

THE AIR FORCE LAW REVIEW



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FUNDAMENTALS OF MILITARY HEALTH LAW:
GOVERNANCE AT THE CROSSROADS OF HEALTH CARE AND
MILITARY FUNCTIONS

*JOHN A. CASCIOTTI**

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I. INTRODUCTION

Health care is the professional undertaking that seeks to minimize the incidence and effects of illness and injury. The armed forces are authorized to use lethal force when necessary to protect and advance national security interests. Where these two functions intersect operates the Military Health System. Governance at this crossroads of health care and military functions is the subject of military health law and this article.

To start, the following definition is offered: military health law is the set of legal powers and duties of the United States government derived from the Constitution, statutes, regulations, judicial decisions, and international law requirements to carry out military and related humanitarian functions through health care professionals and systems interacting with military personnel, public and private entities, and other individuals.

This definition is shaped by the attributes and functions of the Military Health System. As stated in a 2001 Department of Defense (DoD) Directive, the mission of the Military Health System “is to provide, and to maintain readiness to provide, medical services and support to members of the Armed Forces during military operations, and to provide medical services and support to members of the Armed Forces, their dependents and others entitled to DoD medical care.”¹ In 2015, the Military Health System included 56 inpatient hospitals, 359 outpatient clinics, 249 dental clinics, 85,000 military personnel, and 67,000 civilian personnel in the United States and a number of other countries.² The Military Health System also includes a world-wide aeromedical evacuation system,³ a medical school (the Uniformed Services University of the Health Sciences),⁴ and other assets. Additionally, it includes a health services reimbursement system for private sector health care, called TRICARE,⁵ similar to Medicare and health insurance programs.

¹ U.S. DEP’T OF DEF. DIRECTIVE NO. 5136.12, TRICARE MANAGEMENT ACTIVITY (TMA) 3 (May 31, 2001). All Department of Defense directives, instructions, and manuals cited in this article are available at <http://www.dtic.mil/whs/directives/>.

² Office of Mgmt. & Budget, Budget of the United States Government, Fiscal Year 2016 Supplemental Appendix 249 (Jun. 3, 2015) available at <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/mil.pdf>.

³ U.S. DEP’T OF DEF. INSTRUCTION NO. 6000.11, PATIENT MOVEMENT (PM) (May 4, 2012).

⁴ 10 U.S.C. § 2112 (2015).

⁵ 10 U.S.C. §§ 1072(7), 1097 (2015).

II. INTERACTIONS WITH MILITARY PERSONNEL

A. The Function of Force Health Protection

A good place to begin a summary of military health law is in relation to the interaction of the Military Health System with military personnel. This in turn must start with a recognition that, as stated succinctly by the Supreme Court, the "military constitutes a specialized community governed by a separate discipline from that of the civilian," and that "the very essence of [military] service is the subordination of the desires and interests of the individual to the needs of the service."⁶ This fundamental principle that for members of the armed forces the needs of the military take precedence over the interests of the individual is a foundation block of military medicine and military health law.

As an example of the operation of this principle in the health care context, the Court of Appeals for the District of Columbia Circuit upheld the right of the DoD and the Food and Drug Administration (FDA) to allow the military command preparing for the 1991 Persian Gulf War to require members to receive drugs the military thought necessary against potential biological and chemical weapons but classified by the FDA as investigational.⁷ The Court explained that although in most circumstances "the Constitution's due process guarantee protects an individual's liberty to decide whether or not to submit to serious medical treatment," DoD had "legitimate government interests that...counterbalance an individual's interest in being free from experimental treatment without giving informed consent."⁸ First, "administering the drugs uniformly prevents unnecessary danger to troops and medical personnel from injury to, or the death of, fellow military personnel in battle. Also, the [DoD] had an interest in successfully accomplishing the military goals of Operation Desert Storm."⁹ In this case, the Court found the desires and interests of the individual in having autonomy over his own health care decisions were subordinated to the needs of the service in preserving the effectiveness of the fighting force and accomplishing the military mission. Other judicial decisions have affirmed that military commanders have authority to order members to receive medical treatment, such as a vaccine to protect against a potential biological warfare agent, determined appropriate for accomplishing a military purpose, and that members who refuse to obey such a lawful order may be punished under the Uniform Code of Military Justice.¹⁰ Balancing the interests of individual autonomy

⁶ Orloff v. Willoughby, 345 U.S. 83, 92, 94 (1953).

⁷ Doe v. Sullivan, 938 F.2d 1370, 1371 (D.C. Cir. 1991).

⁸ *Id.* at 1383 (internal quotations and citations omitted).

⁹ *Id.*

¹⁰ *E.g.*, U.S. v. Kisala, 64 M.J. 50 (C.A.A.F. 2006).

over health care decisions and the collective fighting effectiveness of the force is a recurring theme in military health law.

This interaction of military members with the health system is also the subject of a significant amount of legislation and DoD regulation, particularly for members deploying in support of a military operation. For each person entering the armed forces, DoD must collect "baseline health data."¹¹ For members deploying overseas for a military operation, they must receive a pre-deployment medical examination, a post-deployment medical examination, and a subsequent reassessment 90 to 180 days after the deployment, which must include, among other tests, an assessment of traumatic brain injury, post-traumatic stress disorder and mental health.¹² In addition, reserve component members must "have a comprehensive medical readiness health and dental assessment on an annual basis."¹³ All members on active duty or in drilling reserve units must receive an annual "person-to-person mental health assessment."¹⁴ All members must undergo "a physical examination immediately before" separation from the armed forces.¹⁵ These are implemented through a set of DoD regulations.¹⁶

Additionally, the Military Health System, through the Armed Forces Health Surveillance Center, carries out comprehensive health surveillance during a member's period of military service, including capturing data on health status, medical interventions, occupational and environmental exposures, and other information for evaluation and analysis of health concerns, as well as for sharing information with the Department of Veterans Affairs for purposes of future health care and possible disability compensation.¹⁷ The Armed Forces Health Surveillance Center also maintains a DoD Serum Repository of periodic serum samples that may assist future clinical diagnoses and sero-epidemiologic studies of deployment related exposures.¹⁸

These health examinations, assessments, and surveillance activities serve two purposes. First, consistent with the Hippocratic tradition of medical care as a profession, they serve the humanitarian purpose of identifying potential health

¹¹ 10 U.S.C. § 1092a (2015).

¹² 10 U.S.C. §§ 1074f, 1074m (2015).

¹³ 10 U.S.C. § 10206 (2015).

¹⁴ 10 U.S.C. § 1074n (2015).

¹⁵ 10 U.S.C. § 1145(a)(5) (2015).

¹⁶ U.S. DEP'T OF DEF. INSTRUCTION NO. 6490.03, DEPLOYMENT HEALTH (Aug. 11, 2006) [hereinafter DODI 6490.03]; U.S. DEP'T OF DEF. INSTRUCTION NO. 6025.19, INDIVIDUAL MEDICAL READINESS (Jan. 3, 2006); U.S. DEP'T OF DEF. INSTRUCTION NO. 6490.12, MENTAL HEALTH ASSESSMENTS FOR SERVICE MEMBERS DEPLOYED IN CONNECTION WITH A CONTINGENCY OPERATION (Feb. 26, 2013).

