How Clinician Transparency Optimizes Care in the Context of Conscience Objections to Healthcare Services

Krista B. Highland[1], Kris Shea[2], Fazlah Rahaman[3], Ryan C. Costantino[4], Margaret C. Baisley[5]

[1]*Department of Anesthesiology, Uniformed Services University, Bethesda, MD, USA*

[2]*Naval Medical Center Portsmouth, Portsmouth, VA, USA*

[3]*School of Medicine, Uniformed Services University, Bethesda, MD, USA*

[4]*Enterprise Intelligence and Data Solutions (EIDS) program office, Program Executive Office, Defense Healthcare Management Systems (PEO DHMS), San Antonio, TX, USA*

[5]*Reclaim Justice Movement*

Conflicts of Interest and Disclaimer: The authors have no conflicts of interest or competing interests to report. Each author certifies that there are no funding or commercial associations (consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted article related to the author or any immediate family members. The views expressed are solely those of the authors and do not reflect the official policy or position of the Uniformed Services University, US Army, US Navy, US Air Force, the Department of Defense, or the US Government.

Centering Scenario

Imagine you are seeking guideline-congruent, evidence-based healthcare that is explicitly covered as part of your insurance benefits. You make an appointment with a clinician who, as part of their basic clinical training and credentials, would be able to provide the healthcare you seek. The earliest appointment available was a month away, but you took it because it is important to your overall health and well-being to receive this healthcare. However, upon meeting the clinician, they indicate that the reason for your visit and the exact healthcare you seek is not something they will provide due to their personal beliefs. They indicate that instead, you need to schedule another appointment with their colleague who practices in the same clinic, but their next available appointment is another month away. While information was not provided to you at the time of scheduling the first appointment, you would have preferred to wait another week or two to visit the other clinician instead, especially since another patient could have taken the appointment today and received healthcare that the clinician would have otherwise delivered.

Ethical Guidance and Military Health System (MHS) Policies

Ethical guidance by the American Psychological Association, American Medical Association, American Pharmacy Association, and other practice organizations outline the overarching requirement for clinicians to practice beneficence and avoid malfeasance; treat patients with dignity and respect; and honor patient agency, autonomy, and consent (American Medical Association, 2001; American Pharmacists Association, 1994; American Psychological Association, 2017). In one analysis, most medical ethical principles outlined by the American Medical Association were largely overlapping with the MHS Principles of Medical Ethics, but with some exceptions (Thomas et al., 2020). The MHS Principles of Medical Ethics, outlined in a Department of Defense (DoD) Instruction (Office of the Under Secretary of Defense for Personnel and Readiness, 2017) states that personnel will:

- Provide competent health care with compassion and respect for human dignity and rights. All individuals are treated with respect and tolerance. Discrimination on the basis of age, sexual orientation, gender, race, ethnicity, language, disease, disability, religion, or rank is forbidden because it is inconsistent with the ideals and principles of the MHS.
- Advocate for the best possible health interests of patients while respecting the law and lawful military authority.
- Respect the rights of patients, colleagues, and other healthcare personnel, and safeguard patient confidences and privacy within the constraints of the law.
- Complete appropriate education and training, as necessary, and provide competent and ethical health care.

This Instruction also states that MHS leaders must adhere to additional policies that include the ability to accommodate a service member's beliefs "unless it could have an adverse impact on military readiness, unit cohesion, and good order and discipline" (Office of the Under Secretary of Defense for Personnel and Readiness, 2017). A later Defense Health Agency (DHA) Procedural Instruction on

Medical Ethics in the MHS cites the common thread of all these as the professional responsibilities healthcare clinicians have to their patients "first and foremost, and to society, as a whole" (Defense Health Agency, 2021b). However, the Procedural Instruction does not provide additional guidance on how accommodations can be made and who is responsible for providing oversight on such requests.

The Patient Bill of Rights and Responsibilities in Military Hospitals and Clinics has an accompanying DHA Procedural Instruction (Defense Health Agency, 2021b). The Patient Bill of Rights are located on military treatment facilities' websites and are required to be physically posted in each facility. This Bill outlines several rights in the areas, including the right to:

- Receipt of quality healthcare.
- Timely access to specialty care.
- Considerate and respectful care that recognizes patients' personal dignity, values, and belief systems.
- Patients' access to their provider's information, such as names and credentials.
- A safe environment.
- A choice of clinicians adequate to ensure high-quality healthcare accessibility at each military treatment facility.

