The DoD Times (Redacted)

The USS Theodore Roosevelt (CVN 71) – Glacier Bay National Park in Canada

The Moral Imperative of Military Medicine

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General George Washington once said, "A nation is judged by how well it treats its Veterans." Similarly, we as a military should be judged by how well we treat the young men and women entrusted to our care.

As it has been my distinct honor for over 25 years to care for the young men and women that we send into harm's way, I think it is worth remembering the countless thousands who have been wounded or killed in our Nation's service. I'll admit, I struggle some with the disconnect between how rewarding it is to provide medical care in remote places, helping our men and women in uniform, helping the victims of war, and recognizing that while it is professionally rewarding for me, the injured have months and likely years of recovery ahead of them, and the families of the dead have years and years of recovery ahead of them, if they ever do truly recover.

I read a book when I was in Kandahar, Afghanistan in 2009 called "The Photographer" by Emmanual Guibert, a Frenchman, documenting the experiences of Doctors without Borders in Afghanistan when the Soviets invaded in the 1980s. There is a quote in the book that sums up some of the disconnect I feel:

> *"The disparity between what we are told or what we believe about war and war itself is so vast that those who come back are often rendered speechless. What do you say to those who advocate war as an instrument to liberate the women of Afghanistan or bring democracy to Iraq? How do you tell them what war is like? How do you explain that the very proposition of war as an instrument of virtue is absurd? How do you cope with memories of children*

bleeding to death with bits of iron fragments peppered throughout their small bodies? How do you speak of war without tears?"

We in military medicine have the honor and duty to care for those with bits of iron fragments peppered throughout their bodies. So, what is the moral imperative of military medicine? The first step here is to define moral imperative. According to Immanuel Kant, the eighteenth-century German philosopher, a moral imperative is a belief that is so strongly held that it forces one to action because to do otherwise is self-defeating and, therefore, contrary to reason. So, what do I believe is the moral imperative of military medicine? I believe it is to be willing to do whatever is necessary to take care of the young men and women that we routinely send into harm's way. And that harm's way could come in the form of armed conflict, whether it is conventional or unconventional warfare, routine military operations, or dealing with a once-in-a-lifetime pandemic from a novel virus.

"*Testing does not stop transmission of the virus*"

To date, there have been over 7 million deaths worldwide from COVID-19 and over 1.2M deaths in the United States. But let's go back in time to March 2020, when there were few reported deaths in the US from this pandemic, and take a look at a small, secluded town with a population of 5,000, that was pondering how it would deal with this virus. They've ordered all the requisite personal protective equipment (PPE), but that won't be delivered for another 6 months. They have a small rural hospital, with a staff of approximately 45 people and limited capabilities. They have no advanced imaging, and they have an "ICU" that could care for one or two patients on ventilators but only one nurse on staff. They have reviewed the guidance that is coming out from many different organizations - county and state health departments, national medical organizations, the Center for Disease Control (CDC), and the World Health Organization and it becomes readily apparent to them that if the outbreak were to strike their town that they did not have the organic capability to comply with the guidelines that were being followed by the rest of the world. Specifically, due to the communal nature of the town, with many high-density boarding houses, they were going to be unable to perform adequate isolation and quarantine.

And in late March, the virus arrives. Interestingly it arrives several weeks after a large inter-community event with another nearby town. Despite limited testing capabilities, the outbreak is quickly established with the expected exponential spread, a spread that is unable to be contained due to lack of PPE and lack of appropriate quarantine and isolation spaces. The town leadership quickly asks for and receives assistance with getting infected personnel into isolation but is essentially told to figure out how to quarantine their community in high-density boarding houses. They are also told that the most important objective is wide-scale testing to ensure that accurate numbers of COVID-positive cases are reported to state and national leadership. This testing takes on a life of its own with a near maniacal obsession from state and national leadership in obtaining testing supplies, flying test samples to another country due to lab limitations, and rigorous reporting. The town complies but repeatedly points out that testing does not stop transmission of the virus; all it does in this case is give good numbers for PowerPoint presentations. And there is no question of a significant outbreak in the town with exponential spread of disease. Exponential spread that is not broken by testing.