¹⁷ U.S. DEP'T OF DEF. DIRECTIVE NO. 6490.02E, COMPREHENSIVE HEALTH SURVEILLANCE (Feb. 8, 2012).

¹⁸ *Id.* at 2; DODI 6490.03, *supra* note 16, at 24, 31.

problems to promote or restore optimal health of the individual members. This humanitarian purpose of military medicine is recognized in international law, including the Geneva Conventions, which refer to the “humanitarian duties” of medical units in treating the fighting force and require that medical personnel be “protected in all circumstances” as noncombatants.¹⁹ Even beyond the Hippocratic tradition at the core of the medical profession generally, the Military Health System is expected to be a major implementing agent of a fundamental trust obligation of the military that in return for the obedience of military members, even at the risk of life and health, the military and the U.S. Government will do everything feasible to preserve life and restore health.²⁰

The second purpose of these force health protection activities, complementary to the first, is to ensure that military members are fit for duty. Under 10 U.S.C. § 1201, a member who is “unfit to perform the duties of the member’s office, grade, rank, or rating” is to be separated or retired.²¹ DoD’s implementing regulation provides that a Service member “will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating,” the “member’s disability represents a decided medical risk to the health of the member or to the welfare or safety of other members,” or the “member’s disability imposes unreasonable requirements on the military to maintain or protect the Service member.”²² The primary purpose of these statutory and regulatory provisions regarding fitness for duty is to preserve the capability of the fighting force.

Other examples of this dual purpose mission of the Military Health System include rehabilitation of members with substance abuse disorders;²³ tailored medical monitoring of special categories of personnel, such as those who have mission responsibilities involving nuclear weapons;²⁴ mandatory medical clearance for return

¹⁹ Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field arts. 21, 24, Aug. 12, 1949, 6 U.S.T. 3114 [hereinafter Wounded and Sick].

²⁰ *See, e.g.*, National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 110-181, § 1611 (2008).

²¹ 10 U.S.C. § 1201(a) (2016).

²² U.S. DEP’T OF DEF. INSTRUCTION NO. 1332.38, DISABILITY EVALUATION SYSTEM (DES) 27–30 (Aug. 5, 2014).

²³ U.S. DEP’T OF DEF. INSTRUCTION NO. 1010.04, PROBLEMATIC SUBSTANCE USE BY DoD PERSONNEL (Feb. 20, 2014).

²⁴ U.S. DEP’T OF DEF. INSTRUCTION NO. 5210.42, NUCLEAR WEAPONS PERSONNEL RELIABILITY PROGRAM (PRP) (Jul. 16, 2012).

to full duty for members exposed to potentially concussive events;²⁵ and specific protocols for combat and operational stress control.²⁶

B. Application of FDA Rules to Force Health Protection

This focus on force health protection sometimes presents the need for balance noted above between individual autonomy and the strength of the fighting force. One example of this, as in the appellate case mentioned above, relates to the role of the FDA. In general, the FDA is the federal government's instrument for protecting the consumer community at large from unsafe or ineffective medical products. For the "specialized community" of military personnel, FDA rules intertwine with military command authority in complex ways to reconcile autonomy interests, patient protection, and collective fighting effectiveness. Under 10 U.S.C. § 1107, enacted in 1997, DoD generally follows FDA rules in providing medical services to military personnel. The FDA generally disallows interstate distribution or marketing of unapproved products, as well as approved products for unapproved uses. An exception, based on the FDA's lack of jurisdiction over medical practitioners in a provider-patient relationship, allows them to use an approved product for an unlabeled indication as part of the practice of medicine.²⁷ Another exception allows investigational use of medical products under special rules designed for the regulation of medical research, usually requiring the informed consent of the patient.²⁸ These exceptions are allowed for military practitioners, and section 1107 further allows the President to waive informed consent for use of an investigational new drug "if the President determines, in writing, that obtaining consent is not in the interests of national security." Executive Order 13139, issued by President Clinton in 1999, outlines detailed standards and procedures for such a waiver.²⁹ Since the enactment of § 1107 there has never been a waiver of informed consent under this section.

Congressional enactment of § 1107 implicitly reflected an acknowledgment that generally applicable FDA-administered processes, largely designed to protect against for-profit drug and other medical product manufacturers marketing medical products without adequate proof of safety and effectiveness, also keep from the market less profitable but needed medical countermeasures for novel threats, such as chemical and biological weapons. Following the terrorist attack on the United States in 2001 and the unsuccessful effort a few months later by the Centers for Disease Control and Prevention—in response to an attack using anthrax sent through the

²⁵ U.S. DEP'T OF DEF. INSTRUCTION NO. 6490.11, DoD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/CONCUSSION IN THE DEPLOYED SETTING (Sept. 18, 2012).

²⁶ U.S. DEP'T OF DEF. INSTRUCTION 6490.05, MAINTENANCE OF PSYCHOLOGICAL HEALTH IN MILITARY OPERATIONS (Nov. 22, 2011).

²⁷ 21 C.F.R. § 312.2(d) (2014).

²⁸ 21 C.F.R. pt. 312 (2014).

²⁹ Exec. Order No. 13139, 64 Fed. Reg. 54,175 (Sept. 30, 1999).

mail—to protect postal workers with anthrax vaccine under an investigational new drug protocol and its required research-based informed consent form,³⁰ Congress gave the FDA new authority to permit the emergency use of promising but unapproved medical countermeasures to chemical, biological, radiological, and novel disease threats.³¹

This “Emergency Use Authorization” (EUA) mechanism involves a reduced standard compared to the standard applicable to approval of a product for general commercial marketing. Rather than proof of safety and effectiveness, an EUA requires a conclusion by the FDA Commissioner that “based on the totality of scientific evidence...it is reasonable to believe that...the product may be effective in diagnosing, treating, or preventing” a serious or life-threatening condition and “the known and potential benefits of the product...outweigh the known and potential risks, taking into consideration the material threat posed” by the agent or disease threat.³² Further, in contrast to the informed consent requirements applicable to unapproved products used under the investigational new drug rules, the FDA may establish conditions for the emergency use, including that “to the extent practicable given the circumstances” of the emergency, “individuals to whom the product is administered are informed...of the option to accept or refuse administration of the product.”³³

FDA consideration of a product for an EUA is preceded by a determination by the Secretary of Health and Human Services that circumstances exist justifying the authorization on the basis of a determination by either the Secretary of Homeland Security, Secretary of Defense, or Secretary of Health and Human Services of a real or significant potential emergency. In the case of the Secretary of Defense, the military emergency involves “a heightened risk to United States military forces of attack with a biological, chemical, or nuclear agent or agents.”³⁴ The requirement that the military emergency involve an “attack with a biological, chemical, or nuclear agent” results in an EUA not being available for unapproved but promising medical countermeasures for traumatic injuries caused by firearms and explosives. This separation of medical response to trauma from that to chemical or biological harm contrasts with National Institutes of Health authorities under which research on trauma treatment encompasses injuries resulting from “exposure to” “a mechanical force” or “another extrinsic agent, including an extrinsic agent

³⁰ Sandra Quinn, *The Anthrax Vaccine and Research: Reactions from Postal Workers and Public Health Professionals*, 6 *BIOSECURITY AND BIOTERRORISM: BIODEFENSE STRATEGY, PRACTICE, AND SCIENCE*, 321, 321 (2008).