Lastly, Access to Care standards outline the time frame in which patients enrolled in TRICARE Prime should have access to care (Office of the Assistant Secretary of Defense for Health Affairs, 2011). Care access standards indicate emergency care must be immediately accessible, urgent care must be accessible within 24 hours, and routine care (e.g., primary care) must be accessible within 7 days. Specialty and preventative care appointments must be provided within 4 weeks of care request. Moreover, specialty care should not require more than one hour of travel time. If care is not available within a local military treatment facility and within the specified time periods, then patients are referred to the TRICARE network to meet these standards. Per findings from the DoD Inspector General, Access to Care standards are not consistently met for urgent and routine appointments across the military treatment facilities they investigated (Office of Inspector General - Department of Defense, 2018). The DoD Inspector General released another report in 2023 describing similar lack of timely care, especially for service members located in areas lacking adequate civilian healthcare facilities or clinicians that accept TRICARE (Office of Inspector General - Department of Defense, 2023).

Clinician Accommodations to Refrain From Specific Aspects of Healthcare

In 2024, the Final Rule for the implementation of Section 1557 of the Patient Protection and Affordable Care Act was released and applied to entities receiving Federal financial assistance from the US Department of Health and Human Services (Centers for Medicare & Medicaid Services, 2024). The Rule reiterates that discrimination (e.g., denial of healthcare based on aspects of identity) is prohibited (Centers for Medicare & Medicaid Services, 2024). The Rule also indicates that clinicians are not obligated to provide healthcare services they believe violate their religious freedom and conscience protections. However, state policies and licensing requirements also vary, with some states passing legislation outlining clinicians' rights to not participate in healthcare services they perceive to violate their conscience beliefs, and others describing or not describing the duty to notify patients of care refusal (Kogan et al., 2020). Such variation may pose the need for different procedures, across military treatment facilities, depending on local regulations.

Additionally, state-level structural stigma (e.g., policies impacting covered benefits, criminalization related to diagnoses and care provision, and public health programming), is associated with worse health outcomes, reduced healthcare receipt, and greater barriers to receive healthcare (Borah et al., 2023; Falck & Bränström, 2023; Hatzenbuehler et al., 2024; Johnstone et al., 2023; Siegler et al., 2020), whereas anti-discrimination legislation is associated with improved access to pre-exposure prophylaxis to prevent HIV transmission and gender affirming healthcare (Raifman et al., 2023; Walton et al., 2024). Moreover, access to healthcare clinicians in the purchased care network who provide various types of healthcare (e.g., gender affirming healthcare; obstetrics and gynecological care overall) may also be impacted by state-level policies (Hammoud et al., 2024; Hollinsaid et al.). Taken together, a TRICARE enrollee who requires healthcare services stationed at one location may have greater accessibility in the military treatment facility or in the local community, when compared to a different location. Therefore, ensuring access to care is not as simple as referring patients to the network, as evidenced by the DoD Inspector General report (Office of Inspector General - Department of Defense, 2023).

Some clinicians may object to providing specific clinical services within the scope of their credentialed practice and training (e.g., prescribing or dispensing contraception, pre-exposure prophylaxis, misoprostol, and exogenous sex steroid hormone therapy to transgender patients) and respecting patients' identities and relationships (e.g., using the patient's pronouns, encouraging a polyamorous patient's partners to take part in pregnancy and parenting classes before and after delivery) due to personal beliefs. As a result, they may ask for accommodations to refrain from delivering aspects of healthcare, receiving training, or engaging in referral processes. However, clinicians cannot discriminate against patients and refuse to provide them healthcare on the basis of patients' identities (e.g., race, ethnicity, sex assigned at birth, gender, sexual orientation, religion) (Defense Health Agency, 2019) and, as described above, all patients should be treated with dignity and respect.

The Defense Health Board Ethical Guidelines and Practices for US Military Medical Professionals Report indicates that clinicians "should not refuse to accept patients for reasons of discrimination, including, but not limited to the patient's race, creed, color, sex, national origin, sexual orientation, gender identity or handicap" (Defense Health Board, 2015). The Report also notes that "because objections to providing care based on conscience affect someone's health or access to care, considerations must also be given to the patient's rights. Thus, codes of conduct recommend that healthcare professionals with moral objections to specific services alert their colleagues to these objections and that the conscientious objector not interfere with the patient's ability to obtain the services elsewhere" (Defense Health Board, 2015).

