increase in the use of psychotropic medication given the likely increase in rates of psychological stress. It is likely that the increased use, both in theater and in garrison, reflects appropriate professional judgment and prescribing." Memorandum from the Def. Health Bd. Psychological Health External Advisory Subcomm. to the Off. of the Assistant Sec'y of Def. for Health Affairs 26 (Aug. 17, 2010), *available at* http://www.govexec.com/pdfs/092711bb1.pdf [hereinafter Def. Health Bd. Memorandum].

[28] *See infra* Part 0.

[29] Thompson, *America's Medicated Army*, *supra* note 24.

[30] *Id.*

[31] There are two components to assessing psychological fitness for potential recruits: (1) assessing aptitude through the Armed Services Vocational Aptitude Battery and (2) a determination of educational achievement. Robert Cardona & Elspeth Cameron Ritchie, *Psychological Screening of Recruits Prior to Accession in the US Military in* RECRUIT MEDICINE 304 (Bernard L. DeKoning ed., 2006), *available at* https://ke.army.mil/bordeninstitute/published_volumes/recruit_medicine/RM-ch16.pdf.

[32] *See, e.g.*, Lisa Chedekel & Matthew Kauffman, *Special Report: Mentally Unfit, Forced to Fight*, HARTFORD COURANT (May 14, 2006), http://www.courant.com/news/special-reports/hc-unfit0515.artmay14,0,5622628.story; Charley Keyes, *Army To Implement New Mental Health Screening Procedures*, CNN.COM (Jan. 19, 2011), http://articles.cnn.com/2011-01-19/us/military.mental.health_1_suicidal-ideation-predeployment-screening-process-combat-stress?_s=PM:US; James Dao, *Military Study Finds Benefits in Mental Health Screening*, N.Y. TIMES (Jan. 18, 2011), http://www.nytimes.com/2011/01/19/us/19military.html; Mark Thompson, *Army Mental Health: Better Screening Yields Better Results*, TIME (Apr. 17, 2011), http://battleland.blogs.time.com/2011/04/17/army-mental-health-better-screening-yields-better-results/; Neal Conan, *Grading The Military's Mental Health Screenings*, NPR.ORG (Mar. 20, 2012), http://www.npr.org/2012/03/20/149002197/grading-the-militarys-mental-health-screenings.

[33] Thompson, *America's Medicated Army*, *supra* note 24.

missions.[34]

A. CHALLENGES UNIQUE TO THE MILITARY'S USE OF PSYCHOTROPIC MEDICATIONS

Service members in combat settings endure stressors such as "IEDs [improvised explosive devices], ambushes, severe sleep deprivation, [and] direct combat"[35] and could experience "nearly being killed by an IED blast, being ambushed and pinned down by small arms fire during ground combat, or witnessing the death of a shipmate in a fire below decks."[36] Such challenges faced by military personnel in combat settings can seemingly justify the usage of psychotropic medications, the usage of which in civilian life might not seem as justifiable.

However, psychotropic medicines were not created to cope with war but rather to treat civilian mental disorders. Professor Michael H. Shapiro observes, "[i]f we are sick and medical technology restores us to our initial baseline, we are obviously enhanced in *some* sense,"[37] whereas the use of psychotropic medications for the enhancement of one's ability to remain alert in combat settings is certainly not restoring an individual to a baseline. Instead, such usage seeks to propel an individual's capabilities—for example, to remain awake for twenty-four hours or more in order to carry out a mission—beyond what an average human without enhancement could competently handle.[38] Yet the aforementioned life-threatening conditions that combat service members endure perhaps justify stepping outside the natural scope of a disorder treatment model. Surely a strong argument for using psychotropic medications exists if doing so would increase a service member's chance of surviving a particular mission.[39]

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[34] *See infra* Parts 0, and 0A.

[35] Elspeth Cameron Ritchie, Address at The PA 2nd Annual Veterans Conference: Psychological Effects of War Since 9/11 4 (Mar. 21–22, 2012), *available at* http://www.drexelmed.edu/drexel-pdf/program-behavioral-health/conference-handout-veterans-psychological-effects-war.pdf [hereinafter Ritchie Address].

[36] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1 at 2-2.

[37] MICHAEL H. SHAPIRO ET AL., CASES, MATERIALS AND PROBLEMS ON BIOETHICS AND LAW 1431 (2d ed. 2003).

[38] *See* NAVAL STRIKE & WARFARE CTR., PERFORMANCE MAINTENANCE DURING CONTINUOUS FLIGHT OPERATIONS: A GUIDE FOR FLIGHT SURGEONS (2000), *available at* http://www.med.navy.mil/directives/Pub/6410.pdf [hereinafter NAVAL STRIKE & WARFARE CTR.].

[39] *See* Brad Knickerbocker, *Military Looks to Drugs for Battle Readiness*, CHRISTIAN SCI. MONITOR (Aug. 9, 2002), http://www.csmonitor.com/2002/0809/p01s04-usmi.html.

The President's Council on Bioethics faced the issue of using psychotropic medications in a military context in its 2003 report on enhancement drugs.[40] The Council wrestled with the notion that ensuring that service members perform in a "certain special superior" manner is "not only edifying but urgent," due to the fact that they perform under "moments of extreme peril and consequence . . . when superior performance is a matter of life or death."[41] Regardless of any individual hesitations about taking medication, "life or death" situations would likely encourage most people to take a performance-enhancing drug if it would improve one's chances of survival. Service members in such circumstances might agree to take a performance-enhancing medication and justifiably allow themselves to be treated as "alterable artifacts . . . in order to 'get the job done.'"[42] Indeed, the military views service members as such,[43] and for individual service members, obeying commands and doing what is best for the unit and military in general is ingrained into their psyches from the very beginnings of their military careers.

IV. AUTONOMY AND MILITARY CULTURE

From the start of their military careers, service members are encouraged to form a group mentality, to serve selflessly and to privilege the health of the group over the health of themselves as individuals.[44]

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[40] PRESIDENT'S COUNCIL ON BIOETHICS, BEYOND THERAPY: BIOTECHNOLOGY AND THE PURSUIT OF HAPPINESS (2003).

[41] *Id.* at 154.

[42] *Id.*

[43] *See* Catherine L. Annas & George J. Annas, *Enhancing the Fighting Force: Medical Research on American Soldiers*, 25 J. CONTEMP. HEALTH L. & POL'Y 283, 289–90 (2009) (citing PRESIDENT'S COUNCIL ON BIOETHICS, *supra* note 40, and noting that as long as soldiers become "de facto robots, enhancements are acceptable . . . . Such biotechnical interventions might improve performance in a just cause . . . .").

[44] The values of each individual service branch reflects an attitude of group over individual. *E.g.*, *Our Values*, U.S. AIR FORCE, http://www.airforce.com/learn-about/our-values (last visited Apr. 13, 2013) (citing "service before self" as its second core value); *The Army Values*, U.S. ARMY, http://www.army.mil/values/ (last visited Apr. 13, 2013) (citing "loyalty, duty, and selfless service" among its core values); *Core Values*, U.S. COAST GUARD, http://www.uscg.mil/hq/osc/values.asp (last visited Apr. 13, 2013) (citing "Greater Good of the Coast Guard" as a core value); *Principles & Values: Semper Fidelis*, U.S. MARINE CORPS, http://www.marines.com/history-heritage/principles-values (last visited Apr. 13, 2013) (citing its motto, *Semper Fidelis*, as the guide for Marines "to remain faithful to the mission at hand, to each other, to the Corps and to country, no matter what"); *Core Values of the Navy*, U.S. NAVY, http://www.navy.mil/navydata/navy_legacy_hr.asp?id=193 (last visited Apr. 13, 2013) (citing a serviceperson's "commitment" to "obey the orders . . . up and down the chain of command" as a core value).