³¹ The Project BioShield Act of 2004, Pub. L. No. 108-276, 118 Stat. 835 (2004).

³² 21 U.S.C. § 360bbb-3(c) (2015).

³³ 21 U.S.C. § 360bbb-3(e) (2015).

³⁴ 21 U.S.C. § 360bbb-3(b) (2015).

that is thermal, electrical, chemical, or radioactive.”³⁵ In the Iraq and Afghanistan hostilities during the period 2001 – 2015, there were approximately 6,800 deaths of U.S. military personnel³⁶ caused primarily by firearms and explosives and none caused by biological, chemical or nuclear agents. Some of those deaths that occurred after the initiation of medical care, either before or after the patient reached a combat hospital, involve what military medical researchers classify as “potentially survivable injuries,” with hemorrhage accounting for many of these.³⁷ Increasing survival rates among those potentially survivable injuries remains a major objective of military medicine through whatever means are available under statutory and regulatory authority.

C. Human Research Subjects Protection and Medical Information Confidentiality

Another context in which military health law addresses interests of individual autonomy is in the area of protection of human research subjects. DoD has adopted the “common rule” for protection of human research subjects³⁸ and has issued a companion regulation, incorporating a DoD-specific statute applicable to human research subjects³⁹ and providing additional protections for military personnel as human subjects.⁴⁰ These include a prohibition on superiors in a member’s chain of command being present at recruiting sessions for volunteers, the inclusion of an ombudsman on an Institutional Review Board for research involving more than minimal risk, and special additional rules for any research where any information required by the institutional review board for review or oversight or by the research subjects for informed consent includes classified information.⁴¹

The DoD human subjects protection rules also seek to resolve applicability issues that may be the source of confusion in civilian public health and social services agencies and organizations. The DoD regulation clarifies that not every systematic investigation using scientific methods and involving individuals constitutes human subjects research. Excluded are activities, including program evaluation, customer satisfaction surveys, user surveys, outcome reviews, and other methods, designed solely to assess the performance of DoD programs where the results of the evalu-

³⁵ 42 U.S.C. § 300d-61(h)(3) (2015).

³⁶ <http://www.defense.gov/casualty.pdf> (May 10, 2016).

³⁷ Nicholas Langan, *Changing Patterns of In-Hospital Deaths Following Implementation of Damage Control Resuscitation Practices in U.S. Forward Military Treatment Facilities*, 149 JAMA SURGERY 940, p. E6 (2014).

³⁸ 32 C.F.R. pt. 219 (2014).

³⁹ 10 U.S.C. § 980 (2015).

⁴⁰ U.S. DEP’T OF DEF. INSTRUCTION NO. 3216.02, PROTECTION OF HUMAN SUBJECTS AND ADHERENCE TO ETHICAL STANDARDS IN DoD-SUPPORTED RESEARCH (Nov. 8, 2011).

⁴¹ *Id.* at 23–24, 29–30.

ation are only for the use of government officials responsible for the operation or oversight of the program being evaluated and are not intended for generalized use beyond such program.⁴²

The confidentiality or lack thereof of health information is another context in which military health law governs the balancing of individual autonomy and mission effectiveness. The general rule under the health information privacy regulations of the Department of Health and Human Services promulgated under the Health Insurance Portability and Accountability Act (HIPAA) is that control of one's health information is a function of health care autonomy controlled by the patient unless outweighed by a greater society interest, such as one reflected in disclosures required by law.⁴³ Under the Department of Health and Human Services (HHS) HIPAA regulations, a "covered entity" (which includes a covered entity not part of or affiliated with the DoD) "may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission."⁴⁴ DoD's implementing regulation parrots this language and adds examples of such purposes, including "to determine the member's fitness for duty" or "fitness to perform any particular mission."⁴⁵

But the subordination of the individual's autonomy interest to the military command's interest in disclosure is limited by several DoD policies that subordinate the command's interest to the individual's desire for confidentiality to encourage members to overcome any reluctance they may have to seek mental health care. As part of a policy initiative to dispel stigma in seeking mental health care, a DoD regulation reverses the general HIPAA rule allowing disclosure to command authorities and directs military medical personnel not to tell command about mental health services provided to members unless a specific exception applies – the exceptions essentially identifying cases of serious mental health conditions, such as a risk of harm to self or others or unfitness for duty.⁴⁶ This effort to de-stigmatize mental health care for military members is reinforced by a specific statutory direction in 10 U.S.C. § 1090a to the Secretary of Defense to promulgate regulations that "to the greatest extent possible" "seek to eliminate perceived stigma associated with seeking and receiving mental health services, promoting the use of mental health services on a basis comparable to the use of other medical and health services."⁴⁷

⁴² *Id.* at 37–38.

⁴³ 45 C.F.R. pt. 164 (2014).

⁴⁴ 45 C.F.R. § 164.512(k)(1)(i) (2014).

⁴⁵ U.S. DEP'T OF DEF. REGULATION 6025.18-R, DoD HEALTH INFORMATION PRIVACY REGULATION 69–70 (Jan. 2003).

⁴⁶ U.S. DEP'T OF DEF. INSTRUCTION NO. 6490.08, COMMAND NOTIFICATION REQUIREMENTS TO DISPEL STIGMA IN PROVIDING MENTAL HEALTH CARE TO SERVICE MEMBERS (Aug. 17, 2011).

⁴⁷ 10 U.S.C. § 1090a(b)(1) (2015).