The accommodation process for MHS clinicians as it relates to medical care provision is not readily discernible based on accessible resources, as a DoD Instruction outlining religious accommodations does not contextualize the process for healthcare clinicians (Office of the Under Secretary of Defense for Personnel and Readiness, 2020b). Albeit, there is one provision that indicates: "A Service member's religious practices will be considered in acting on a request for exemption from required medical practices. Action on a request for medical exemption must be consistent with mission accomplishment, including consideration of potential medical risks to other persons comprising the unit or organization." This Instruction, similar to language in the Instruction on medical ethics (Office of the Under Secretary of Defense for Personnel and Readiness, 2017), indicates that an "accommodation of individual expressions of sincerely held beliefs (conscience, moral principles, or religious beliefs)" does not have "an adverse impact on military readiness, unit cohesion, good order and discipline, or health and safety." As such, the policy indicates that the accommodation can be denied if (a) "The military policy, practice, or duty is in furtherance of a compelling governmental interest" or (b) "It is the least restrictive means of furthering that compelling governmental interest."

Per the DoD Instruction on religious accommodations, a service member's immediate commanders can resolve accommodation requests that do not require a waiver to uniform, appearance, and grooming policies. If a waiver or exception to policy is required, then a higher-level approval, specific to each Service, is required. The Instruction also notes that records related to accommodation requests and responses need to be maintained consistent with the DoD Instruction on privacy and civil liberties (Office of the Under Secretary of Defense for Personnel and Readiness, 2020a).

Under Title VII of the Civil Rights Act, civilian employees can request and receive accommodations reflective of religious beliefs, practices, and observances if the reasonable accommodation does not result in undue hardship on the employer (U.S. Equal Employment Opportunity Commission, 1964). The Equal Employment Opportunity Commission (EEOC) specifies that an employer does not have to accommodate an employee's religious expression if such expression "could potentially constitute harassment of coworkers, because that would pose an undue hardship for the employer" or "impose the religious beliefs of an employee onto others" (U.S. Equal Employment Opportunity Commission, 2021). The EEOC also recommends that employers should "immediately intervene when they become aware of objectively abusive or insulting conduct, even absent a complaint" (U.S. Equal Employment Opportunity Commission, 2021). In a previous DHA Policy Memorandum regarding COVID-19 vaccinations, DHA Federal civilian employees could request a religious exemption to vaccination in writing through their supervisory channels, and that any employee who received such an exemption was required to follow safety protocols (e.g., wear masks) (Defense Health Agency, 2021a). The Department of Veterans Affairs also provides a specific form for employees to be excused from providing aspects of reproductive healthcare (Department of Veterans Affairs, 2023). To date, there is a lack of specific, accessible guidance for civilian DoD clinicians to request accommodations and how local clinics are required to document and address such accommodations beyond what has been described broadly in aforementioned Instructions.

Considerations for Clinician and Care Transparency in the MHS: Invitation for a Thought Exercise

Centering the narrative on the patient and their experience, contextualized within a networked healthcare system that has variation between and within military treatment facilities, consider your current and past practice locations. Reflect on the process of requesting and receiving belief-based accommodations to refrain from aspects of healthcare and how or whether the local institution acted to meet the accommodation without negatively impacting patients and the healthcare system. Below are several scenarios. The scenarios are invitations for imagination in optimizing beneficence, minimizing malfeasance, upholding dignity and respect, and advocating for the best interests of patients in support of their autonomy and agency.

For each scenario, consider the following questions as they relate to clinician and care transparency:

- What about this scenario went well?
- What about this scenario did not go well?
- How is information regarding the clinicians' objections to providing healthcare disclosed?
- What are the institutional and structural solutions to address what did not go well?

Scenario 1

An anesthesiologist expresses to their Department Chief that they have personal beliefs against providing anesthesia services for gender affirming surgical procedures. The Department Chief then works with the schedulers to ensure the anesthesiologist is not scheduled for gender affirming surgical procedures. There are also many anesthesiologists who specifically request to be part of gender

affirming surgical teams. As a large medical facility, there is no disruption to surgical scheduling and all anesthesiologists have similar caseloads.

- **Impact:** No service disruption or delay occurs; no perceivable negative impact on patients occurs.
- **Catalysts and Conditions:** The reason for visit is clear and schedules can be constructed with such clarity. Leadership was engaged and created processes; the processes are functional. There is an adequate number of clinicians who can and want to perform the required care.

Scenario 2

A patient makes an appointment with primary care to initiate oral contraceptives. The reason for the visit is documented as "initiate oral contraceptives." The primary care clinician reviews charts to prepare for tomorrow's appointments and reads the patient's primary reason for the visit. Because the clinician does not prescribe contraception or refer patients to fertility services, the clinician alerts their Department Chief, who has left work for the day. The next morning, after reviewing patients with similar appointment times for potential contraception and fertility care requirements, the Department Chief swaps appointments between the original clinician and their colleague. This switch reduces the continuity of care for the second patient, who has received care at the clinic with the same clinician for about a year, but ensures both patients receive timely medical care.