The various governing bodies in this story - county, state, and national - all offer assistance and guidance that at times is contradictory and does not result in any real action when it comes to the one action that will stop the spread of the virus, which is getting proper quarantine spaces. What it does result in is the town mayor and senior physician writing letters to their respective leadership organizations requesting assistance for the town before things get even worse. Leadership response, when the mayor's letter is made public, is rapid. Contracts are suddenly put into place for appropriate quarantine facilities in a neighboring town. Just as suddenly, the mayor is fired. The senior physician is immediately called by his leadership at the state level, who was surprised by the letter, and told

that they "didn't realize that the situation was so bad." The senior physician, who is then recommended to be fired by the national leadership, continues to take care of the town, even while he is in isolation with COVID. The recommendations that were made by the mayor and senior physician were ultimately implemented and the town was able to return to normal activities in 2 months with no additional cases.

The mayor goes on to continued service with a national organization, ultimately retiring to significant acclaim and a well-received book. The senior physician leaves the town, with a glowing review from town leadership, and finishes his medical career at a nearby hospital. Interestingly, state and national organizations continued to pursue action against the senior physician with documents and actions questioning his capabilities and trying to limit his pension.

By now, you may recognize that this is the story of the USS Theodore Roosevelt (CVN 71) and its battle with the COVID outbreak in March/April 2020 after a port call in Vietnam. You may even recognize some of the players. And yes - the outcomes I describe for the mayor, Captain Brett Crozier, and the senior physician, me, are true. For me, this included a Report of Substandard Performance, Board of Inquiry, and Retirement Grade Determination. I was finally allowed to retire as a Navy Captain after over 33 years of service, but it did make for an interesting last couple of years on active duty.

"*We had really just discovered the tip of the iceberg.*"

So, what do we learn from an event like this? It is my hope that the Navy is evaluating its strategic plans for how to deal with outbreaks like this. This is not the first and it certainly won't be the last. While we preach and praise autonomy, I was repeatedly surprised by how often I was asked to provide the solution for this situation, a situation that the world wasn't close to solving. If that isn't what large staff at headquarters are for, then we need to re-evaluate the purpose of those staffs. I gave my opinion as the physician in the middle of the maelstrom and asked for appropriate quarantine and isolation for our crew. I simply wanted us to be able to follow the same guidelines that the rest of the world and the military were following. When we had our first cases, we were 15 days out from our port visit in Vietnam. Based on the timeline of COVID from exposure to symptoms, which at the time was approximately 5 days, we were likely dealing with the third generation of COVID cases when we finally got our first positive tests…which meant there were lots of undiagnosed cases running around the ship.

With that knowledge, I recommended that we focus less on testing and more on securing appropriate quarantine and isolation spaces, because we really had just discovered the tip of the iceberg. And while I made those recommendations, what I got in return was detailed requests for how many personnel I needed to support this, what type of equipment would be needed, how many nasal swabs, etc. In my opinion, those are strategic-level plans that should be in place, as opposed to asking the lead physician on the ground what he needs to solve this problem of a novel virus causing a once-in-a-lifetime pandemic. This is analogous to the 911 operator asking the person who calls in to report that their house is on fire what the best way is to put out the fire. Even if the caller is a fireman, he's more focused on getting his family safely out of the house. I find it somewhat ironic that the official Navy investigation that recommended I be fired also recommended that Navy Medicine conduct a thorough debrief with me for lessons learned and best practices.

"*A system that emphasizes conformity and perception over learning.*"

Another lesson from this experience is for our leadership. When your organization is faced with a crisis and multiple senior leaders directly involved in the crisis are willing to put their names down on paper requesting assistance in what may seem to be an alarming fashion - that should make everyone up the chain of command take a long, hard pause to question their own staff regarding what is being missed. These weren't junior members of the

crew raising the alarm, these were senior, well-respected individuals. And when that happens, and your response is to fire the individuals who raise the alarm, or at least to repeatedly go after them (and their pension), then all that will do is make current and future leaders all the more reluctant to report bad news and request assistance. A good friend of mine, a highly respected retired Navy SEAL, said this about this situation: "The military is so quick to punish. And so slow to learn. There's no handbook of perfect and proper action for novel situations. The ONLY worthy response is to focus on intent and learn from the actions, not judge them. I'm disappointed in a system that emphasizes conformity and perception over learning." The military is not unique in this situation. That same concept of "emphasizing conformity and perception over learning" happens routinely…how often do you hear "Because that's how we've always done it?" Doesn't mean it's always right. Mike Ryan, epidemiologist at the WHO, in March 2020 said: "Be fast, have no regrets... If you need to be right before you move, you will never win." We, on the ship, living in the outbreak, knew that. Unfortunately, the Navy wanted all the answers before making decisions and committing to a plan. Medicine is often better at dealing with shades of gray, we took the information we had at hand and made the best decisions we could for our patients, that's something we have experience in…in this situation, the operational side of the Navy wasn't that comfortable with the shades of gray which led to delays and confusion.

