

The Experiences of U.S. Army Primary Care Providers  
Meeting Sexual Health Care Needs  
During Post-Vietnam Deployments

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## Report Documentation Page

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During Post-Vietnam Deployments

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## Abstract

The purpose of this study was to explore the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments and associated ethical issues providing care in an atmosphere that forbids sexual contact. As the Army has sought to add the role of advanced practice nurses to deployments, they will potentially find themselves faced with providing sexual health care in the field. A phenomenological approach was used in this study for the purpose of understanding, interpreting, and describing provider experiences during deployment. Purposeful sampling was used and dialogical engagements were conducted with six U.S. Army primary care providers who had served in post-Vietnam deployments. The Parse method was adapted to synthesize 21 core concepts and four structures that enabled the researchers to describe the experiences of the providers. The four structures are: provider experiences, soldier experiences, command experiences, and ethical experiences. Recommendations for further areas of research include rates of STI and pregnancy, feminine hygiene needs in the field, suppression of sexuality in the field, and ethical decision making among military providers.

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## Chapter I: Introduction

Sexually transmitted infection (STI) is the most commonly reported category of communicable disease in the United States. Historically, military populations have had greater rates of STIs than the civilian population. (Eitzen & Sawyer, 1997; Sena et al, 2000) The risk factors, sexual behaviors and external influences that may be contributing to STIs in the military population require further investigation.

Background

Studies have reported STI rates and sexual risk behavior of U.S. Navy and Marines on ship deployments with frequent port calls. (Malone et al, 1994; Means-Markwell et al, 1998) However, no published studies were found that addressed the sexual risk behavior, or rates of STI and unplanned pregnancies during post-Vietnam U.S. Army deployments.

Several factors should be considered in explaining why U.S. Army personnel are at high risk for developing STIs. Recognition that the global involvement of the U.S. Army includes a strong and continuous presence in regions with high human immunodeficiency virus (HIV) and STI prevalence makes disease transmission a growing concern.

Operation Desert Shield/Storm involved the largest number of female U.S. service members ever deployed in combat. Additionally, the many humanitarian missions and peacekeeping missions that have followed--Somalia, Bosnia, Haiti and the hurricane relief missions--have included both men and women. The U.S. Army's policy during these deployments has been abstinence from sexual activity while in the theater of operations.

Availability of condoms may be at the discretion of the Unit Commander. This command approach to contraception could be a possible contributing factor to the incidence of STIs and unplanned pregnancies. This policy presents health care providers with a potential ethical challenge: Do they follow regulations and refrain from offering

condoms or oral contraceptives to soldiers knowing that sexual activity will occur with or without safe sex practices? Or do the providers render these services irrespective of regulations? Health care providers usually provide the requested condoms and oral contraceptives in order to promote the public health of the unit and surrounding community.

The issues surrounding sexual health care during deployments are significant to advanced practice nurses (APNs). As the Army has sought to add the role of APNs to deployments, Army APNs will potentially find themselves faced with the issues of sexual health care in the field.

#### Purpose

The purpose of this study was to explore the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments and associated ethical dilemmas while providing these services in a command atmosphere that forbids sexual contact.

#### Research Questions

What were the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments?

Did the providers experience any ethical issues providing sexual health care in a command atmosphere that forbids sexual contact between soldiers?

#### Definitions

Primary health care provider - A nurse practitioner (NP), medical doctor (MD), doctor of osteopathy (DO) or physician's assistant (PA).

Sexual intercourse - Heterosexual intercourse involving penetration of the vagina by the penis. Also intercourse involving genital contact between individuals other than penetration of the vagina by the penis.

Oral contraceptive - An oral, hormonal medication that when taken daily

suppresses ovulation and alters cervical mucous and the endometrium significantly reducing the likelihood of conception. Also commonly used to regulate menses. This medication has no inherent protection against sexually transmitted infection.

Condom - A sheath of latex worn over the penis as a mechanical barrier to prevent conception or sexually transmitted infection. Condoms must be used with each sexual encounter.

Table of organization & equipment (TO&E) - The specific manifest of equipment and personnel deployed with an Army unit.

PROFIS - An acronym for professional officer filler system. It is the system in which the Army assigns medical personnel to specific units for future deployments.

Deployment - Participation in a combat operation or operation other than war.