- **Impact:** There is no expected service delay. The other patient may be impacted due to reduced continuity of care; both clinicians may now lack time to review their new patients' charts. Both clinicians may experience higher cognitive demand to account for the switch and lack of preparation.
- **Catalysts and Conditions:** The reason for the visit became clear and the clinician notified their supervisor upon discovery, but the timing was late. This scenario only works if patients specify the reason for visit as relating to contraceptive prescriptions. Not all patients who want to initiate contraceptive prescriptions or other types of healthcare will explicitly describe it as their reason for visit when making the appointment.

Scenario 3

A primary care clinician has prescribed a patient exogenous estrogen hormone therapy for about a year, which has been really helpful in reducing care delays, since the military treatment facility's Endocrinology Clinic is very booked and there is a lack of clinicians in the purchased care network who will prescribe gender affirming medications. Recently, the patient came in for a routine checkup and the primary care clinician said, "you know, as a woman in your fifties, it's important to get health screenings. I noticed you have a family history of prostate cancer and haven't been screened. Would you like to get your PSA tested?" The patient agrees, appreciating how and why the clinician provided the recommendation, and returns for the test results two weeks later. The primary care clinician indicated that based on research to date, they would recommend the patient follow-up with a urologist for a MP prostate MRI since the patient's PSA levels were >1 (Bertoncelli Tanaka et al., 2022). The patient then schedules the earliest appointment available with the urologist, which will happen in about two months.

At the appointment, the patient is ushered to an exam room by a nurse. The nurse does not take the patient's vitals or ask any routine questions. About 10 minutes later, the urologist walks in, does not greet the patient or introduce themself. The urologist states "I do not treat patients who are *post-op*. Call the appointment line and make an appointment with Dr. A instead." The urologist leaves the room. The patient waits a minute, unsure of whether a nurse will take vitals or if there is anything else she needs to do, then walks out and goes to the front desk. The patient asks the front desk administrator whether she could make the next appointment there, since she's typically on hold for 15 minutes to an hour when calling the appointment line. The administrator indicates "I would be happy to help you make an appointment."

The appointment with Dr. A happened five weeks later (the earliest appointment possible). Unknown to the patient, the urologist is the only one within the clinic of four urologists who will treat trans patients; this urologist is regularly referred patients by the other urologists because this urologist has a reputation of being compassionate and can work with "difficult patients." At the appointment, Dr. A was very professional and helpful. The exam went well and Dr. A provided more information about the lack of research in interpreting PSA levels in people who have undergone vaginoplasty and receive exogenous estrogen hormone therapy. Dr. A then provides thorough information regarding the MP prostate MRI and what happens based on exam results. The patient feels reassured that Dr. A is taking the time to provide education and clarity with everything. Through the patient portal and with a phone call, Dr. A calls the patient to tell her that the MRI results came back negative and provides future screening recommendations.

The patient is also currently working with a psychologist for prolonged grief disorder after losing their spouse of 27 years. The patient discloses to the psychologist that the first urologist's actions were difficult to process, as their father had prostate cancer and the delay in getting screened, combined with the ambiguity of not knowing whether the first urologist was avoiding trans patients altogether, caused additional distress, insomnia, and difficulty concentrating. The patient disclosed that they wish they would have known to schedule with the second urologist, because it would have been a much shorter time to getting answers *and* the second urologist provided excellent care.

- **Impact:** The primary care clinician encouraged the patient to receive guideline-congruent screenings and wanted the patient to receive care from clinicians who could provide additional screening within

the standards of urology care. The patient experienced service delays that exceed the Access to Care standards. The first urologist's decline of care lacked respect and dignity, and the urologist did not let the patient know they could schedule the next appointment with the front desk instead calling the appointment line (which tends to take a lot of time for many patients). For Dr. A, it is unclear whether the referrals impact their overall workload disproportionately to other clinicians.

- **Catalysts and Conditions:** Policy indicates that patients should be able to access specialty care in 4 weeks. For some patients, referral to the network may result in similarly long wait times as well, per previous Inspector General reports, as staffing may not account for local community care accessibility. Moreover, current facility staffing does not account for types of services clinicians will not provide. At large facilities, for example, staffing may ensure that there is a variety of orthopedic surgeons who specialize in different procedures (e.g., joint replacement, hand surgery, ligament repair), but not types of healthcare that would be considered standard practice across different fields. For Dr. A, there appears to be a lack of involvement of clinic leadership in mitigating care delay due to the first urologist not providing care. It is also unclear whether the first urologist is refusing care based on the patient's identity as a trans woman.