"Are we such a fragile institution?"

What is truly disappointing about this story is that this had the chance to be a really good news story. A U.S. Navy aircraft carrier battles an unprecedented outbreak while on deployment on the other side of the world. Approximately 25% of a 5,000-person crew is infected with COVID-19, one sailor dies, and the ship takes drastic action and can get back to sea in 2 months' time with no further cases and complete their deployment. I challenge you to find a story of a similar sized town from the early days of the pandemic with the same results, and you won't be able to. This could have been much worse - during April/May of 2020 the French aircraft carrier (Charles de Gaulle) also had a COVID outbreak with over 60% of the crew infected. Instead, what is mostly remembered about this story is the firing of the Commanding Officer because he raised the alarm about what was happening with his sailors. You must ask yourself, are we such a fragile institution that we can't raise concerns about the young men and women we are sworn to protect? As a physician, it seems to me that we want the parents of our sailors to know that we are doing everything we can to help their sons and daughters.

As I said at the beginning, the moral imperative of military medicine is being willing to do whatever is necessary to take care of the young men and women that we send into harm's way. Based on an article titled "U.S. Navy Response to a Shipboard Coronavirus Outbreak: Considerations for a Medical Management Plan at Sea" published in the journal Military Medicine in November 2020, authors include Dr. Eric Elster, the Dean of the School of Medicine at the Uniformed Services University in Bethesda, Maryland (where I trained), our actions on the ship decreased potential cases by approximately 1000, decreased hospitalizations by a factor of 6, and decreased ICU admissions and potential deaths by a factor of 20. Those actions were implemented by a medical department that was reading the articles coming out of Italy and other places describing the higher risks borne by healthcare providers as they were exposed to the virus every day, and this medical department continued providing high-level care to the sailors on the ship. The sailors, especially the young Hospital Corpsmen, in that department deserve to be recognized for being heroes at the outset of this pandemic. They truly understand the moral imperative of military medicine. Countless USS Theodore Roosevelt sailors and their families are forever in their debt.

"*Biases, like viruses, spread.*"

The biggest lesson from this saga is that I firmly believe that biases contributed to and worsened this situation: If your opinion is that the most important thing is to keep an aircraft carrier in the South China Sea, then this virus

isn't that big of a deal. I was specifically told by the Vice Chief of Naval Operations that I was a failure, because, and I quote: "If we couldn't handle this little virus, then how could we handle a hypersonic Chinese cruise missile hitting the ship." The 2nd highest-ranking officer in the Navy believes that trauma medicine, which I have a fair amount of experience in, and dealing with a novel respiratory spread virus that the world has three months of experience dealing with is the same thing; actually, he believes that trauma medicine is the more pressing problem. If that's his opinion, it's not a stretch to believe that this opinion is shared by his subordinates. Biases, like viruses, spread. They can infect organizations; they can be passed from leaders to subordinates. And if that bias was infecting the Navy, then the Navy would be quick to believe that Vietnam had COVID under control before we arrived. In the 2 weeks before our port visit, every country in the region had rising COVID cases (based on daily medical intelligence briefings), except for one country…the Communist country that shares a border with China and has a high-profile port visit from a US Navy aircraft carrier coming up.

When I brought this odd statistical anomaly up to higher headquarters, I was repeatedly told in no uncertain terms that Vietnam had COVID under control, and the day we left Vietnam, their reported COVID cases started to rise again. How odd. Another example - Less than 2 weeks after we left Vietnam, as it has now been declared a pandemic, the Navy releases an order that anyone who had traveled to a Level 2 or Level 3 country (which included Vietnam) within the past 2 weeks needed to quarantine (with the accepted definition of single room). I reached out to higher headquarters and reminded them that virtually our entire ship had been ashore in Vietnam and that we didn't have 5000 individual rooms on the aircraft carrier for quarantine. I was told that this order didn't apply to ships and to continue screening for symptoms. Again, if your bias is that keeping a carrier in the South China Sea is the most important thing, then you'll come up with a nonsensical position that an order for the entire U.S. Navy doesn't apply to ships.