Presumably to encourage individual fitness, group bonding, obedience and submission to commanding officers, and to hasten development from civilian to service member, recruits are inundated with mental, emotional, and physical messages of intolerance for weakness.[45] Service members learn that any concerns of mental or physical health should be kept to oneself.[46] The military emphasizes that "[d]iscipline is the means by which leaders at all levels communicate relentlessly to subordinates the entire set of [knowledge, skills, and attitudes] they need to absorb and to master in order to answer every threat they will face with an immediate and resounding, 'Yes, I can handle this!'"[47] The nature of the military's missions means that physical and mental weakness on behalf of any service members can put people's lives in danger.

One example of indoctrinating service members with an intolerance for weakness is the process by which Marine recruits in basic training undergo visual bodily inspections. A former Marine I spoke with described the experience:

> All the privates stand completely naked in front of the officer. You spin in a circle with your arms held straight in front of you, lifting your knees to your chest, while repeatedly shouting, "Sir, this recruit has no medical, dental, or psychological problems to report at this time, Sir!"[48]

From the outset of one's time in the military, an individual is taught to push aside psychological concerns in favor of a fully positive report to one's superior. The public performance of demonstrating one's physical and mental fitness, in front of a crowd of officers and fellow recruits, does not readily facilitate being forthcoming with any concerns.

A. OBEYING SUPERIORS AND LEARNING TO TAKE COMMANDS

Service members are trained to obey and submit to their commanding officers from the moment they enter the military.[49] The military maintains that the nature of its missions necessitates a hierarchical structure in which service members who fail to obey the orders of commanding officers are penalized.[50] Commanding officers need to be able to "trust that every unit

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[45] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1 at 5-5.

[46] *Id.*

[47] *Id.* at 2-12.

[48] Interview with Steve, former U.S. Marine Corps member, in L.A., Cal. (Sept. 23, 2011).

[49] 10 U.S.C. § 502 (requiring people enlisting in the military to swear that they "will obey the orders of the . . . officers appointed over [them]").

[50] 10 U.S.C. § 892 (detailing that a court martial may direct disciplinary actions for Service

member will perform effectively during every future challenge and perform their assigned roles without limitations,"[51] and indoctrinating service members with messages of selflessness and imperatives to obey commands appears to be the military's way of accomplishing that.

B. SOCIAL COHESION AND THE TRANSFORMATION FROM "I" TO "WE"

All branches of the armed forces emphasize the loss of self for the benefit of one's fellow service members.[52] In detailing the transformations that one undergoes in the process of becoming a Marine, the Marine Corps states that for recruits,

> [Q]uitting is not an option, as the consequences are too great, not just for themselves—but for their entire platoon. . . . It's not just respect for others that Marines develop; it's a genuine concern for their well-being. Training with, enduring alongside and relying on those to their left and right during such a challenging experience redirects their focus from self to that of accomplishing missions together.[53]

All service members are trained to think not of themselves, but of their fellow service members and the greater wellbeing of the group and the mission at hand.[54] The military notes that fostering unit cohesion leads service members to "respond to a threat situation with a positive, 'Yes, I can handle this!' because in a cohesive unit, the 'I' can be replaced with 'we.'"[55] No service members want to derail the group's mission or let down their fellow service members, particularly if they have been repeatedly proclaiming that they are physically and mentally fit.

For modern-day service members, joining the armed forces is voluntary,[56] which may lend itself to the argument that those who enlist knowingly consent to self-sacrifice for the good of the group. However, potential service members can never know what the stress of war is like

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Members who fail to obey orders or regulations from a superior or who are derelict in the performance of their duties).

[51] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1 at 6-2.

[52] *See supra* text accompanying note 44.

[53] *Marine Corps Transformation*, U.S. MARINE CORPS, http://www.marines.com /becoming-a-marine/transformation (last visited Apr. 13, 2013).

[54] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1 at 2-11.

[55] *Id.* at 2-10.

[56] The introduction of the all-volunteer force came in 1973 with the end of the draft. BERNARD ROSTKER, RAND CORPORATION, I WANT YOU!: THE EVOLUTION OF THE ALL-VOLUNTEER FORCE 2 (2006), *available at* http://www.rand.org/pubs/monographs/2007 /RAND_MG265.pdf.

and what their reactions to such stress will be until they experience it. Whereas the valuing of a group over one's individual interests may be vital to accomplishing the goals of the United States Armed Forces, on an individual level it can mean dealing with crippling mental illness alone and can potentially do more harm to the group than good. For example, if a Marine is trying to push aside concerns of combat-related anxiety and depression—thinking that it is in the best interest of the platoon—eventually the anxiety could overtake the Marine while in a vulnerable position, putting not only that Marine's life in danger, but the lives of the other platoon members as well.[57] Service members who choose to medicate with psychotropic medications are reacting to the practical circumstances in which they find themselves and treating themselves in the most seemingly efficient manner. Yet psychotropic medication is rarely, if ever, the only recommended mental health treatment for individuals; and if it is the only option for a service member—either because of a fear that voicing mental health concerns could lead to stigma or hinder career aspirations, or because of a lack of mental health professionals from whom to seek alternative help—the service member will likely end up suffering silently, with possible negative consequences.[58]

C. OVERVIEW OF MENTAL HEALTH CARE TREATMENT FOR DEPLOYED SERVICE MEMBERS

The armed forces have acknowledged that they lack a uniform system for providing mental health care treatment, including the prescription of psychotropic medications, and cite the "transient nature of the military population" that "makes continuity of care a challenge for military medicine."[59]

As opposed to psychiatrists or psychologists—medical professionals who typically oversee the use of psychotropic medications for civilians—primary care physicians and medical technicians "provide the majority of

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[57] *See, e.g.*, Murphy, *supra* note 1818 (explaining that compared to the general population, "'[t]he big difference is these are people who have access to loaded weapons, or have responsibility for protecting other individuals who are in harm's way,' said Grace Jackson, a former Navy staff psychiatrist who resigned her commission in 2002, in part out of concerns that military psychiatrists even then were handing out too many pills").

[58] *See* JOINT MENTAL HEALTH ADVISORY TEAM 7, OPERATION ENDURING FREEDOM 2010: AFGHANISTAN 73 (2011), *available at* http://www.armymedicine.army.mil/reports/mhat/mhat_vii/J_MHAT_7.pdf; *see also* Thompson, *America's Medicated Army*, *supra* note 24.