Scenario 4

A service member would like to initiate gender affirming hormone therapy and must, per policy, receive a diagnosis of gender dysphoria to initiate this therapy. The service member calls the appointment line to make an initial appointment. They ask the appointment line whether the psychologist with whom they are scheduled is an inclusive clinician. The person on the appointment line says "I don't know." The patient asks, "is this someone people go to for gender dysphoria assessment?" Again, the person on the appointment line says "sorry, I don't know that either." The patient then tries to search the internet for any information about the psychologist. They find a popular website that has a therapist finder search tool and notes that there's a lot of psychologists in the area who specifically indicate in their online profiles that they are "LGBTQIA+ affirming" and have worked with trans people who require gender affirming medical care. However, none of the clinicians at the local military treatment facility have a profile on this site.

- **Impact:** For many patients, regardless of the healthcare sought, knowing more about a clinician can help reduce ambiguity and anticipatory stress. Being able to know more about a clinician may be especially salient for people who have experienced prior healthcare discrimination and trauma.
- **Catalysts and Conditions:** While the Patient Bill of Rights and Responsibilities notes that patients should have access to their healthcare clinicians' names and credentials, such information is not displayed in accessible profiles, similar to civilian healthcare clinicians. Clinicians may decline to make profiles or provide little information in their profiles, as well. Moreover, the ability for clinicians to create profiles, if desired, and share information as to their clinical practices, training, and experiences can be an opportunity to balance the information known by clinicians about their patients versus what patients know about their clinicians. Similarly, having clinician profiles available through the patient portal would mean patients *could* access the information *if desired* and the information would only be accessible to those with patient portals.

Scenario 5

An enlisted service member received a 6-month prescription for contraceptive medication prior to deployment. They just found out that due to unforeseen circumstances, they will need to stay on deployment for an extra two months. They go to the unit's clinician who indicates that the service member can pick up the prescription tomorrow from the pharmacy. When the patient gets to the pharmacy, the pharmacist says that they cannot dispense this medication because of their deeply held beliefs "that service members should not be having sex while deployed and outside of marriage."

- **Impact:** The pharmacist's refusal to dispense contraceptive medication based on personal beliefs creates an environment where the service member is stigmatized for making personal healthcare decisions. By framing the issue as a moral or ethical one, rather than simply as the fulfillment of a medical prescription, the pharmacist imposes their values onto the service member, who may feel judged or shamed for seeking healthcare and taking contraception. This lack of respect and dignity may erode trust in the healthcare system that can intersect with other healthcare services (e.g., vaccine hesitancy, willingness to take prophylaxis medication, openness to report sexually transmitted infections). The pharmacist's rank also plays a role in this scenario. Military hierarchies introduce power dynamics that can make it difficult for subordinate service members to question or challenge decisions made by those of higher rank. The service member may not feel empowered to assert their right to care or file a complaint, fearing potential repercussions or feeling they lack autonomy in the situation. The pharmacist's decision not to not dispense contraception may create a gap in contraception, which can have broader implications for the service member's medical readiness. For service members who use contraception for reasons beyond preventing pregnancy, such as suppression of menstruation during deployment, failure of a clinician to understand this care and provide it affect their physical comfort and combat effectiveness (Schindler, 2013). Menstruation in the field can be difficult to manage, and un-

planned pregnancies could lead to medical or political issues. For example, in some countries where the U.S. operates, people who are not married and pregnant may face legal charges and punishment. Overall, barriers to accessing contraception during deployments have the potential to not only cause medical and readiness issues, but can also be contributing factors that could lead to diplomatic incidents.

- **Catalysts and Conditions:** Beyond pregnancy prevention, contraceptive medication is used to suppress menstruation, which is often necessary in environments like deployment, where sanitation, and access to hygiene products can be limited. Denying contraception in this context may reflect a lack of understanding of numerous reasons for oral contraceptive use. The service member's need for this medication is not solely about preventing pregnancy but about maintaining operational effectiveness in austere environments. A pharmacist's refusal to dispense the medication based on "deeply held religious convictions" highlights a conflict between personal belief and professional responsibility. Whereas military medical professionals are entitled to their religious beliefs they should also be required to clearly express and document their beliefs so that Commanders can mitigate their impact on the mission. Pharmacies located in the United States often deal with this situation by directing the patient to another pharmacy or pharmacist, but this may not be practical in a deployed setting given there may only be one pharmacist in a geographic area. While existing military policies (United States Army, 2013) provide alternative means to dispense a medication that do not involve a pharmacist, it may not be initially clear to non-medical professions and there is nothing inherently in the policy that directs a clinician to report or resolve a refusal to dispense. This situation suggests a gap in doctrine, training, and leadership/education to screen and enforce policy to ensure that personal beliefs do not obstruct care. The service member, as a junior enlisted person, may not feel confident in challenging the pharmacist, especially given the power differential. There may be a lack of education or awareness on how to escalate concerns or a process to escalate issues on a relevant timeline in a deployed setting, leaving the service member without access to necessary medication and feeling voiceless. The scenario suggests that existing policies may not sufficiently protect service members from being denied care based on personal beliefs of the healthcare provider nor do they set the conditions for the MHS, or its providers to proactively report their beliefs so they can be accommodated and mitigated.