Similar rules disallowing command notification as a means to encourage members to obtain appropriate health care include a generally applicable requirement that health care personnel honor decisions of sexual assault victims and domestic violence victims on whether they wish to involve command or law enforcement authorities.⁴⁸

The recurring theme of balancing of individual autonomy of military members with mission needs of military command is also reflected in unique requirements for members of the armed forces to provide a specimen sample suitable for DNA identification analysis. In contrast to statutory privacy protections that generally prevent employers of civilians from collection genetic information,⁴⁹ military personnel must provide a specimen sample to the Armed Forces Repository of Specimen Samples for the Identification of Remains, which is for the exclusive purpose of identifying a dead, captured, or missing member.⁵⁰ The only exceptions to this exclusive use, other than internal quality assurance purposes, are with the consent of the member or next-of-kin or upon a court order under 10 U.S.C. § 1565a for a criminal investigation of a felony or sexual offense when no other source is reasonably available. In contrast to the rule in the civilian employment context, the military has an overriding interest in personnel accounting of the fighting force.⁵¹

III. RELATIONSHIP TO NON-MILITARY REGULATION OF CLINICAL PRACTICE

A. Application of Professional Standards

In addition to the balancing of interests between individual autonomy and mission needs, military health law balances military mission needs with other governmental interests that regulate clinical practice. In this regard, the Military Health System operates as part of the American medical system and is subject to at least some of the same regulatory apparatus that applies generally. For example, under 10 U.S.C. § 1094, DoD health care practitioners must hold a State license to practice their profession. For physicians, the license must be “an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by the jurisdiction that granted the license.”⁵² However, in contrast to typical health professional practice in States, it need not

⁴⁸ U.S. DEP’T. OF DEF. INSTRUCTION NO. 6495.02, SEXUAL ASSAULT PREVENTION AND RESPONSE (SAPR) PROGRAM PROCEDURES, 35–36 (Mar. 28, 2013); U.S. DEP’T OF DEF. INSTRUCTION NO. 6400.06, DOMESTIC ABUSE INVOLVING DoD MILITARY AND CERTAIN AFFILIATED PERSONNEL 40–44 (Aug. 21, 2007).

⁴⁹ 42 U.S.C. § 2000ff-1 (2015).

⁵⁰ U.S. DEP’T OF DEF. INSTRUCTION NO. 5154.30, ARMED FORCES INSTITUTE OF PATHOLOGY OPERATIONS 15–17 (Mar. 18, 2003).

⁵¹ See *Mayfield v. Dalton*, 901 F. Supp. 300 (D. Haw. 1995), *vacated as moot*, *Mayfield v. Dalton*, 109 F.3d 1423 (9th Cir. 1997).

⁵² 10 U.S.C. § 1094(a) (2015).

be a license from the State where the health care is being provided. State Medical Practice Acts typically exempt physicians practicing in Federal facilities,⁵³ but even where that is not in force, 10 U.S.C § 1094(d) preempts State laws to the extent they would interfere with members of the armed forces, civilian employees of the Department of Defense, personal services contractors, or potentially certain other individuals who hold a current license from a State from “performing authorized duties for the Department of Defense” “at any location in any State.”⁵⁴ This operates to permit practice of the applicable health profession in circumstances such as training in civilian facilities, disaster response, and telemedicine across State lines. In recognition of the important role of State licensing boards, DoD regulations generally require coordination with those boards “before performing off-base duties” and cooperation with any board inquiries or investigations that might arise.⁵⁵ But overall it is clear that in reconciling the interest in an effective system of military medicine – which is a uniquely Federal interest – with that of regulating professional medical practice – primarily a State function – the Federal interest sometimes takes precedence.

In addition to licensure of individual health care professionals, the Military Health System also requires that its hospitals and clinics be accredited by The Joint Commission or other appropriate accrediting body.⁵⁶ Further, the Military Health System reports to the National Practitioner Data Bank adverse privileging actions, and also reports malpractice or military disability case payment awards in cases in which the Surgeon General of the Army, Navy, or Air Force, as applicable to the case involved, determines that the payment was caused by a provider’s failure to meet the prevailing standard of care.⁵⁷ As with civilian health systems, peer reviews of Military Health System clinical performance and clinical quality are under 10 U.S.C. § 1102 confidential and generally exempt from civil discovery or disclosure outside the DoD. Moreover, under the Federal Tort Claims Act, for most health care provided in military hospitals and clinics (exclusive of care to military members incident to service, as discussed below), Federal law adopts State law standards for establishing the prevailing standard of care, the failure of which to meet may lead to a determination of medical malpractice.⁵⁸ These attributes of military health law reflect that while military medicine has some unique characteristics, it also incorporates many prevailing mechanisms of general health law that promote quality health care.

⁵³ *E.g.*, Cal. Bus. & Prof. Code § 715 (2015).

⁵⁴ 10 U.S.C § 1094(d) (2015).

⁵⁵ U.S. Dep’t of Def Manual No. 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) 27–28 (Oct. 29, 2013).

⁵⁶ *Id.* at 17–20.

⁵⁷ *Id.* at 68–73.

⁵⁸ 28 U.S.C. § 2674 (2015).

B. Medical Malpractice Compensation

Another context in which military health law reflects a balancing of individual interests and those of the military service is the inapplicability of medical malpractice litigation actions or other judicial remedies to address alleged medical malpractice by U.S. government personnel against military members on active duty. The Supreme Court decided in 1950, in *Feres v. United States*, that military personnel may not sue the United States under the Federal Tort Claims Act for personal injuries or death incurred incident to military service.⁵⁹ In the 65 years since, Congress and the Supreme Court have often considered but never acted to reverse the *Feres* Doctrine for medical malpractice or other tort actions. Although the *Feres* Doctrine has been criticized as lacking textual support in the Federal Tort Claims Act,⁶⁰ supporters offer several defenses.

Among these is that reversal of *Feres* would create an unsustainable inequity between some military members allowed to sue and others, such as those injured in combat, not allowed to sue. Without the doctrine, an injured member or the family of a deceased member outside of combat would be allowed to sue the U.S. Government based on an allegation that some other military member or government employee was negligent, but military members injured or the families of members killed in combat or other military operations would have only the normal military no-fault compensation system, even if the injury or death were due to “friendly fire” or there were some other issue of negligence by another military member. The combat injury or death would appear to be valued lower than an injury or death where a tort claim would be allowed. Such disparate treatment would conflict with the premise of the no-fault compensation system currently applicable to all workers’ compensation programs, including military death and disability compensation programs. It would also run counter to the premise of the military compensation system that like injuries are treated alike. All State and Federal workers’ compensation laws provide a no-fault compensation system as the exclusive remedy for work-related injuries.⁶¹ Employees may not sue the employer to seek larger recoveries, but employees will be compensated even if there was no negligence by the employer or a fellow employee. The military compensation system has the same premise, except that military members are considered to be “on duty” 24-hours a day. Their no-fault compensation applies to virtually all injuries at work or at home, and they may not sue their employer (the United States) for any injuries. For serious injuries, that system provides a military retirement, including lifetime pension, health coverage, and other benefits.⁶²

⁵⁹ *Feres v. United States*, 340 U. S. 135, (1950).

⁶⁰ *E.g.*, *United States v. Johnson*, 481 U. S. 681, 693 (1987) (Scalia, J., dissenting).

⁶¹ *E.g.*, 5 U.S.C. § 8116(c) (provision of Federal Employees Compensation Act, 5 U.S.C. §§ 8101–8151) (2015).

⁶² 10 U.S.C. §§ 1201–1222 (2015).