[59] Def. Health Bd. Memorandum, *supra* note 27 at 15.

psychological health care in-theater"[60] and consequently often lack the training of a skilled mental health care provider. Psychological help is generally offered under the guise of a primary care setting due to the dearth of deployed mental health specialists, and also to counteract any stigma associated with obtaining mental health treatment.[61]

Due to circumstances of combat, which often include being in remote locations, service members who receive prescriptions for mental health problems do not have routine follow-up visits with doctors as do those civilians who receive the same psychotropic medicines; according to a former Army sergeant, "In the civilian world, when you have a problem, you go to the doctor, and you have therapy followed up by some medication. In Iraq, you see the doctor only once or twice, but you continue to get drugs constantly."[62] According to an investigative report by *The Hartford Courant*,[63] "[M]ilitary doctors treating combat stress symptoms were sending some soldiers back to the front lines after rest and a three-day regimen of medication despite evidence that it typically takes two to six weeks for the prescribed medications to begin working."[64]

In response to the acknowledged need for better mental health care support, some branches of the armed forces have created special teams dedicated to such treatment, including the deployment of a Navy Medicine team for "conducting mental health surveillance, command consultation, and coordinating mental health care for sailors . . . ."[65] Additionally, the Army has significantly increased its staffing ratio of behavioral health personnel to service members, from 1:1123 in May 2009 to 1:646 in August 2010.[66] (For comparison, the military's Mental Health Advisory Team recommends 1:700).[67] However, despite recent efforts to improve the situation, service members often find themselves unable to obtain adequate treatment. The Joint Mental Health Advisory Team's report for 2009 noted that for "[s]ervice members who need help with psychological and behavioral health concerns, only about 50% seek it, and of those who do, only 42% receive it."[68] Reported reasons for not getting help included

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[60] *Id.* at 32.

[61] *Id.* at 12.

[62] Thompson, *America's Medicated Army*, *supra* note 24.

[63] Chedekel & Kauffman, *supra* note 32.

[64] Def. Health Bd. Memorandum, *supra* note 27, at 2.

[65] *Id.* at 32.

[66] Ritchie Address, *supra* note 35, at 18.

[67] *Id.*

[68] Def. Health Bd. Memorandum, *supra* note 27, at 11.

fear of stigma (50% or more), difficulty getting time off (40%), lack of access (40%), and leaders discouraged use of mental health services (21%).[69]

D. How Service Members Receive Psychotropic Medications

Service members can access psychotropic medications in a variety of ways: pre-deployment, they can fill prescription medications for up to 180 days; they can bring prescription drugs that were prescribed by private sector providers; they can access them at military treatment facilities, which receive bulk shipments of medications; friends and family can mail medications; technicians can dispense medications to service members in far-forward combat areas; and fellow service members can distribute them.[70]

Coupled with the varied methods of obtaining medications, the military lacks a unified pharmacy database for tracking individuals' prescriptions.[71] This makes it possible for service members to have prescriptions for and to take several different medications at once, increasing the risk of excessive medication and adverse side effects of medication interactions.[72]

E. Side Effects of Taking Psychotropic Medications

Regardless of any benefit taking a stimulant or depressant would have for a service member and for the military generally, the side effects of such medications cannot be ignored. With amphetamine use, an individual may experience fast heartbeat, tremors, dizziness, headache, and insomnia, all of which could end up being counterproductive to the service member's mission, not to mention the initial reason—anxiety, for example—for taking the medication.[73] Dexedrine is an amphetamine

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[69] Ritchie Address, *supra* note 35, at 12.

[70] Def. Health Bd. Memorandum, *supra* note 27, at 18.

[71] Interestingly, the military points out that increased tracking and identification can result in "unintended consequences" such as "stigmatization of the Service member and his or her family." *Id.* at 2–3.

[72] One distressing example is that of Chad Oligschlaeger, a young Marine who did two tours in Iraq and came home "complaining of nightmares and hallucinations. He was taking trazodone, fluoxetine, Seroquel, Lorazepam and propranolol, among other medications." Oligschlaeger died two months before he was scheduled to leave the Marines; his death was concluded to have been "accidental due to multiple-drug toxicity—interactions among too many drugs." Murphy, *supra* note 18.

[73] Annas & Annas, *supra* note 43 at 293.

officially sanctioned by the United States Air Force for pilot use. In its guide to performance maintenance,[74] the Navy acknowledged that:

> [F]atigue in sustained, continuous naval flight operations[75] is expected and can lead to poor flight performance and increased aircraft mishap potential. . . . The uses of sleep, combat naps, proper nutrition, and caffeine are currently approved and accepted ways flight surgeons can recommend to prevent and manage fatigue. However, in sustained and continuous operations these methods may be insufficient to prevent fatigue and maintain combat-ready performance. Properly administered use of stimulant and sedative medications, i.e., Dexedrine, Ambien, and Restoril, is an additional measure flight surgeons can recommend to manage fatigue and maintain pilot performance in continuous, sustained naval flight operations.[76]

Yet in its prescribing information, Dexedrine's manufacturer cautions that "[a]mphetamines may impair the ability . . . to engage in potentially hazardous activities such as operating machinery or vehicles . . . ."[77] The military recognizes this, noting that:

> [Certain mental health] treatments can impact fitness for duty and deployment either because the side effects of the treatment . . . may interfere with adequate performance of duties or because sudden withdrawal of the treatment during deployment because it is no longer available may lead to serious worsening of the underlying stress symptoms or to other withdrawal symptoms.[78]

The military refers not only to psychotropic medications as possibly interfering with the performance of duties, but also to all "psychological treatments,"[79] a phrase that it does not expand upon but which presumably includes psychotherapy.

Beyond the Air Force, "the medications—combined with the war's other stressors—created unfit soldiers: 'There were more than a few convoys going out in a total daze.'"[80] An Army major commented that he

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[74] NAVAL STRIKE & WARFARE CTR., *supra* note 39.

[75] Continuous operations are those lasting longer than twenty-four hours; they do not necessarily involve more working hours for individuals, but the Navy admits that during such operations, "sleep may be intermittent, broken, and unrestorative." *Id.* at 3. Sustained operations are those that require individuals to work longer than twenty-four hours at a time, until the mission is complete, during which time "sleep deprivation is common." *Id.*

[76] *Id.* at 6.

[77] Annas & Annas, *supra* note 43, at 293.

[78] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 6-6 to 6-7.

[79] *Id.*

[80] Thompson, *America's Medicated Army*, *supra* note 24.

felt "like people with my symptoms are becoming the majority of the Army . . . [f]eeling anxious when you don't have a reason to, being a little depressed, having low-grade anhedonia, not sleeping well—this is the new normal for those of us who've been repeatedly deployed."[81] Moreover, "[a]bout a third of soldiers in Afghanistan and Iraq say they can't see a mental-health professional when they need to," and surges in troop numbers have not been accompanied by corresponding surges in mental-health workers.[82] This further compounds the difficulty in seeking and obtaining adequate mental health care treatment.[83] The military admits that "there may be an underuse of alternative treatment strategies, particularly in theater."[84]

Moreover, those service members who are using psychotropic medications may not have the benefit of physician oversight to monitor their psychotropic medication intake. The military's Defense Health Board, a federal advisory committee to the Secretary of Defense, has acknowledged that "[i]n the military setting, care has to be taken to ensure that the effects of polypharmacy[85] do not impair readiness. The appropriateness of polypharmacy might differ between civilian and military settings."[86] Although the Defense Department utilizes an electronic health records system, access to it may be limited, particularly in combat settings.[87] Even with access to the system, prescribing providers and technicians "may not uniformly code for psychological conditions . . . [and] avoid diagnostic codes that may implicate a more serious mental health issue in an environment with ongoing combat."[88] Some prescribers have even miscoded mental health diagnoses to shield service members "from potential stigmatization or discrimination."[89]

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[81] Senior, *supra* note 6.