Scenario 6

An enlisted service member recently deployed to Kuwait. Before deploying, the service member expressed to their primary care clinician that they would like to know the general processes of receiving exogenous hormone therapy someday in the future as part of gender affirming care. The primary care clinician indicated that the process would require a series of medical appointments to confer the diagnosis of gender dysphoria and a medical treatment plan that would need to be signed off by their commander. The primary care clinician reflected that medical treatment plans can take months to get approved. The enlisted service member tried to make an appointment with behavioral health, to at least get the process started so that there would be one less thing to do when coming back from deployment. However, no behavioral health appointments were available before deployment six weeks later. Now knowing the process, the service member felt like maybe it would be best to wait until they got stationed somewhere else, especially since their commander had previously made a negative comment about trans service members and laughed when other service members made jokes about trans people.

While on deployment, the commander had to be medically evacuated. Over the past two months, the new commander has had a really positive impact on unit cohesion and inclusion. The commander has been checking in with service members, coaching some on aspects of professional development, and providing answers to enlisted service members about how to enroll in college courses as part of their military benefits. When the new commander checks in with the service member, the service member discloses that they are trans and hope to someday get gender affirming care once they return from deployment and get to a new duty station, but felt like the process was pretty insurmountable.

The new commander indicates that in their last deployment, one of their service members received a documented diagnosis of gender dysphoria from the behavioral healthcare clinician deployed with the unit. With the support of the new commander, the service member meets with the behavioral health clinician assigned to the unit. The behavioral health clinician, however, says that supporting gender affirming care is against their beliefs and they cannot assess the service member for that diagnosis. They also asked the service member to think carefully about what it means to have that diagnosis and cautioned them to consider "the consequences."

- **Impact:** The decision to seek any type of healthcare can be stymied by leadership and climate. Seeking healthcare with the only clinician available to render the healthcare, and being denied healthcare without other opportunities or referrals is avoidable. While declining to provide aspects of healthcare may be an option for some deployed clinicians, the behavioral health clinician did not treat the service member with dignity or respect, and instead, attempted to imbue fear and doubt in the patient.
- **Catalysts and Conditions:** Having a supportive, genuine leader can be really positive in ensuring service members access the healthcare they need.

While some healthcare may not be accessible during deployment, deployed behavioral health clinicians are generalists and expected to deliver a wide range of services. There is currently a lack of credentialing validation prior to deployment as it relates to a clinician's willingness and ability to provide healthcare.

Scenario Synthesis

Across each scenario, transparency in terms of clinician service delivery or lack thereof and institutional response varied. Such scenarios provide an opportunity to consider ways to mitigate healthcare barriers and structural stigma when clinicians do not provide aspects of healthcare. The options below are ideations, each with their pros and cons that require considerable thought and discussion with patient partners. At the interpersonal level, if care will not be rendered at a clinical visit, the hand off to a different clinician should be ethical and respectful. Beyond the interpersonal level, additional procedures and tools could be implemented at the institutional- and system-levels.

At the institutional level, transparency could be provided several ways. Altering the appointment line process such that clarity in the types of services a clinician provides is known by the appointment line (all clinicians and services). Then, the appointment line can ask the patient if they would potentially be accessing the specific services (already ask patients if they want a provider of a specific gender?). This approach would be consistent with an informed consent model of care. This approach does not prevent patients from scheduling with a particular clinician, but it gives them information in which they can decide whether to wait longer and schedule with a different provider, or proceed forth with this clinician.

Another option is to enable clinicians to have professional profiles available to patients through patient portals or on public-facing websites. Here, patients would have the opportunity to learn more about their clinicians, their training, additional certificates, clinical emphasis, and more. Information would only be disseminated based on the patient searching for their clinicians' profiles. Having this information available to patients is consistent with language in the Patient Bill of Rights, as well as general online information availability of clinicians in civilian healthcare systems.