Ethical dilemma - A choice between two or more equally justifiable alternatives.  
(Aikem, 1994)

### Assumptions and Limitations

The assumptions for this study were:

1. Condom and oral contraceptives were available and part of the unit TO&E.
2. Study participants gave an honest accounting of their experiences.
3. Primary care providers had an interest in participating in this study.
4. Primary care providers had the time available to participate in the dialogical engagements investigating their experiences.

The limitations of this study are:

1. Lack of time and resources available.
2. The experience of the researchers in conducting qualitative research.
3. Details of experiences may not be remembered.

### Theoretical Framework:

The theoretical frameworks chosen for this study were the principles of beneficence and veracity as defined by Beauchamp and Childress and the human becoming theory as described by Rosemarie Rizzo Parse.

Beneficence is the “duty to do good”. Beneficence is traditionally viewed as an expression of charity. This principle requires that the individual always make decisions that will enhance the welfare of others and serve their best interests. (Beauchamp and Childress, 1989)

The beneficence model identifies the good relevant to the application of the principle of beneficence in clinical practice. Medicine should seek on mankind’s behalf the prevention of unnecessary death and prevention, cure, or at least management of morbidity. Morbidity can take the form of disease, injury, handicap, or unnecessary pain and suffering. (Beauchamp and Childress, 1989)

Veracity is defined as the obligation to “tell the truth and not to lie or deceive others”. (Beauchamp and Childress, 1989) As officers in the military, the Army Values demand that primary care providers have the integrity to “do what’s right, legally and morally”.

The potential exists for the primary care provider to be placed in a deployment situation where they are asked to meet sexual health care needs in an environment where sexual contact between soldiers is forbidden. Does the primary care provider practice the beneficent act of providing care that conflicts with their duty as an officer to exhibit veracity and report policy violations?

The human becoming theory was created by Rosemarie Rizzo Parse. Parse believes that humans are part of the universe. Humans make choices with others regarding their health care. By creating descriptions of lived experience, human knowledge is enhanced. Researcher/participant dialogue discovers meaning of the phenomenon “as lived”. Researchers create structures of lived experience that enhances the knowledge of nursing. (Parse, 2000)

## Chapter II: Review of Literature

The military population has historically been at a particularly high risk for sexually transmitted infection. STIs are as much as five times more prevalent in the military than in the civilian population. (Eitzen & Sawyer, 1997; Sena et al, 2000) During the Vietnam conflict sexually transmitted infection was listed as the most common outpatient diagnosis. (Sena et al, 2000) Service members often engage in risky sexual behaviors. There has been little research in Army personnel's sexual practices, risk behavior and sexual health needs during deployments in the post-Vietnam era. Such research would be helpful in defining the current public health threat to soldiers while on deployment.

Prevalence of Sexually Transmitted Infection

Military service members are at high risk for developing sexually transmitted infections. A 1993 study exploring risk factors for sexually transmitted infections among deployed United States Navy personnel found that as many as 10% of the personnel develop a new sexually transmitted infection while deployed. Prior to the deployment a questionnaire was given to the sailors. A past history of sexually transmitted infection was reported by 22% of the sailors. (Malone et al, 1993)

New recruits in the military are frequently studied. A 1998 study looked at chlamydia infections in women reporting to Army basic training. The researchers found that 9.2% of the women reported to basic training with a chlamydia infection that was asymptomatic in the majority of the cases. (Gaydos et al, 1998)

Another retrospective study tracked trends in gonorrhea and chlamydia infection rates in active duty soldiers at Ft. Bragg, North Carolina during 1985-1996 and compared them with rates in the North Carolina civilian population. Review of the database maintained at the Ft. Bragg Epidemiology and Disease Control Clinic found that the soldiers had a 300-600% higher incidence of sexually transmitted infection than the

population of North Carolina and the United States in general. The authors felt that the incidence may actually be even higher, as many of the cases of sexually transmitted infections may go unreported. (Sena et al, 2000)

Increased incidence of sexually transmitted infection among the military is not limited to The United States. A 1994 retrospective study of male British soldiers deployed to the tropics found 815 cases of sexually transmitted infection in a population of 1441 soldiers over a one-year period. These individuals were twenty five times more likely to acquire a sexually transmitted infection than men in England and Wales. (Adams et al, 1994)

Clearly, the research shows that the military has increased incidence of sexually transmitted infections. Male and female service members engage in a high degree of risky sexual behaviors both at home and while deployed. Unfortunately, service members are less likely to engage in behaviors that are protective in nature.