[82] Thompson, *America's Medicated Army*, *supra* note 24.

[83] *Id.*

[84] Def. Health Bd. Memorandum, *supra* note 27, at 27.

[85] Polypharmacy refers to "the use of multiple medications by a patient regardless of the route of receipt. It can refer to too many forms of medication or more drugs than are clinically indicated or warranted." Def. Health Bd. Memorandum, *supra* note 27, at 9.

[86] *Id.*

[87] *Id.* at 16.

[88] *Id.*

[89] *Id.*

V. THE STIGMA OF MENTAL HEALTH ISSUES IN THE ARMED FORCES

As a service member, admitting that it may be necessary to seek medical treatment for physical or mental health concerns can be a complicated decision. By its very nature, the work of the military stigmatizes health concerns: the ideal service member is physically fit, fearless, and mentally and emotionally stable enough to handle intense, potentially life-threatening situations.[90] The military admits that mental health stigma arises as a result of "an admiration for strength in body, mind, and spirit, and a similar intolerance for weakness of any kind."[91] The military goes on to say that such an attitude is "necessary for individuals and units in the military to perform challenging missions under difficult conditions."[92] However, these attitudes can:

> Cause significant and unintended harm if they prevent individuals from admitting to themselves or others that they are wounded, injured, or ill for fear of appearing weak. The wish to avoid any appearance of weakness can motivate Service members to hide not only their stress symptoms, but also their physical health problems.[93]

Thus, it appears to be up to the individual service member to wrestle with the competing messages that are received from commanding officers: do not show any weakness, but know that you may be doing yourself further harm by not displaying weakness and seeking help if you are seriously hurt. Female service members are especially vulnerable to the stigma of seeking mental health treatment because they are under heightened pressure to appear as fit and as tough as their male counterparts.[94]

The military has a long history of stigmatizing mental health issues and the circumstances that surround mental illness. Prior to the recognition of "shell shock," combat fatigue, and PTSD, service members who endured traumatic experiences and consequently suffered tremendous mental and emotional strain were labeled as having "hysteria." As the military describes, this term was "deliberately chosen to produce shame in the young men given that label. Hysteria literally meant 'disturbances of

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[90] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 5-5.

[91] *Id.*

[92] *Id.*

[93] *Id.*

[94] *See* Jennifer Boldry et al., *Gender Stereotypes and the Evaluation of Men and Women in Military Training*, 57 J. OF SOC. ISSUES 689, 690 (2001).

the uterus;' even uneducated young European men in 1916 knew that being compared to a female reproductive organ was feminizing and shameful."[95]

The attitude of viewing mental health issues as sources of shame and signals of character weakness prevailed throughout the twentieth century and "intentionally *increased* the social stigma attached to psychological problems of all kinds."[96] Instead of recognizing psychological trauma as a natural result of witnessing traumatic events, the prevailing attitude in the military was "that only morally weak or unmotivated individuals develop[ed] significant problems because of stress."[97] Despite the strides being made toward reducing the stigma of mental health issues, stigma continues to operate both on broad, institutional levels in the military, as well as on an individual level.[98]

A. INSTITUTIONAL STIGMA

Institutional stigma of mental health issues has been built into and continues to pervade the military system, an issue that the military recognizes and is attempting to change.[99] The Departments of the Navy and the Marine Corps acknowledge that through their policies, procedures, and organizational attitude, fundamental system-wide stigma "is the one that is most tangible and most based on fact—the real harm that can occur to a military career or to future employability because of having been diagnosed and treated for a mental health problem."[100]

For example, "[a]pplications for security clearances and licensure in a number of fields . . . still include questions asking whether the individual has ever been treated for a mental illness."[101] Although having a mental health record will not disqualify an applicant immediately, "it does trigger a requirement for additional documentation and possibly a current psychiatric evaluation to determine fitness and suitability."[102] Consequently, service members hoping to advance in careers—military or civilian—that require security clearances might understandably be

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[95] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1 at 5-6 to 5-7.
[96] *Id.* at 1-5 (emphasis in original).
[97] *Id.*
[98] *Id.* at 5-2 to 5-4.
[99] *Id.* at 5-4.
[100] *Id.*
[101] *Id.*
[102] *Id.*

reluctant to admit to mental health problems with the knowledge that such a record could derail a future career.[103]

B. INDIVIDUAL STIGMA

On an individual level, stigma operates through the prevailing attitudes of one's environment; peers reinforce stigma through the "language and behaviors that groups use to include or exclude members."[104] Stigmatized individuals face isolation and ridicule from their peers—in addition to the shame they likely inflict on themselves—which is an especially frightening prospect for service members, for whom social cohesion and camaraderie is of paramount importance to completing missions.[105] Service members do not want to be perceived as mentally unstable and in a position to put fellow service members at risk.[106] If there is knowledge of a comrade taking pills, this can lead to distrust of that individual, and fellow service members might begin to question that individual's ability to complete duties and perform under intense combat pressure.[107]

The result of these stigmas is that individuals who believe they need mental health treatment might avoid seeking such treatment due to a fear of being distrusted or shunned by their fellow service members; instead, they may simply hope that their problems will dissipate.[108] On the other hand, individuals in need of mental health treatment might have so internalized stigmatization of mental health problems that they do not realize their need for help "until marriages have been lost, violations of the Uniform Code of Military Justice have been committed, or other life or career damage has been done."[109]

C. CONSEQUENCES OF STIGMA

As a result of institutional and individual stigma, "[m]embers of all Services have reported a reluctance to seek help for stress or mental health problems for fear of being branded as weak by their peers and

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[103] *Id.*
[104] *Id.* at 5-3.
[105] *Id.* at 3-20, 5-2 to 5-3.
[106] *Id.* at 5-5.
[107] *Id.* at 6-10.
[108] *Id.* at 1-13.
[109] *Id.*

superiors."[110] Even for physical health ailments, the pressure to be and to be perceived as superhumanly physically fit is intense and can result in service members' reluctance or failure to seek treatments that involve taking medications, such as painkillers.[111]

Consequently, stigma creates disincentives to seeking more "visible" mental health treatment such as seeing a therapist—which is often impossible in combat zones even if one were to seek such help—or requesting a change of duty or leave.[112] Instead, those wishing to confront mental health issues in a discreet manner might prefer to quietly take a psychotropic medication. Or, service members exhibiting signs of mental distress may be directed by their commanding officers to seek a prescription for psychotropic medication. However, the threat of stigma might prove so great that a service member will never seek treatment of any kind, nor admit a need for help, and "[w]ithout early treatment, problems are more likely to become chronic and entrenched."[113]

VI. CONSEQUENCES OF AN OVERMEDICATED MILITARY

As a result of a military culture intolerant of weakness but simultaneously stigmatizing treatment for mental disorders, soldiers are frequently given medication while the underlying causes of their mental strains remain unaddressed.