And if that is the dominant bias infecting the organization, you'll be confident that this virus is no big deal, so when you give highly valuable testing equipment to the ship, you put tight constraints on its use such that it is only allowed to be used for research purposes with all testing results de-identified. Specifically, we were only allowed to test groups of individuals, and then the only result we would be given was that someone in the group of up to 20-40 sailors was positive. Contact tracing is next to impossible when you don't know actually who is positive. I told the lab officer, in the form of an order, that if we were going to test sailors, then I wanted results by name. After our first positive cases, I was called by the senior physician from higher headquarters who was very irate that I had used the testing equipment in that fashion. I told him that I needed actionable information, not a general idea that someone in a group of 20-40 sailors is positive. Side note - I alluded to that same physician earlier.

When I sent my letter to the Navy Surgeon General, I also sent it to a variety of other people in Navy Medicine, including this physician. He called me immediately and was rather upset and wanted to know why I sent it and what I hoped to accomplish. I told him that I had real concerns that the gravity of the situation onboard the ship wasn't being conveyed up the chain of command. After some back and forth, he said "I didn't realize things were so bad on the ship." For context, he was the senior medical advisor to the Admiral leading the Navy's response to the COVID outbreak on the Theodore Roosevelt. If the subject matter expert, who was on all the conference calls I was on where I talked about the public health disaster enveloping the ship, doesn't realize how bad things are…what advice or recommendations is he giving his boss? Biases can be more dangerous than ignorance. Biases can spread like viruses and can have widespread effects, including making a bad situation worse. When faced with a novel virus, especially one that has significant unknowns with regards to its short-term and long-term effects on the people involved, a healthy dose of humility and erring on the side of the individual is required.

Ultimately this story is about doing what is right for your patient. You must determine what is your responsibility to your patient. How far are you willing to go to ensure your patient gets the community standard treatment? Do

your treatment recommendations change if he is an Admiral versus a junior enlisted sailor? Do your recommendations change when you have 5000 patients? Do they change because the solution is hard? Back to the Theodore Roosevelt, what would you do if you had 5000 patients who were exposed to a virus, where the community standard, the military standard, was appropriate isolation/quarantine, but they weren't able to receive the community standard? Hopefully I've given you some things to think about. While the title of this article is "The Moral Imperative of Military Medicine," aren't we really talking about the moral imperative of medicine…of always looking to do the right thing for our patients…in spite of whatever challenges or hurdles we might face? That's our job; we've taken an oath to do whatever we can to help our patients. It doesn't matter if you're on a floating petri dish in the midst of a pandemic or you're working at the local hospital.

"Sailors do not need to die."

This remains a story of doing what you believe to be right for those entrusted to your care. Hindsight will always say we could have done things differently or better. During the early stages of the pandemic, in the fog of medical war, we took the information at hand and made the best decisions we could for the health and safety of the crew. There will always be a split between Medicine and the operational side of the military. Different medical decisions will be made depending on whether we are in an active shooting war. When we are not in an active shooting war, in my opinion, we should always be on the side of the patient. When we are not in an active shooting war and amid a once in a lifetime pandemic, then we really, really should be on the side of the patient. As I said to one of the Admirals at my Board of Inquiry regarding my actions to take care of the sailors: "You know I would do it all over again."

Or to put it in the words of my friend, Captain Brett Crozier, "We are not at war. Sailors do not need to die. If we do not act now, we are failing to properly take care of our most trusted asset - our sailors." That was my opinion then, that remains my opinion to this day.

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1. SIGN THIS PETITION demanding that our leaders in Congress change the DoD's unjust administrative investigatory system.
2. SIGN THIS PETITION demanding real anti-harassment reform in the Military and Coast Guard now.
3. SIGN THIS PETITION urging the Supreme Court of the United States to hear the case of Staff Sergeant Ryan Carter who was paralyzed from the chest down following a routine surgery at Walter Reed.

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