#### Condom Use

A 1997 study of Ft. Jackson, South Carolina female recruits found that 41% of the soldiers could be categorized into groups labeled as using condoms “never”, “rarely”, or “occasionally”. They also found that recruits who reported alcohol use were less likely to use condoms than their non-drinking peers. (Eitzen & Sawyer, 1997)

The Gaydos et al (1998) study of female recruits at Ft. Jackson, South Carolina found similar data. Only 16.9% of the women reported that their partners always used condoms. Having a partner who did not always use a condom in the past 90 days was a variable that was associated significantly with chlamydia infection. (Gaydos et al, 1998)

A 1998 study of women’s health needs while deployed on United States Navy ships found that active duty women also frequently engage in intercourse without using a condom. Sexual activity during shore visits was reported by 32% of women in this study. The women reported that a condom was never used 58% of the time. Only 27% of the

women reported that a condom was always used. (Means-Markwell et al, 1998)

### Condom Use with High-Risk Populations

Male soldiers are more likely to use condoms as a protective strategy when engaging in the high-risk behavior of sex with prostitutes. Malone et al (1993) found in their study of United States service members deployed to South America, West Africa, and the Mediterranean that 42% engaged in sexual contact with prostitutes. Condoms were reported to have been used by 93% of the individuals. Correcting for those who were inconsistent in condom use, 90% were categorized as having used condoms while engaging in sex with prostitutes. However, the researchers felt this number to be unusually high and that perhaps many study participants over reported this number.

A 1995 study of Dutch marines tracked risk behavior and incidence of sexually transmitted infection while deployed as part of a United Nations mission to Cambodia. They reported that sexual contact with prostitutes was occurring, but unfortunately did not report incidence of sexually transmitted infection. The researchers had very similar results to Malone et al (1993). During the deployment 45% of the sample reported to be sexually active with a condom usage rate of 90% (Malone et al reported 42% and 90% respectively). (Hopperus et al, 1995)

The Hopperus et al (1995) Dutch group had two significant outcomes that differed from the Malone et al (1993) group. The Dutch had only a 1.9% occurrence of new sexually transmitted infection, while the Malone et al American group had a 10% new onset rate. Both groups identified age as a risk factor for low incidence of condom use-- however, on the opposite ends of the spectrum. The American group reported a lower incidence of condom use among the young with 11.9% of 20-24 year-olds defined as having used condoms "inconsistently." The Dutch identified their older soldiers as being at greater risk for not using a condom with 14% of soldiers aged 30-39 years and 26% of individuals greater than 40 years of age demonstrating inconsistent condom use.

The Adams et al (1994) study of British male soldiers in the tropics differed from the Malone et al American study and the Hopperus et al Dutch study. The British soldiers did not use a condom during 70% of sexual contacts and did not use a condom during sex with 69% of the prostitutes. This group had an incidence of 815 cases of sexually transmitted infection in a population of 1441 personnel over a one-year period. The low condom use reported by the researchers was consistent with past findings of British soldiers. They unfortunately had no theories to explain why British soldiers had such a high rate of failure of condom use as compared to British men in the standard population.

The reviewed literature portrays interesting differences between male and female reports of condom use. The new female recruits study by Eitzen and Sawyer (1997) found that 41% of the soldiers could be categorized as using condoms “never”, “rarely”, or “occasionally”. With the exception of the British study, reported male condom use was much higher. It is not clear from the reviewed literature why active duty men reported condom use more frequently than Eitzen and Sawyer’s Ft. Jackson group of women.

#### Numbers of Partners as a Risk

The Gaydos et al (1998) study of Ft. Jackson military recruits compared number of partners to incidence of disease. They found that women who had a new partner within the past 90 days were 1.3 times more likely to acquire a new case of chlamydia as those who did not have a new partner.

Malone et al (1993) questioned their sample as to the number of partners they had during a six-month deployment at sea. Of the total participants 29% reported one partner, 35% reported two or three partners, and 35% had four or more. Similarly, Eitzen and Sawyer (1997) collected data on the number of partners over the course of the participant’s lifetime. The researchers found that 22.6% of the women--who had a mean

age of 20 years--placed themselves in the six to ten partner category. Unfortunately, in both of these studies the researchers did not discuss whether or not this was a risk factor for a new sexually transmitted infection.

The Hopperus et al (1995) study of Dutch marines limited itself simply to the number of sexual contacts over the course of the six-month deployment. The researchers reported that 36% of the total group of Dutch had one to three contacts and 64% of the total group had four or more contacts. If the researchers would have compared numbers of partners to incidence of sexually transmitted infection then some conclusions about exposure risk might have been made.