A. CYCLICAL NATURE OF "GO" AND "NO-GO" PILL USAGE

In the military, "go pills" denote those psychotropic medications used to keep personnel awake and alert during particularly long missions or those conducted during normal sleeping hours.[114] To ensure that individuals using "go pills" eventually are able to rest, the effects of the amphetamines must be counteracted with "no-go pills," which aid military

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[110] *Id.* at 3-7.

[111] *Id.* at 5-5. The Departments of the Navy and Marine Corps report, "Less well-known, but of equal importance, is the stigma in certain segments of the military associated with seeking help even for a *physical* health problem, especially if it is an injury or illness not caused by direct enemy action. Particularly in ground combat communities in which toughness and stoicism are highly prized, Marines and Sailors may suffer through entire deployments with mild to moderate physical health problems they are unwilling to report to their leaders or medical personnel for fear of being seen as less tough or of being removed from their duties and units." *Id.* at 3-7 to 3-8 (emphasis in original).

[112] Thompson, *America's Medicated Army*, *supra* note 25.

[113] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 1-6.

[114] NAVAL STRIKE & WARFARE CTR., *supra* note 39, at 10.

personnel in getting to sleep in-between missions.[115] As a result of the repeated usage of both go and no-go pills, service members' sleep cycles and fatigue levels are reasonably distorted and such usage can have severe consequences for service members, who may become addicted to a "cyclic use of a stimulant/sedative combination."[116]

B. LONG-TERM ECONOMIC CONSEQUENCES

Using psychotropic medications to treat deployed service members with mental health problems saves the military money it would otherwise spend to train and deploy replacement service members, but the projected long-term effects are troubling. Because service members are being redeployed into combat with more frequency, "the number of soldiers requiring long-term mental-health services soars,"[117] and the military eventually will feel the effects of its reliance on psychotropic medications—such as antidepressants and sleeping aids—to treat and continuously redeploy service members.[118]

According to the Army, "Defense Department spending on Ambien, a popular sleep aid, and Seroquel, an antipsychotic, has doubled since 2007, . . . while spending on Topamax, an anti-convulsant medication often used for migraines, quadrupled; amphetamine prescriptions have doubled, too."[119] In 2010, the *Military Times* newspaper exposed the numbers behind Defense Department spending on psychiatric and pain medications: the Defense Logistics Agency[120] had spent $1.1 billion from 2001 to 2009.[121] The investigation found that during that period, the use of psychiatric medications increased seventy-six percent, and that at least one in six service members was on at least one form of a psychotropic

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[115] *Id.*

[116] *Id.* at 9.

[117] Thompson, *America's Medicated Army*, *supra* note 24.

[118] *See generally* Linda J. Bilmes, *Current and Projected Future Costs of Caring for Veterans of the Iraq and Afghanistan Wars*, COSTS OF WAR (June 13, 2011), http://costsofwar.org/sites/default/files/articles/52/attachments/Bilmes%20Veterans%20Costs.pdf.

[119] Senior, *supra* note 6.

[120] "The Defense Logistics Agency is the Department of Defense's largest logistics combat support agency . . . ." *About the Defense Logistics Agency*, DEF. LOGISTICS AGENCY, http://www.dla.mil/pages/about_dla.aspx (last visited Apr. 13, 2013).

[121] Andrew Tilghman & Brendan McGarry, *Medicating the Military: Use of Psychiatric Drugs Has Spiked; Concerns Surface About Suicide, Other Dangers*, ARMY TIMES (Mar. 17, 2010), http://www.armytimes.com/news/2010/03/military_psychiatric_drugs_031710w.

medication.[122]

Despite exorbitant associated costs,[123] the military is focused on redeploying troops as opposed to recruiting, training, and deploying new troops, which has more short-term costs.[124] Projected overall medical costs for the years 2011 to 2020 for treating veterans through the Veterans Health Administration ranges from $40 billion to $54 billion.[125] Economists Joseph Stiglitz and Linda Bilmes estimate that "the long-term cost of providing medical care and disability compensation for these veterans . . . [will be] between $589 billion and $934 billion . . . ."[126] Bilmes also noted that:

> [V]eterans from the recent wars are utilizing VA medical services and applying for disability benefits at much higher rates than in previous wars. The higher medical usage is the result of several factors, including . . . higher incidence of post-traumatic stress disorder and other mental health problems [and] more veterans who are willing to seek treatment for mental health ailments . . . ."[127]

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[122] *Id.*

[123] In addition to spending on psychotropic medications, the military must consider the cost of future mental health treatment for the severe psychological problems associated with constantly redeploying troops. *See generally* Bilmes, *supra* note 118.

[124] For example, "A trained service member who separates from the military must be replaced by more than one accession [new recruit] to account for recruits who separate during training or during their first few years of service." CONG. BUDGET OFF., RECRUITING, RETENTION, AND FUTURE LEVELS OF MILITARY PERSONNEL XII (2006), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7626/10-05-recruiting.pdf.

[125] CONG. BUDGET OFF., POTENTIAL COSTS OF VETERANS' HEALTH CARE 27-29 (2010), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/118xx/doc11811/2010_10_7_vahealthcare.pdf.

[126] *The True Cost of War: Hearing Before the Committee on Veterans' Affairs, U.S. House of Representatives*, 111th Cong. 9 (2010) (statement of economist Joseph E. Stiglitz), *available at* http://www.gpo.gov/fdsys/pkg/CHRG-111hhrg61761/pdf/CHRG-111hhrg61761.pdf.

[127] *Id.* at 8 (statement of economist Linda J. Bilmes). Bilmes went on to state, "There are much larger social and economic burdens that are not paid by the Federal Government but nonetheless represent a real burden on society. These include the loss of productive capacity by young Americans who are killed or seriously wounded; lost output due to mental illness; the burden on caregivers who have to sacrifice paid employment in order to take care of a veteran; the cost of those, particularly among Reservists and Guards, who were self-employed and have lost their livelihood. For many veterans, there is simply a diminished quality of life, the costs of which is [sic] borne by individuals and families." *Id.* at 10. In another forum, Bilmes stated that, "recent data shows that 331,514 unique returning veterans have been diagnosed with a possible mental disorder, including 177,149 diagnosed with PTSD." Bilmes, *supra* note 118 at 3.

C. CHOICE IN THE MILITARY

For service members who have been instilled with the belief that self-sacrifice is essential to the mission of the armed forces,[128] taking psychotropic medications may be seen as the most minimal step one can take towards ensuring the wellbeing of the group. By taking these medications, they are able to continue missions with their fellow service members, who can continue to trust their abilities and count on them for support.[129] Considering the frequently life-threatening situations in which service members in combat settings find themselves, a defense expert has noted that "it is very easy to imagine that warriors would consider using any manner of drug they thought would increase their chance of returning home alive."[130] With the pressure of representing the United States Armed Forces, keeping the country safe, and performing one's assigned missions in an effective manner, it is no wonder that service members would turn to medications to aid them in these tasks.[131] In *America's Medicated Army*, Sergeant Christopher LeJeune commented that for himself and his fellow service members in Baghdad, "It's not easy for soldiers to admit the problems that they're having over there for a variety of reasons," and that "[i]f they do admit it, then the only solution given is pills."[132]

Additionally, service members whose superiors direct them to take psychotropic medications for the benefit of the group may not see themselves as having the right to refuse medication.[133] Every other command by a superior must be obeyed, and the command by a superior to take medication—even if merely a suggestion—will likely be seen as something that must be obeyed.[134] Because service members "aren't normally asked for their informed consent before accepting what their command regards as the best preparation for battle . . . it's difficult to see why these [augmenting cognition] enhancements should be regarded differently from anything else a soldier can be legally ordered to do."[135]

Thus, in the military, choice—in the sense of service members'

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[128] *See supra* text accompanying note 44.