In regards to deployment readiness, clinicians' credentials could be validated before deployment and remote verification could be disseminated. For example, a screen could be added to ask: "are you unwilling to provide specific types of healthcare and procedures (if yes, which specific types of healthcare)?" Based on the clinician's responses, procedures could be put in place to ensure access to healthcare is sustained while service members are deployed. Remote pharmacy verification uses technology to allow a separate, often centralized, pharmacist or team of pharmacists to review and approve prescriptions. If an on-site pharmacist refuses to dispense a medication, remote pharmacy verification would allow a qualified pharmacist elsewhere to review and approve the prescription. This process ensures that the patient receives the prescribed medication without unnecessary delay or denial, and ensures that military and healthcare regulations are adhered to, including protections against discrimination and refusal of care. Remote verification systems can include built-in auditing features, which track when and why a prescription was refused and whether it was escalated appropriately. This process creates a record of the decision-making process and can be used for further investigation or performance improvement, as well.

Lastly, some systems-level options could support transparency and care accessibility. First, there are opportunities to expand the current capacity and awareness of healthcare programs, such as walk-in clinics for contraceptive care and behavioral healthcare. Information regarding the types of healthcare clinicians will and will not perform could be explicitly collected as part of credentialing to ensure a centralized location of service delivery capabilities. With such information, DHA could ensure healthcare service accessibility of covered benefits as related to staffing and engage with the Services regarding talent management. This capability can have the added benefit of ensuring clinicians are not being relocated if they doing so would result in a healthcare service delivery gap (unless they want to leave). To provide stable services, DHA may want to consider staffing civilian clinicians who will provide care.

References

American Medical Association. (2001). *AMA Code of Medical Ethics (Adopted June 1957; revised June 1980; revised June 2001)*. https://code-medical-ethics.ama-assn.org/

American Pharmacists Association. (1994). *Code of Ethics for Pharmacists*. https://www.pharmacist.com/Code-of-Ethics

American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct (2002, amended effective June 1, 2010, and January 1, 2017)*. https://www.apa.org/ethics/code/

Bertoncelli Tanaka, M., Sahota, K., Burn, J., Falconer, A., Winkler, M., Ahmed, H. U., & Rashid, T. G. (2022). Prostate cancer in transgender women: what does a urologist need to know? *BJU Int, 129*(1), 113-122. https://doi.org/10.1111/bju.15521

Borah, L., Zebib, L., Sanders, H. M., Lane, M., Stroumsa, D., & Chung, K. C. (2023). State Restrictions and Geographic Access to Gender-Affirming Care for Transgender Youth. *JAMA, 330*(4), 375-378. https://doi.org/10.1001/jama.2023.11299

Nondiscrimination in Health Programs and Activities, (2024). https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities

Defense Health Agency. (2019). *Procedural Instruction 6025.10: Standard Processes, Guidelines, and Responsibilities of the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) Military Medical Treatment Facilities (MTFs)*. Retrieved from https://www.health.mil/Reference-Center/DHA-Publications/2019/12/20/DHA-PI-6025-10

Defense Health Agency. (2021a). *Policy Memorandum on the Defense Health Agency Coronavirus Disease 2019 Vaccination Attestation, Screening Testing, and Vaccination Verification*. (DHA-POLICY MEMORANDUM 21-004). Retrieved from https://www.health.mil/Reference-Center/DHA-Publications/2021/11/03/DHA-PM-21-004

Defense Health Agency. (2021b). Procedural Instruction 6025.39: *Medical Ethics in the Military Health System*. Retrieved from https://www.health.mil/Reference-Center/DHA-Publications/2021/08/20/DHA-PI-6025-39

Defense Health Board. (2015). *Ethical Guidelines and Practices for U.S. Military Medical Professionals*. https://health.mil/Reference-Center/Reports/2015/03/03/Ethical-Guidelines-and-Practices-for-US-Military-Medical-Professionals

Department of Veterans Affairs. (2023). *Exemption and Accomodation Form: Employee Request to Be Excused from an Aspect of Reproductive Health*. (VA FORM 10-330). Retrieved from https://www.va.gov/vaforms/medical/pdf/VA%20Form%2010-330.pdf

Falck, F., & Bränström, R. (2023). The significance of structural stigma towards transgender people in health care encounters across Europe: Health care access, gender identity disclosure, and discrimination in health care as a function of national legislation and public attitudes. *BMC Public Health, 23*(1), 1031. https://doi.org/10.1186/s12889-023-15856-9

Hammoud, M. M., Morgan, H. K., George, K., Ollendorff, A. T., Dalrymple, J. L., Dunleavy, D., Zhu, M., Banks, E., Akingbola, B. A., & Connolly, A. (2024). Trends in Obstetrics and Gynecology Residency Applications in the Year After Abortion Access Changes. *JAMA Netw Open, 7*(2), e2355017. https://doi.org/10.1001/jamanetworkopen.2023.55017

Hatzenbuehler, M. L., Lattanner, M. R., McKetta, S., & Pachankis, J. E. (2024). Structural stigma and LGBTQ+ health: a narrative review of quantitative studies. *The Lancet Public Health, 9*(2), e109-e127. https://doi.org/10.1016/S2468-2667(23)00312-2