In addition to the debate over injury compensation policy and equity, Feres Doctrine supporters also argue that repeal would weaken the effectiveness of military medicine and ultimately the fighting force. As stated by dissenting members of the House Judiciary Committee with respect to 2010 proposed legislation (which was not enacted) to establish a medical malpractice exception to the Feres Doctrine:

Because of the nature of the military, the medical system interacts with the individual patient to a much greater extent than in the civilian world. Health screenings and assessments, limitations on duty, eligibility for deployment, annual physicals, fitness for duty determinations, specialized evaluations for pilots, indigenous disease vaccinations, biological defense countermeasures, mental health evaluations, and other interactions are the everyday work of the military medical system. And while these medical interactions are usually far removed from the battlefield, they are essential to effective military operations. Every such interaction would be a potential tort claim for which defenses would need to be planned and defensive medicine practiced, threatening to re-delegate military medical readiness from medical professionals and military commanders to civilian lawyers and judges.⁶³

This caution from members of the House Judiciary Committee sounded an echo from a unanimous 1983 Supreme Court decision disallowing Constitutional tort claims by military members against their superiors.⁶⁴ In that case the Court reasoned that because “centuries of experience have developed a hierarchical structure of discipline and obedience to command, unique in its application to the military establishment and wholly different from civilian patterns,” “[c]ivilian courts must, at the very least, hesitate long before entertaining a suit which asks the court to tamper with the established relationship” of military members to command, a relationship “at the heart of the necessarily unique structure of the Military Establishment.”⁶⁵ This relationship and the need for medical readiness of the fighting force make the Feres Doctrine a keystone of military health law.

C. Public Health Emergencies

Another example of the reconciliation of potentially competing interests is on the issue of emergency health powers. In the Military Health System, as with civilian sector public health activities, the potential relationships among those activities, police powers of the jurisdiction, and individuals subject to those powers may change significantly in a public health emergency. A DoD regulation addresses

⁶³ H. REPT. NO. 111-466, at 23–24 (2010) (dissenting views).

⁶⁴ *Chappell v. Wallace*, 462 U.S. 296, (1983).

⁶⁵ *Id.* at 300.

those potential changes and directs a program of planning and preparedness for such an emergency.⁶⁶ Among the emergency powers that may be invoked in a public health emergency in order to protect a military installation, the missions carried out there, and those who work and live there are restrictions of movement, including potential quarantines, which can be enforced under a criminal statute.⁶⁷ Informed by the Model State Emergency Health Powers Act,⁶⁸ the DoD regulation includes procedures for allowing affected individuals to request review of a quarantine order and for coordinating activities with the Centers for Disease Control and Prevention at the Federal level and State and local public health agencies, or with host nations outside the United States.

DoD policy also authorizes “situational standards of care” “to the extent necessary to deal with mass casualties” “without unnecessarily compromising the quality of care.”⁶⁹ Among these could be to expand the scope of practice certain categories of providers (such as hospital corpsmen) are ordinarily authorized to perform, suspending normal practices for specialty referrals, confirmatory clinical testing, provider-to-patient ratios, and the like, reducing recordkeeping requirements, use of alternate sites that do not meet normal facilities standards, expanded utilization of telemedicine, and greater use of volunteers. In addition, when “all available resources are insufficient to meet the health care needs of beneficiaries in a public health emergency,” the Military Health System “shall use the limited resources to achieve the greatest good for the greatest number,” with “‘good’ defined as lives saved and suffering alleviated.”⁷⁰

Related to the issue of managing public health emergencies on military installations, the Military Health System has a role in supporting civil authorities in their management of public health emergencies off military installations. Under the National Response Plan, for which the Department of Homeland Security is the overall Federal lead, HHS is the lead agency and DoD a supporting agency for Emergency Support Function (ESF) 8, Health Services.⁷¹ Under the authority of the Stafford Act⁷² for a major emergency or the Economy Act⁷³ for more routine

⁶⁶ U.S. DEP’T OF DEF. INSTRUCTION 6200.03, PUBLIC HEALTH EMERGENCY MANAGEMENT WITHIN THE DEPARTMENT OF DEFENSE (Mar. 5, 2010) [hereinafter DODI 6200.03].

⁶⁷ *Id.*, Enclosure 3, § 2.

⁶⁸ The Model State Emergency Health Powers Act, A Draft for Discussion Prepared by The Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities for the Centers for Disease Control and Prevention (2001), <http://www.publichealthlaw.net/ModelLaws/MSEHPA.php> (January 3, 2015).

⁶⁹ DODI 6200.03, *supra* note 65, at 29–32.

⁷⁰ *Id.*

⁷¹ 42 U.S.C. § 300hh (2015).

⁷² 42 U.S.C. §§ 5121–5201 (2015).

⁷³ 31 U.S.C. § 1535 (2015).

support, the Military Health System may, with the approval of the Secretary of Defense, deploy assets requested by the Secretary of HHS. In such a case, while the Secretary of HHS exercises “operational control of emergency public health and medical response assets,” “members of the armed forces under the authority of the Secretary of Defense shall remain under the command and control of the Secretary of Defense, as shall any associated assets of the Department of Defense.”⁷⁴ This ensures that the normal chain of command for the armed forces, which runs to the President through the Secretary of Defense, remains intact when military forces provide support to civil authorities in a public health emergency.

Another Military Health System role in support of the Department of HHS-led emergency preparedness is the operation, along with the Department of Veterans Affairs, of Federal Coordinating Centers for the National Disaster Medical System (NDMS) network of hospitals to provide definitive medical care in response to a disaster or catastrophic event, as determined by the Secretary of HHS.⁷⁵ The NDMS network of hospitals has a dual purpose for DoD in that it can also be activated by the Assistant Secretary of Defense for Health Affairs in the event of a military health emergency, such as the possibility of military casualties exceeding the inpatient capability of the Military Health System and Veterans Health Administration.⁷⁶

One other aspect of potential DoD support to civil authorities in a public health emergency – although this is decidedly outside the role of the Military Health System – is in providing security or law enforcement capability in support of a Federal response, such as enforcement of a Federal quarantine ordered by the Secretary of HHS under 42 U.S.C. § 264. The armed forces are generally barred by the Posse Comitatus Act⁷⁷ from undertaking law enforcement functions in the civilian community, but the President may order the armed forces to perform such functions if the President considers it necessary to suppress “any insurrection, domestic violence, unlawful combination, or conspiracy” that “obstructs the execution of the laws of the United States,”⁷⁸ such as widespread violations of a Federal public health quarantine.

⁷⁴ *Id.*

⁷⁵ 42 U.S.C. § 300hh-11 (2015); National Disaster Medical System Memorandum of Agreement Among the Departments of Homeland Security, Health and Human Services, Veterans Affairs, and Defense (2005) (available at http://fhp.osd.mil/ndms/docs/NDMS_Partners_MOA_24_Oct05.pdf).

⁷⁶ *Id.*

⁷⁷ 10 U.S.C. § 375 (2015), 18 U.S.C. § 1385 (2015).

⁷⁸ 10 U.S.C. § 333 (2015) (commonly referred to as “Insurrection Act”).