[129] *See generally* Thompson, *America's Medicated Army*, *supra* note 24.

[130] Knickerbocker, *supra* note 39.

[131] *Id.*

[132] Thompson, *America's Medicated Army*, *supra* note 24.

[133] *See* Annas & Annas, *supra* note 43 at 300.

[134] *Id.*

[135] *Id.* at 300 (citing JONATHAN D. MORENO, MIND WARS: BRAIN RESEARCH AND NATIONAL DEFENSE 53 (2006)).

autonomy to make decisions in their own best interests—is not an option. Indeed, it does not even figure into the equation for most service members, who have been indoctrinated to accede to the commands of their superiors and to value the best interests of the military over the best interests of themselves as individuals.[136] If individual service members begin making choices in their own best interests that go against their leaders' commands, they would soon find themselves out of a job.[137]

D. FAULT IN THE MILITARY

As evidenced in a disturbing example of amphetamine use and its negative effects on military pilots, amphetamines can negatively influence decision-making and patience in combat settings, to disastrous effects.[138] In April 2002, after misidentifying a target in an Iraqi bombing mission and complaining of fatigue due to unobserved rest periods between missions, Air Force pilots were told to "[s]top whining and visit the flight surgeon for some 'go/no-go' pills."[139] One week later and allegedly under the influence of the "go" pill Dexedrine, two pilots of the same Fighter Wing misidentified another target and bombed "a Canadian training force, killing four and injuring eight."[140] At the pilots' hearing to determine whether they should be court-martialed for "manslaughter, assault and dereliction of duty," their attorneys argued that Dexedrine was to blame for the incident.[141] Though charges were eventually dropped against one of the pilots, the other pilot was found guilty of dereliction of duty and fined, reprimanded, and banned from flying Air Force planes, a pronouncement that effectively ended his career.[142]

The continued institutionalized use of amphetamines in the Air Force demonstrates that in cases like the one described above, "[i]t is much more convenient . . . to brush the incident off as rash pilots behaving in an arrogant way, rather than perform a complete system review that might

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[136] *See supra* Parts 0 and 0.

[137] Knickerbocker, *supra* note 39 (stating that "[t]he drugs are legal, and pilots are not required to take them–although their careers may suffer if they refuse").

[138] *See* Elliot Borin, *The U.S. Military Needs Its Speed*, WIRED (Feb. 10, 2003), http://www.wired.com/medtech/health/news/2003/02/57434.

[139] *Id.*

[140] *Id.*

[141] *Id.*

[142] David Stout, *Fighter Pilot Found Guilty of Dereliction in Mistaken Bombing*, N.Y. TIMES (Jul. 7, 2004), http://www.nytimes.com/2004/07/07/us/fighter-pilot-found-guilty-of-dereliction-in-mistaken-bombing.html?ref=harryschmidt.

raise more generic safety problems."[143] "Colonel Peter Demitry, Chief of the United States Air Force Surgeon General's Science and Technology Division, has referred to prescribing amphetamines for pilots as the 'gold standard for anti-fatigue,'"[144] and that its usage "is a life-and-death issue for our military."[145]

E. REPEATED DEPLOYMENTS AND A "STRAPPED" MILITARY

In its present state, the military is overextended: service members are being asked to perform more missions than they would if additional troops were available to continuously replenish them.[146] They are aware that there is no draft from which to recruit new service members, and that they are being asked to redeploy more than would be ideal. Due to this lack of supply in troop numbers, perhaps the military has no choice but to request that service members use drugs in order to manipulate their sleep and wake cycles in furtherance of completing missions successfully.[147] Indeed, as the military states, its current mission "to fight a long war on multiple fronts with an all volunteer force demands that military personnel resources be tightly conserved. Hence, identifying and treating all health problems early so full functional capacity can be restored as quickly as possible is an important means toward that end."[148] In its guidebook to performance maintenance for its flight surgeons, the Navy asserts, "We manage maintenance, fuel and weapons; we can also manage fatigue."[149] To the military, fatigue and other symptoms of stressful, endurance-testing circumstances are considered issues to be "managed" on par with routine weapon maintenance, as opposed to being considered a mental health problem in need of specialized mental health treatment.[150] The military justifies its position on frequently redeploying service members with potential mental health risks by posing an ominous question:

> If personnel issues were of no concern—if recruits and seasoned veterans were both in limitless supply and the impact on mental health stigma of

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[143] Annas & Annas, *supra* note 43 at 296.

[144] *Id.* at 295–96.

[145] Borin, *supra* note 138.

[146] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 6–10 (stating that, "[s]ince the modern military is an all volunteer force of limited size, Service members and their units must be recycled repeatedly and often").

[147] Annas & Annas, *supra* note 43, at 296–97.

[148] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 5-8.

[149] NAVAL STRIKE & WARFARE CTR., *supra* note 38, at 5.

[150] *Id.*

> personnel policies could be ignored—one way to ensure maximum psychological readiness would be to quickly separate from active duty everyone that showed signs of significant distress or loss of normal functioning due to stress. . . . But what would be the consequences of such an extreme policy?[151]

Further, the military asserts that absolutely barring service members with histories of mental health issues would result in even more hesitation to voice mental health concerns, noting that:

> If everyone who sought care for a stress injury were automatically separated from the Service, the only Marines and Sailors who would come forward asking for help would be those who were looking for a way out of the Service or those whose impairment or distress had become so profound they could no longer hide it.[152]

The military compares separating active duty troops with mental health issues to those with physical health issues, explaining that those who fully recover from physical injuries should not be barred from returning to combat, so those recovering from mental health injuries should not be barred either.[153]

However, repeated deployments compound the likelihood of developing mental health problems[154] due to repeated exposure to traumatic events.[155] The military's Defense Health Board concluded:

> The psychological and behavioral effects on Service members of multiple deployments and the mental health impact of serving in the combat settings of Afghanistan and Iraq—dangerous situations for long periods in extreme environments—are ongoing, growing, and urgent national concerns. Exposure to deployment-related stressors is linked to Service members experiencing elevated rates of post-traumatic stress disorder (PTSD), acute anxiety disorder, sleep disturbances, anxiety, depression, and substance abuse disorders.[156]

The risks of mental health issues developing due to repeated deployments are especially prominent when coupled with insufficient recovery time between combat tours.[157] Currently, service members

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[151] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 6-2.

[152] *Id.* at 6-3.

[153] *Id.*

[154] JOINT MENTAL HEALTH ADVISORY TEAM 7, *supra* note 58, at 7.

[155] Def. Health Bd. Memorandum, *supra* note 27, at 2.

[156] *Id.* at 1.