Hollinsaid, N. L., Price, M. A., & Hatzenbuehler, M. L. Transgender-Specific Adolescent Mental Health Provider Availability is Substantially Lower in States with More Restrictive Policies. *Journal of Clinical Child & Adolescent Psychology*, 1-12. https://doi.org/10.1080/15374416.2022.2140433

Johnstone, T., Thawanyarat, K., Eggert, G. R., Navarro, Y., Rowley, M. A., Lane, M., Darrach, H., Nazerali, R., & Morrison, S. D. (2023). Travel distance and national access to gender-affirming surgery. *Surgery, 174*(6), 1376-1383. https://doi.org/10.1016/j.surg.2023.09.008

Kogan, R., Kraschel, K. L., & Haupt, C. E. (2020). Which Legal Approaches Help Limit Harms to Patients From Clinicians' Conscience-Based Refusals? *AMA J Ethics, 22*(3), E209-216. https://doi.org/10.1001/amajethics.2020.209

Office of Inspector General - Department of Defense. (2018). Access to Care at *Selected Military Treatment Facilities*. US Federal Government Retrieved from https://media.defense.gov/2018/May/16/2001917965/-1/-1/1/DODIG-2018-111.PDF

Office of Inspector General - Department of Defense. (2023). *Management Advisory: Concerns with Access to Care and Staffing Shortages in the Military Health System*. Washington, DC: US Federal Government Retrieved from https://media.defense.gov/2023/Nov/30/2003349496/-1/-1/1/DODIG-2024-033_REDACTED.PDF

Office of the Assistant Secretary of Defense for Health Affairs. (2011). TRICARE Policy for Access to Care. (HA POLICY: 11-005). Retrieved from https://www.health.mil/Reference-Center/Frequently-Asked-Questions/~/link.aspx?_id=16A76D7DD2E5409F96CF2A3E9DD52483&_z=z

Office of the Under Secretary of Defense for Personnel and Readiness. (2017). *Department of Defense Instruction 6025.27: Medical Ethics in the Military Health System*. Retrieved from https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/602527_dodi_2017.pdf?ver=2017-11-08-130043-890

Office of the Under Secretary of Defense for Personnel and Readiness. (2020a). *Department of Defense Instruction 5400.11: DoD Privacy and Civil Liberties Programs*. Retrieved from https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/540011p.pdf

Office of the Under Secretary of Defense for Personnel and Readiness. (2020b). *DoD Instruction 1300.17: Religious Liberty in the Military Services*. Retrieved from https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/130017p.pdf

Raifman, J., Cheng, D. M., Skinner, A., Hatzenbuehler, M. L., Mayer, K. H., & Stein, M. D. (2023). State same-sex marriage policies and pre-exposure prophylaxis implementation among men who have sex with men in the United States. *J Int AIDS Soc, 26*(11), e26180. https://doi.org/10.1002/jia2.26180

Schindler, A. E. (2013). Non-contraceptive benefits of oral hormonal contraceptives. *Int J Endocrinol Metab, 11*(1), 41-47. https://doi.org/10.5812/ijem.4158

Siegler, A. J., Mehta, C. C., Mouhanna, F., Giler, R. M., Castel, A., Pembleton, E., Jaggi, C., Jones, J., Kramer, M. R., McGuinness, P., McCallister, S., & Sullivan, P. S. (2020). Policy- and county-level associations with HIV pre-exposure prophylaxis use, the United States, 2018. *Annals of Epidemiology, 45*, 24-31.e23. https://doi.org/https://doi.org/10.1016/j.annepidem.2020.03.013

Thomas, R., Lough, F., Girton, J., & Casciotti, J. A. (2020). A Code of Ethics for Military Medicine. *Military Medicine, 185*(5-6), e527-e531. https://doi.org/10.1093/milmed/usaa007

Title VII of the Civil Rights Act, 42 U.S.C. §§ 2000e–2000e-17 (as amended) (1964). https://www.eeoc.gov/statutes/title-vii-civil-rights-act-1964

U.S. Equal Employment Opportunity Commission. (2021). *Section 12: Religious Discrimination, OLC Control Number EEOC-CVG-2021-3*. Retrieved from https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination

United States Army. (2013). *Army Regulation AR 40-3 Medical, Dental, and Veterinary Care*.

Walton, E., Manda, P., Patil, D., & Mehta, A. (2024). Impact of Anti-Discrimination Legislation on Access to Gender-affirming Care: A Commercial Claims *Analysis. Urology, 190*, 156-161. https://doi.org/10.1016/j.urology.2024.05.025