IV. FUNCTIONING OUTSIDE TRADITIONAL ROLES OF A HEALTH CARE PROVIDER

A. Support of Law Enforcement, Judicial, Intelligence, and Detention Operations

In addition to the role of health care provider, the Military Health System also supports military functions in roles different from those of typical civilian health systems. For example, the Military Health System includes the Armed Forces Medical Examiner System. Under 10 U.S.C § 1471, the Armed Forces Medical Examiner may conduct a forensic pathology investigation, including autopsy, to determine the cause or manner of death of a deceased active duty member or other person in certain circumstances, such as a death on a military installation of apparently unnatural or unlawful means or from an infectious disease or hazardous material that threatens the military installation. The medical examiner provides direct support to Military Department Criminal Investigation Divisions. The Armed Forces Medical Examiner is also authorized by the statute to conduct such an investigation at the request of the Federal Bureau of Investigation, the National Transportation Safety Board, or any other Federal agency. In a case where a State, local, or foreign authority has primary jurisdiction to conduct a forensic pathology investigation, the Armed Forces Medical Examiner must defer, but then may proceed if the authority with primary jurisdiction fails to perform an autopsy.

In addition to this law enforcement-related function, the Military Health System may also be called upon by a commanding officer with authority to convene a court martial for a violation of the Uniform Code of Military Justice or military judge to conduct "an inquiry into the mental capacity or mental responsibility of the accused."⁷⁹ The inquiry is conducted by "a board consisting of one or more persons," each member of which "shall be either a psychiatrist or a clinical psychologist."⁸⁰ The board is required to provide findings on whether the accused has "a severe mental disease or defect" that caused him or her to be at the time of the alleged criminal conduct "unable to appreciate the nature or quality or wrongfulness of his or her conduct," or that presently causes him or her to be "unable to understand the nature of the proceedings...or to conduct or cooperate intelligently in the defense."⁸¹

Similar to these roles supporting law enforcement or judicial functions, Military Health System practitioners on some occasions may provide support to intelligence gathering. In this context, a clinical psychologist may be temporarily detailed from clinical activities and noncombatant status to an assignment as a behavioral science consultant to an intelligence unit conducting interrogations.

⁷⁹ RULES FOR COURTS-MARTIAL 706, MANUAL FOR COURTS-MARTIAL (2012 ed.).

⁸⁰ *Id.*

⁸¹ *Id.*

Under a detailed DoD regulation,⁸² behavioral science consultants “are authorized to make psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees” and “advise authorized personnel performing lawful interrogations.”⁸³ They “may observe, but shall not conduct or direct, interrogations” “nor act as medical monitors during interrogations.”⁸⁴ Although affiliated during this assignment with an intelligence unit rather than a medical unit, the psychologist continues to “have a duty in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the Department of Defense, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, in accordance with and as defined in U.S. law.”⁸⁵ This duty includes reporting suspected violations of standards for the protection of detainees to the chain of command, and if not acted upon properly, to senior Military Health System officials.⁸⁶

Also related to detainee operations, the Military Health System must not only provide health care to prisoners of war or other detainees, it must also support the U.S. Government policy on preventing self-harm by those being detained in the conduct of hunger strikes. Consistent with U.S. Bureau of Prisons policy,⁸⁷ the DoD regulation on medical program support for detainee operations authorizes involuntary enteral feeding “based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm.”⁸⁸ Because this policy subordinates patient autonomy to other governmental interests, it is controversial in the general medical community. The American Medical Association, for example, although not mentioning hunger strikes in its ethics code or policy statement, endorses a World Medical Association declaration that favors deference to the wishes of a determined hunger striker, if apparently competent and exercising free will, even if it leads to his death.⁸⁹ But in contrast to the controversy in the general medical community, Federal court rulings in both the U.S. Bureau of Prisons and the U.S. Detention Facility at Guantanamo Bay contexts have consistently upheld

⁸² U.S. DEP’T OF DEF. INSTRUCTION 2310.08E, MEDICAL PROGRAM SUPPORT FOR DETAINEE OPERATIONS (Jun. 6, 2006) [hereinafter DODI 2310.08E].

⁸³ *Id.* at 9.

⁸⁴ *Id.* at 9–10.

⁸⁵ *Id.* at 2.

⁸⁶ *Id.* at 4.

⁸⁷ 28 C.F.R. pt. 549, subpt. E, “Hunger Strikes, Inmate” (2014).

⁸⁸ DODI 2310.08E, *supra* note 81, at 5.

⁸⁹ Am. Med. Ass’n Policy Statement H-65-997 (2016) (available at <https://www.ama-assn.org/ssl3/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-65.997.HTM>); World Med. Assembly Declaration of Malta on Hunger Strikes (2006) (available at <http://www.wma.net/en/30publications/10policies/h31/>).

the legality of the U.S. Government policy on management of hunger strikes.⁹⁰ In addition to the strong penological interest in keeping order in the detention facility, courts have recognized the difficulty in assuring capacity to make a life or death decision when “incarceration can place a person under psychological strain and the jail or prison under a commensurate duty to prevent the prisoner from giving way to the strain.”⁹¹ And with respect to free will, the Supreme Court has acknowledged (in a different context) a detention facility’s “substantial interest in preventing” risk taking actions by inmates “as a result of coercion” by other inmates.⁹²

B. Humanitarian Assistance, Health Stability Operations, and Global Health Engagement

Another Military Health System function different from typical civilian health systems is its engagement in a variety of activities defined in statute as “health stability operation[s] conducted by the Department of Defense outside the United States in coordination with a foreign government or international organization to establish, reconstitute, or maintain the health sector of a foreign country.”⁹³ The legal authorities for these activities include 10 U.S.C. § 401, which authorizes humanitarian and civic assistance in conjunction with military operations, including “medical, surgical, dental, and veterinary care provided in areas of a country that are rural or are underserved, . . . including education, training, and technical assistance relating to the care provided.”⁹⁴ DoD policy calls for medical stability operations to be given “priority comparable to combat operations” in providing governmental services, infrastructure, and humanitarian relief.⁹⁵ As an example of global health engagement, the Military Health System administers a portion of the President’s Emergency Plan for AIDS Relief (PEPFAR).⁹⁶

Related to humanitarian assistance, another dimension of this recurring theme of reconciling the potentially competing interests of military mission and personal autonomy occurs in the context of the relationship between military command and military health care professionals. Again, legal authority supports the preeminence of the military mission. For example, in a case from the Vietnam War era, the U.S. Court of Appeals for the Third Circuit held that a military physician was punishable under the Uniform Code of Military Justice for willful disobedience

⁹⁰ *E.g.*, *Aamer v. Obama*, 953 F. Supp. 2d 213 (D.D.C. 2013), *aff’d*, 742 F.3d 1023 (D.C. Cir. 2014).

⁹¹ *Freeman v. Berge*, 441 F.3d 543, 547 (7th Cir 2006).

⁹² *Florence v. Bd. of Chosen Freeholders of Burlington*, 132 S. Ct. 1510, 1520 (2012).

⁹³ National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, § 715(d) (2013).

⁹⁴ 10 U.S.C. § 401(e) (2015).

⁹⁵ U.S. DEP’T OF DEF. INSTRUCTION 6000.16, MILITARY HEALTH SUPPORT FOR STABILITY OPERATIONS (May 17, 2010).