[157] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at R-1 (stating that "[t]he incidence of COS [combat and operational stress] can increase when operating tempo is high

receive twelve months off between tours, which, according to top Army psychiatrist Colonel Charles Hoge, does not allow service members enough time "'to reset' and recover from the stress of a combat tour before heading back to war."[158] Moreover, because there is no "frontline" in the current wars, deployed service members must be on guard and prepared for combat at all times.[159] Service members may be under near-constant fire and attacks may happen in seemingly benign places:

> The nature of this conflict is also quite unusual. As in Vietnam, the enemy blends in with civilians, rendering everyone a potential threat; but unlike in Vietnam, this war is fought in cities as much as in the hinterlands, which means soldiers are never allowed to mentally decompress. There's no front in this war, and no rear either, which means there's no place to go where the mortar rounds aren't.[160]

As a result of this constant tension, service members develop "unremitting combat anxiety" and have no time to "mentally decompress,"[161] further multiplying their stress levels.

F. CONSEQUENCES OF DISOBEYING A SUPERIOR'S COMMAND REGARDING MENTAL HEALTH TREATMENT

The increased prevalence and acceptance of psychotropic medications for service members in combat settings has resulted in prescriptions entering the picture even before a service member is deployed. According to one New York psychiatrist who spoke with the *Los Angeles Times*, despite the fact that "maybe 10 or 12 years [ago], you couldn't even go into the armed services if you used any of these drugs, in particular stimulants . . . . I'm getting a new kind of call right now, and that's people saying the psychiatrist won't approve their deployment unless they take psychiatric drugs."[162] Service members who have been diagnosed by a military physician as needing to take psychotropic medications to be fit for deployment cannot continue their careers in the military without heeding such a directive.[163]

Returning to the Air Force's sanctioned use of amphetamines

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due to multiple 'back to back' deployments/extended combat operations").

[158] Thompson, *America's Medicated Army*, *supra* note 24.

[159] Senior, *supra* note 6.

[160] *Id.*

[161] *Id.*

[162] Murphy, *supra* note 18.

[163] *See* Winkenwerder Memorandum, *supra* note 20, at 4.1.4 to 4.2.

discussed in Part IV.E, a pilot who receives Dexedrine must sign an informed consent form that "mentions the voluntary nature of the program no fewer than seven times," but also includes a statement that "the pilot can be grounded for exercising his right not to imbibe."[164] To be "grounded" means to be taken off flight status, effectively ending a pilot's duties and possibly career.[165] Retired Air Force officer Major Glenn MacDonald commented that through such a policy, the Air Force "was coercing its pilots to possibly become drug addicts and endangering their health."[166] The threat of losing one's job if a service member refuses to take psychotropic medication indicates there is no meaningful choice for members of the Air Force as to whether to take the amphetamines.

Moreover, all consequences generated from the decision to take or not to take a psychotropic medication are borne by the individual service members. For an Air Force pilot, refusing to take Dexedrine may result in being grounded and losing his or her career.[167] Conversely, agreeing to take Dexedrine may result in an inability to properly perform one's mission, and in some instances, can have tragic consequences,[168] with sole responsibility placed on the individual.

VII. IMPLICATIONS OF THE USE OF PSYCHOTROPIC MEDICATIONS FOR MILITARY PHYSICIANS

As opposed to civilian physicians, military physicians are in a particularly sensitive position in terms of prescribing psychotropic medications.[169] Whereas a physician's primary duty of care is to the patient, military doctors must consider implications of treatment not only for an individual's health, but also for the wellbeing and safety of a combat mission and the military on a larger scale.[170] Military physicians have pledged not only the Hippocratic Oath to "uphold a number of professional ethical standards" and "do no harm,"[171] but also have taken a

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[164] Borin, *supra* note 138.

[165] *See id.*

[166] *Id.*

[167] *Id.*

[168] *See supra* note 72 and accompanying text.

[169] *See* Victor W. Sidel & Barry S. Levy, *Physician-Soldier: A Moral Dilemma?*, *in* MILITARY MEDICAL ETHICS VOLUME 1 296 (Thomas E. Beam et al. eds., 2003), *available at* https://ke.army.mil/bordeninstitute/published_volumes/ethicsVol1/Ethics-ch-11.pdf.

[170] *See id.* ("[T]he ethical principles of medicine make medical practice under military control fundamentally dysfunctional and unethical.").

[171] HISTORY OF MED. DIV., NAT'L INST. OF HEALTH, GREEK MEDICINE–THE

military oath and are members of the military.[172]

Indeed, the motto of the American military physician is "[T]o conserve the fighting force."[173] While seemingly a well-intentioned phrase, it hints eerily at the notion that military physicians should be more interested in preserving military resources by certifying existing service members as fit for combat, despite any health concerns.[174] According to the former chair of the President's Council on Bioethics, "medical ethics are and must be the same for civilian and military physicians, 'except in the most extreme exigencies.'"[175] Likewise, the editors of *Military Medical Ethics* insist, "'instances of significant conflict' between civilian and medical ethics are 'very rare.'"[176] Still, it is the individual physician's responsibility "to reflect on how his personal values relate to being a physician in the military in war and peace. In particular, the physician-soldier needs to reflect on the concept of conservation of force and his response and responsibilities to it."[177] The underlying message appears to subvert individual-centered care in favor of care for the military as a whole.[178]

HIPPOCRATIC OATH (Michael North trans., Nat'l Library of Med., 2002), *available at* http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Apr. 13, 2013).

[172] *See* William Madden & Brian S. Carter, *Physician-Soldier: A Moral Profession*, *in* MILITARY MEDICAL ETHICS VOLUME 1 271 (Thomas E. Beam et al. eds. 2003), *available at* https://ke.army.mil/bordeninstitute/published_volumes/ethicsVol1/Ethics-ch-10.pdf. "Physicians are made a part of that military system in a very formal way. They are sworn in as members of the profession of arms, taking the same oath as those who lead in combat. They wear the same uniform, have the same rank and title system as other soldiers, and are given the privileges granted by society to the profession of arms. These physician-soldiers also take at least rudimentary training in basic military skills and are issued a weapon when there is a threat to their well-being." *Id.*

[173] Annas & Annas, *supra* note 43, at 287.

[174] *See id.*

[175] *Id.* at 300–01. The former Chairman also stated that, "[T]here are no special medical ethics for active-duty military physicians any more than there are for Veterans Affairs physicians, National Guard physicians, public health physicians, prison physicians, or managed care physicians." *Id.* at 301 (citing Edmund D. Pellegrino, *The Moral Foundations of the Patient-Physician Relationship: The Essence of Medical Ethics*, *in* MILITARY MEDICAL ETHICS VOLUME 1, (Thomas E. Beam et al. eds., 2003), *available at* https://ke.army.mil /bordeninstitute/published_volumes/ethicsVol1/Ethics-ch-11.pdf).

[176] Annas & Annas, *supra* note 43, at 301.

[177] Madden & Carter, *supra* note 172, at 285.

[178] *See* George J. Annas, *Military Medical Ethics–Physician First, Last, Always*, 389 NEW ENG. J. MED. 1087, 1087–89 (2008) [hereinafter Annas, *Military Medical Ethics*].