#### Well Woman Screenings

Given that young women are at risk for developing sexually transmitted infections, Eitzen and Sawyer (1997) investigated frequency of well woman exams in their Ft. Jackson female recruit population prior to their entrance into active duty. They asked their sample how often they had received a pelvic examination. The researchers reported that 50.1% of the respondents received a pelvic examination either “annually” or “frequently” and that 18.7% of the sample reported that they had a pelvic examination "occasionally". The remaining 29% reported that they had "never" or "rarely" received a pelvic exam. This data is significant in that it could reflect civilian attitudes towards pelvic examinations and could be used to develop educational strategies. As these women are required while on active duty to receive regular pelvic examinations, education for active duty women should stress the importance of regular screenings both in the military and during their lives after their service has ended.

#### Preventative Education

Since 1985, the Army has had a mandatory HIV education requirement for each soldier. A 1998 study of Fort Bragg, North Carolina soldiers investigated the relationship between HIV education and sexual risk behavior. (Nannis et al, 1998)

Nannis et al (1998) administered a survey to 1,377 non-medical soldiers. The soldiers were questioned about the risk behaviors they engaged in and the amount of Army-based HIV education they had received. Overall, 77% of the soldiers reported that they had received HIV education. Within the previous calendar year of the study, 55% of those soldiers recalled receiving some education.

#### Need For Further Research

Little information exists about U.S Army soldiers' sexual behavior and sexually transmitted infections during post-Vietnam deployments. Although heavily researched, it is inappropriate to generalize research on Navy populations to Army ones because of the difference in command policies on sexual behavior and the different operating environments. Army soldiers have been deployed to areas of the world where policies often exist prohibiting sexual contact between other soldiers or civilians--effectively mandating celibacy. Army soldiers often operate in hostile areas where their personal safety is at risk, while sailors often make "port-calls" in foreign communities whose citizens are friendly to the United States.

There has been no research that addressed the sexual risk behavior, rates of STI and unplanned pregnancies of post-Vietnam U.S. Army deployments. Advanced practice nurses may find themselves in conflict with theater regulations and the obligation to meet the sexual health care needs of soldiers. A study of the experiences of deployed primary health care providers may provide some initial insight into provider experiences meeting sexual health care needs during post-Vietnam deployments.

## Chapter III: Methods

### Introduction

A qualitative, phenomenological approach was used to answer the following questions:

1. What were the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments?
2. Did the providers experience any ethical issues meeting sexual health care needs in a command atmosphere that forbids sexual contact between soldiers?

Qualitative research involves investigating broad questions about human experience through research interview sessions with individuals who have experienced the phenomena. The researchers produce descriptions of the data to help others understand the experience. (Munhall & Boyd, 1993)

There are six traditional approaches to qualitative research: phenomenology, grounded theory, ethnography, historic, philosophical inquiry, and critical social theory. Phenomenology is distinct in that it seeks to answer research questions based on the meaning of lived experience. (Burns & Grove, 1997) A phenomenological methodology was used in this study for the purpose of understanding, interpreting, and explaining the experiences of primary care providers meeting sexual health care needs while deployed.

### Phenomenology

Phenomenology derives from the Greek word phenomenon, which means, “to show itself”. (Morse, 1994) Phenomenology is a research method and philosophy that is intended to interpret the experiences of the study participants. (Burns & Grove, 1997) Phenomenology was the best approach for this study because it seeks to examine the phenomenon of the deployments as it was lived by the primary care provider.

Phenomenology as a philosophy views the individual in relation to their

environment. The environment and the individual interact with each other, and both therefore change. Phenomenology proposes that an individual is limited in his ability to view the world by culture and is not totally free to objectively evaluate his experiences. (Caelli, 2000) Experiences are unique to each individual, as each individual has his or her own distinct reality. The researcher's interpretation of the participants' realities is also subjective. Interpretations are strengthened when the experiences of the phenomenon are shared between the participants. (Burns & Grove, 1997)

Phenomenology typically involves small numbers of participants--often fewer than five individuals. Participants who have lived the experience and can articulate a realistic accounting of the experience are to be invited to participate in the research. (Parse, 1987)

Although there are many different styles of phenomenological research, most involve the following steps: bracketing, intuiting and describing. Bracketing refers to the process of identifying and containing any preconceived beliefs or bias the researcher may have regarding the phenomenon. Intuiting occurs when the researcher is accessible to the meaning of the phenomena by those who have experienced it. Analyzing involves coding and categorizing transcript data in an attempt to draw conclusions. The final stage of description involves understanding and defining the phenomena. (Polit-O'Hara & Hungler, 1997)

### Research Design

A phenomenological approach was used in this study for the purpose of understanding, interpreting, and describing the experiences of United States Army primary care providers meeting sexual health care needs during post-Vietnam deployments. Data were obtained through oral dialogical engagements with the participants.