⁹⁶ 22 U.S.C. §§ 2151b-2, 7611 (2015).

of a lawful order to provide medical training to Special Forces aidmen (medical technicians) who would use the training to provide medical services to Vietnamese villagers in an effort to increase support for the U.S. military's combat objectives. The military physician's defense was that this violated his medical ethics to participate in a combat-related mission objective and could potentially associate him with war crimes against Vietnamese villagers. The Court rejected this defense and found that the physician had an obligation to obey the lawful order.⁹⁷

C. International Law Obligations

Some sources of military health law are international law. These are obligations of the U.S. armed forces for which the Military Health System has an implementation role. For example, the Geneva Conventions require that members of an opposing force and certain other affiliated persons shall be "cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria," and "[o]nly urgent medical reasons will authorize priority in the order of treatment to be administered."⁹⁸ In addition, for those who become prisoners of war, those "suffering from serious disease, or whose condition necessitates special treatment, a surgical operation or hospital care, must be admitted to any military or civilian medical unit where such treatment can be given."⁹⁹ Further, Military Health System activities in foreign countries in disease surveillance, health care, medical evacuation, or other matters may trigger a reporting requirement to the World Health Organization (WHO) of a potential "public health emergency of international concern" under the WHO International Health Regulations.¹⁰⁰

V. REGULATION OF HEALTH BENEFITS

A. Affordable Care Act, Insurance Regulation, and Medicare

As noted above, the Military Health System includes TRICARE, a health reimbursement program similar to private sector health insurance. TRICARE is considered "minimum essential coverage" for purposes of the individual mandate under the Affordable Care Act.¹⁰¹ However, Affordable Care Act requirements

⁹⁷ *Levy v. Parker*, 478 F.2d 772, 779 (3d Cir. 1973) (conviction set aside on other grounds but subsequently reinstated by *Levy v. Parker*, 417 U.S. 733 (1974)).

⁹⁸ *Wounded and Sick*, *supra* note 19, at Art. 12.

⁹⁹ Convention (III) relative to the Treatment of Prisoners of War, Art. 30, Aug. 12, 1949 (available at <https://www.icrc.org/ihl/INTRO/375?OpenDocument>).

¹⁰⁰ DODI 6200.03, *supra* note 65, at 1–2; DoD Instruction 6000.11, "Patient Movement (PM)," May 4, 2012, encl. 2, para. 6.a; World Health Association, International Health Regulations (2005), Art. 9.

¹⁰¹ 26 U.S.C. § 5000A(f)(1)(A)(iv) (2015).

applicable to employer-sponsored plans do not apply to TRICARE based on a post-Affordable Care Act amendment to 10 U.S.C. § 1073 providing that “the Secretary of Defense shall have responsibility for administering the TRICARE program and making any decision affecting such program.” Legislative history of this provision indicates it was intended to codify one product of the many negotiations that cobbled together the necessary votes for enactment of the Affordable Care Act, an agreement to reassure champions of military health care that “the Secretary of Defense would continue to maintain sole authority over TRICARE.”¹⁰²

In the context of State regulation of health insurance, TRICARE is exempt from such regulation under 10 U.S.C. § 1103, which preempts any “law or regulation of a State or local government relating to health insurance, prepaid health plans, or other health care delivery or financing methods” “to the extent that the Secretary of Defense” determines necessary to achieve any “important Federal interest.”¹⁰³ TRICARE is administered by regional contractors, which also establish and administer preferred provider networks of institutional and individual providers. These providers generally offer discounted prices and in the case of institutional providers, are, like under Medicare, considered recipients of Federal financial assistance for purposes of Title VI of the Civil Rights Act and related laws.¹⁰⁴ Medicare and TRICARE are also linked in statute in that to maintain eligibility for Medicare reimbursements, institutional providers must accept TRICARE,¹⁰⁵ and for all providers, TRICARE payment methodologies and amounts generally follow those of Medicare.¹⁰⁶

B. Retirees’ Entitlement to Health Care

The Military Health System, as discussed above, identifies its primary mission in relation to health care support of the fighting force. But as measured in dollars spent, the impression can be created that its primary mission is actually retiree health care. As specified in Congressional enactments over time, military retirees and their families are entitled to space-available care in military hospitals and clinics and to coverage under TRICARE for health services received from civilian sector providers, including coverage supplemental to Medicare for those so eligible.¹⁰⁷ The vast majority of DoD-funded health care services for retirees and their families is

¹⁰² 111 CONG. REC. H1714 (daily ed. March 20, 2010) (comments of Mr. McKeon); HASC No. 5, House Armed Services Committee Legislative Text and Joint Explanatory Statement accompanying H.R. 6523, the proposed National Defense Authorization Act for Fiscal Year 2011 (Dec. 2010), at 440.

¹⁰³ 10 U.S.C. § 1103 (2015); 32 C.F.R. § 199.17(a)(7) (2014).

¹⁰⁴ 32 C.F.R. §§ 199.6(b)(2)–(3), 199.17(p)(1) (2014).

¹⁰⁵ 42 U.S.C. § 1395cc (2015).

¹⁰⁶ 10 U.S.C. §§ 1079(h), 1079(h)(j) (2015).

¹⁰⁷ 10 U.S.C. § 1086 (2015).

from private sector providers. In Fiscal Year 2013, there were 3.43 million eligible active duty members and their family members and 5.29 million eligible retirees and their dependents; the Military Health System spent about \$14 billion for active duty members and their families and about \$20 billion for health care for retirees and their families.¹⁰⁸ (These cost data do not include military personnel salaries of those who staff military hospitals and clinics.) Although TRICARE is a generous health plan, it does not provide the “free lifetime health care” some retirees believe they were promised by military recruiters. When this issue was litigated, the U.S. Court of Appeals for the Federal Circuit ruled that no such perceived promises could create a legal entitlement to free lifetime health care:

[The retiree plaintiffs] agreed in an express, written contract to be bound by military regulations and statutes. Those regulations and statutes expressly address health care for military retirees, and provide expressly that retirees and their dependents were not entitled to full free lifetime medical care. Accordingly, the retirees’ contract claim is foreclosed because an implied-in-fact contract cannot exist if an express contract already covers the same subject matter.¹⁰⁹

Retiree health care supports the military mission as a component of a compensation structure that incentivizes retention of skilled combat arms professionals. Congressional decisions on the generosity of TRICARE coverage have been independent of DoD assessments of the cost-benefit analysis for additional retention incentives. Nonetheless, based on Congressional preeminence in matters of government spending, military health law reflects the most favored status of military retirees.¹¹⁰

C. Relationship with the Department of Veterans Affairs

In recent years Congress has enacted numerous statutes requiring that certain Military Health System activities be conducted in coordination with the Department of Veterans Affairs in an effort to promote a smooth transition of military members to veteran status or enhance government efficiency. Examples include multiple provisions of the 2008 Wounded Warrior Act¹¹¹ and requirements for the two Departments to implement electronic health records systems that will be “interoperable,”

¹⁰⁸ U.S. DEP’T OF DEF., DEF. HEALTH AGENCY EVALUATION OF THE TRICARE PROGRAM: ACCESS, COST, AND QUALITY, FISCAL YEAR 2014 REPORT TO CONGRESS (Jan. 3, 2015) (available at <http://www.health.mil/Reference-Center/Reports/2014/02/25/Evaluation-of-the-TRICARE-Program>).