A. THE PHYSICIAN-SERVICE MEMBER RELATIONSHIP

In addition to the many pressures service members face, a seemingly unexpected one may arise in the context of their relationship with military physicians. To have the physician-patient relationship compromised as a result of overriding pressure to "conserve the fighting force" further complicates the issue of service members relinquishing their autonomy and choice.[179] If there exists any place for individual choice in the military, it would seemingly be present in the choice to make informed decisions in one's healthcare. However, a physician's simultaneous oaths of loyalty to both the service member and the military compromises the physician's ability to be fully forthcoming with the best interests of the individual.[180]

B. CERTIFYING TROOPS FOR REDEPLOYMENT

Because of the duration of the wars in Iraq and Afghanistan and the relative shortage of troops,[181] preservation of the existing troops' health is imperative for the Department of Defense.[182] More troops are receiving mental health treatment for serious mental disorders such as depression and anxiety than in previous wars; suicide rates of enlisted personnel and veterans are at all-time highs.[183] Indeed, in order to retain service members in combat areas or return them for another deployment, military physicians are increasingly prescribing psychotropic medications, particularly selective serotonin-reuptake inhibitors, when faced with service members experiencing depression, anxiety, and PTSD.[184]

In *America's Medicated Army*, journalist Mark Thompson interviewed Colonel Joseph Horam, a doctor who was deployed to "Saudi Arabia during the first Gulf War and has been deployed twice to Iraq during [the current] war."[185] Colonel Horam noted that during the first Gulf War, "stressed troops [were given] a little rest and relaxation to see if

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[179] *See id.* (quoting David M. Benedek, et al., *Psychiatric Medications for Deployment: An Update*, 172.7 MIL. MED. 681, 685 (2007)). *See also* Henry Greely et al., *Towards Responsible Use of Cognitive-Enhancing Drugs by the Healthy*, 456 NATURE 702, 704 (2008) (stating that coercion and autonomy are relevant concerns for those in the military).

[180] *See* Annas, *Military Medical Ethics*, *supra* note 178, at 1087–89.

[181] Annas & Annas, *supra* note 43, at 304.

[182] Thompson, *America's Medicated Army*, *supra* note 24.

[183] *Id.*

[184] *Id.*

[185] *Id.*

they improved," and if they did not, they were likely sent home.[186] Conversely, Colonel Horam detailed the treatment of one patient, a guard of Iraqi detainees, in Baghdad in 2006:

> He was distraught while he was having high-level interactions with detainees, having emotional confrontations with them—and carrying weapons. . . . But he was part of a highly trained team, and we didn't want to lose him. So we put him on an SSRI [Selective Serotonin Reuptake Inhibitor], and within a week, he was a new person, and we got him back to full duty.[187]

Colonel Horam did not comment on whether the patient experienced any long-term effects from the circumstances of his treatment. At a National Institutes of Health conference in December 2010, Colonel Christopher Robinson of the United States Air Force described his deployment to Afghanistan as a Combat Stress Detachment Commander, where he oversaw "35 mental health professionals spread across 11 forward operating bases around the eastern part of the country."[188] Colonel Robinson stated, "[O]ur focus is on keeping servicemembers in the fight—providing outreach to platoons with the highest levels of combat."[189] Of the service members that Robinson and his team dealt with, ninety-two percent "were eventually returned to duty without limitation," whereas six percent "were returned with limitations."[190] Despite the admirable intentions of providing more mental health outreach, it seems that military physicians, at least on some scale, are putting the interests of an exhausted military looking to keep valuable members in key positions ahead of the mental health of individual service members.[191]

The Pentagon set a uniform policy for mental health services in November 2006, but explicitly absent from the policy was any directive on newly-available anti-depressants.[192] According to an individual who participated in crafting the Pentagon policy, "the goal . . . was to give SSRIs [Selective Serotonin Reuptake Inhibitors] a 'green light' without

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[186] *Id.*

[187] *Id.*

[188] *Military Challenged to Provide Far-Forward Mental Health Care*, U.S. MEDICINE, THE VOICE OF FEDERAL MEDICINE, http://www.usmedicine.com/psychiatry/military-challenged-to-provide-far-forward-mental-health-care.html (last visited Apr. 13, 2013).

[189] *Id.*

[190] *Id.*

[191] *See id.*

[192] Thompson, *America's Medicated Army*, *supra* note 24.

saying so."[193] In the absence of any military doctrine on SSRI use in combat settings, some military psychiatrists have recommended that their colleagues going to Iraq and Afghanistan "should consider having one SSRI in large quantities, to be used for both depressive disorders and anxiety disorders' to . . . 'conserve the fighting strength.'"[194]

In the Navy's guidelines for performance maintenance, the Surgeon General of the Navy writes that the directive was a response to "the fleet's request to use stimulant and sedative medications during continuous and sustained flight operations."[195] He then notes that the directive and its approval of using medications for those purposes demonstrate "Navy Medicine's commitment to fulfill its primary mission—support to the fleet."[196]

VIII. CONCLUSION

One of the most easily foreseen consequences of war is its toll on the mental health of service members, both during and after their deployments.[197] Due to the enormous sacrifice that United States service members make on behalf of their country, the United States government must similarly devote effective and sufficient mental health treatment for these troops.

The pervasive nature of psychotropic medication use in the armed forces prompts the question of whether individual service members feel pressured out of a sense of duty to take medication to be able to remain deployed, whether the general macho culture of the military discourages service members from voicing concerns about their own mental health, or whether it is the result of an increasing military culture of doctors prescribing pills to certify troops for redeployment or to remain deployed.[198]

The military's awareness of the stigma associated with mental health issues has led it to outline certain suggestions to improve the situation, including more explicit communication of mental health policies and any

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[193] *Id.*

[194] Annas & Annas, *supra* note 43, at 304.

[195] NAVAL STRIKE & WARFARE CTR., *supra* note 38, at 4.

[196] *Id.*

[197] *See* Thompson, *America's Medicated Army*, *supra* note 24.

[198] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 5-3; *see also* Thompson, *America's Medicated Army*, *supra* note 24.

implications (or lack thereof) associated with seeking treatment.[199] Commanding officers are encouraged to "continually monitor" the fitness of service members who have received mental health treatment and to "mentor them back to full duty as they recover."[200] Stigma is to be "continuously addressed" in order to dissipate the mystique surrounding and prejudicial feelings toward mental health issues.[201]

Despite such recommendations, it remains to be seen whether institutional change on mental health issues will soon be implemented and effective in the military. Meanwhile, reports of continued stigma, continued pressure to hide mental health issues, continued pressure to take psychotropic medications, and continued lack of monitoring of service members' mental health concerns persist.[202] Service members have been taught noble lessons of selflessness and to strive for the greater good.[203] Yet through its policies on mental health issues and overall institutionalized coercive nature, the military is manipulating its service members into sacrificing beyond what is helpful or healthy for either themselves as individuals or the general mission of the military. Finally, if it is true that the military has no choice but to request that service members sacrifice their own individual wellbeing for the greater good of the fighting force, the military needs to accept responsibility for exerting such coercion. When faced with negative, perhaps devastating, consequences arising out of a decision to take or not to take psychotropic medications, the military must accept responsibility and share blame instead of letting the guilt fall solely onto the shoulders of individual service members.

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[199] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 5-5.

[200] *Id.* at 1-20.

[201] *Id.*

[202] *See* Thompson, *America's Medicated Army*, *supra* note 24; DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1, at 3-7.

[203] DEP'TS OF THE NAVY & U.S. MARINE CORPS, *supra* note 1.