¹⁰⁹ *Schism v. United States*, 316 F.3d 1259, 1278 (Fed. Cir. 2002) (en banc) (internal citation omitted).

¹¹⁰ See, e.g., H.R. 4310, 112th Cong., § 701 (proposed National Defense Authorization Act for Fiscal Year 2014) (passed on May 18, 2012).

¹¹¹ National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 110-181, Title XVI (2008).

defined as “the ability of different electronic health records systems or software to meaningfully exchange information in real time and provide useful results” to each other.¹¹² Another recent enactment requires that military members’ service treatment records be provided to the Department of Veterans Affairs in an electronic format promptly after separation from military service, specifying that such disclosures are permissible under HIPAA health information privacy rules.¹¹³ Congress also enacted authority for a demonstration project for the two Departments to operate jointly a medical facility complex made up of a Veterans Medical Center in North Chicago, Ill. and an ambulatory care clinic serving Naval Station Great Lakes.¹¹⁴ These Congressional actions are in addition to the more traditional authority of the two health systems to share health resources.¹¹⁵ While collaboration between the Veterans Health Administration and the Military Health System is extensive and growing, the two systems still have decidedly different missions, the former focused on past conflicts, the latter on present and future ones.

VI. MILITARY HEALTH SYSTEM GOVERNANCE

To round out this summary of military health law, some description of the governance of the Military Health System is appropriate. The Military Health System has multiple components and a somewhat complex governance structure. Military medical personnel are almost entirely members of the Army, Navy or Air Force. Similarly, most military hospitals and clinics are under the authority and control of the Secretaries of the Army, Navy, and Air Force (referred to as the Military Departments) and subordinate senior military officers, including the Surgeons General of the Army, Navy, and Air Force. All of these personnel and assets are under the authority, direction and control of the Secretary of Defense.¹¹⁶ The Secretary of Defense has delegated substantial authority for the operation of the Military Health System to the Assistant Secretary of Defense for Health Affairs, who functions under the authority, direction and control of the Under Secretary of Defense for Personnel and Readiness, and the Defense Health Agency, a Defense agency established under the authority of 10 U.S.C. § 191 to “provide for the performance of a supply or service activity that is common to more than one military department by a single agency of the Department of Defense.” Under authority delegated from the Secretary of Defense, the Assistant Secretary of Defense for Health Affairs, a Presidential appointee with Senate confirmation¹¹⁷ – DoD’s “top doc” – “exercises authority, direction, and control over the DoD medical and dental personnel authorizations and policy,

¹¹² National Defense Authorization Act for Fiscal Year 2014, Pub. L. No. 113-66, § 713 (2014).

¹¹³ *Id.* at § 525.

¹¹⁴ National Defense Authorization Act for Fiscal Year 2010, Pub. L. No. 111-84, §§ 1701-1706 (2010).

¹¹⁵ 38 U.S.C. § 8111 (2015); 10 U.S.C. § 1104 (2015).

¹¹⁶ 10 U.S.C. § 113(b) (2015).

¹¹⁷ 10 U.S.C. § 138 (2015).

facilities, programs, funding, and other resources in the DoD,” but may not “direct a change” “with respect to medical personnel assigned” to a chain of command, meaning he or she may not remove a Surgeon General or other military member from an assigned position in a chain of command in a military service.¹¹⁸ Restated, the Assistant Secretary of Defense for Health Affairs can establish binding requirements on the Military Health System, but would need the Secretary of Defense’s authority to replace an officer or employee under a Military Department who the Assistant Secretary believes is unsatisfactorily implementing those requirements.

The Defense Health Agency shares authorities with the Military Departments for the operation of the Military Health System.¹¹⁹ The Director of the Defense Health Agency is a military officer in the grade of Lt. General or Vice Admiral, the same grade as the Surgeons General of the Army, Navy, and Air Force.¹²⁰ The Director of the Defense Health Agency “[e]xercises management responsibility for shared services, functions, and activities in the MHS, including but not limited to, the TRICARE Health Plan, pharmacy programs, medical education and training, medical research and development, health information technology, facility planning, public health, medical logistics, acquisition, budget and resource management, other common business and clinical processes, and other shared or common functions or processes, as determined by” the Assistant Secretary of Defense for Health Affairs.¹²¹ The Director of the Defense Health Agency may issue regulations governing these functions and activities that “are binding on DoD Components,” including the Military Departments.¹²² However, “the Service Medical Departments remain accountable for the delivery of patient care, and related medical and health services in facilities under their jurisdiction.”¹²³ Restated, the Military Departments maintain authority over the hospitals, clinics, and personnel under their jurisdiction, but must defer to Defense Health Agency management authority over shared functions and common business and clinical processes of the Military Health System.

The sharing of authorities among the Assistant Secretary of Defense for Health Affairs, Director of the Defense Health Agency, and Surgeons General of the Military Departments is a subject for “the advice and assistance of governance councils” at multiple management levels of the Military Health System.¹²⁴ The Defense Health Agency is also designated a combat support agency, giving it a

¹¹⁸ U.S. DEP’T OF DEF. DIRECTIVE 5136.01, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)) 1–4 (Sept. 30, 2013).

¹¹⁹ U.S. DEP’T OF DEF. DIRECTIVE 5136.13, DEFENSE HEALTH AGENCY (DHA) (Sept. 30, 2013) [hereinafter DoDD 5136.13].

¹²⁰ 10 U.S.C. §§ 3036, 5137, 8036 (2015).

¹²¹ DoDD 5136.13, *supra* note 118, at 4.

¹²² *Id.* at 12.

¹²³ *Id.* at 6.

¹²⁴ *Id.* at 3.

role of support for operating forces engaged in planning for or conducting military operations. This support is directed to the Combatant Commands with respect to research and development, medical logistics, public health, and other matters.¹²⁵

VII. CONCLUSION

The Constitution, statutes, regulations, judicial decisions, and international law requirements that rule the crossroads of two distinct functions of the United States Government – military and health care – form a unique governance of the powers and duties of the U.S. armed forces and the DoD to carry out military and related functions through health professionals and systems. The major theme of this governance is the reconciliation of the government's interests in accomplishing military missions with other cherished governmental interests, including health promotion, individual autonomy, patient protection, research ethics, privacy, federalism, medical professionalism, public health, emergency preparedness, humanitarianism, health care financing, and governmental efficiency. The increasing emphasis in recent years on many of these cherished government interests coupled with changing national security challenges the military must be prepared to meet makes the governance of this crossroads of military and health care functions of the U.S. government complex and evolving. This unique, evolving governance is the subject of military health law.

¹²⁵ *Id.*