### Parse Method

The Parse method (1987; 2000) was selected as the data analysis approach for this study. The Parse method uses a multiphase approach to understand human experience. It is based on Rosemarie Rizzo Parse's human becoming theory. A modified Colaizzi approach (1978) was used in conjunction with the Parse method. The Colaizzi approach is frequently used for analyzing qualitative data. Although very similar to Parse's method, Colaizzi's method offers clarification and a different perspective on handling the data.

Step One. The Parse method begins with dialogical engagement. Parse does not consider qualitative research sessions to be interviews, but rather an engagement where the true essence of the researcher is engaged with the participant. The researcher does not use questions to direct the flow of dialogue, but rather encourages the participant through guiding the dialogue and requesting that the participant give more details about the experience. Sessions are to be audio taped and transcribed so that the researcher may "dwell with" the meanings of the experiences in the extraction-synthesis phase. (Parse, 1987, 2000) This is similar to the initial Colaizzi step of reading all of the participants' descriptions in order to "acquire a feeling". (Colaizzi, 1978)

Step Two. The second phase of the Parse method is known as extraction-synthesis. In this phase the researcher develops ideas about the phenomenon by listening to the taped dialogue and reading the transcripts. Essences of the dialogue are extracted using the participant's own language and by conceptualizing the experiences in a scientific manner. (Parse, 2000) The essence is an encapsulation of a "core idea" described by the participant. (Parse, 2000) Step two of the Colaizzi approach is to re-read the transcript and extract significant statements. (Colaizzi, 1978)

The researcher will then generate synthesized essences. Synthesized essences are the interpretations of core ideas in the researcher's language (Parse, 2000). Colaizzi defines this step in qualitative analysis as, "Spelling out the meaning of each significant statement." Colaizzi labels this as "formulating meanings". (Colaizzi, 1978)

Step Three. The researcher develops a proposition from the participant's descriptions of experiences. The proposition is the researcher's conceptualization of the joined core ideas expressed by the participants. (Parse, 2000)

Step Four. The researcher uses propositions to develop core concepts. The core concepts are representations of ideas expressed by all of the participants. These core concepts represent central themes interpreted by the researcher. (Parse, 2000) Colaizzi's method calls for organizing formulated meanings into clusters of themes. (Colaizzi, 1978)

Step Five. The last step in the extraction-synthesis phase is to create a structure of the participant's experiences from the core concepts. The structure is the statement synthesized from the core concepts that answers the question of the meaning of the lived experiences. (Parse, 2000) In this step the researcher using Colaizzi's approach would integrate the themes into an "exhaustive description" of the phenomenon under study. (Colaizzi, 1978)

Step Six. The final phase of the Parse method is heuristic interpretation. In this phase the researcher uses their findings to contribute new understanding of the experiences, generating new theory and creating ideas for further research. (Parse, 2000)

Timeline

After institutional review board approval, research sessions were conducted with the primary care providers in the fall of 2001. Analysis of data, final preparation and defense of the research was conducted in the spring of 2002.

Table 1. Time Table

Months 2001/2002

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY
<b>Proposal</b>	X										
<b>IRB</b>		X									
<b>Interview Process</b>			X	X	X	X					
<b>Transcription</b>						X					
<b>Analyze Data</b>							X	X			
<b>Conclusions Recommendations</b>								X	X	X	
<b>Rewrites as needed</b>									X	X	X
<b>Final Defense</b>											X

Tasks

### Sampling and Setting

Purposeful sampling was used for this study, and consisted of 6 primary care providers. The participants were a nurse practitioner and 5 physicians who, while on active duty, provided primary health care to soldiers in post-Vietnam deployments in actual combat environments or in missions other than war.

The sample was obtained through the method of network sampling. Network sampling, also known as "snowballing" takes advantage of relationships the participants have with others meeting the study criteria. (Burns & Grove, 1997)

The setting consisted of locations that provided a quiet, relaxed atmosphere. Ample time was allowed to facilitate complete and appropriate discussion with the participants.

### Dialogical Engagement Methods

Participants were asked to describe their experiences providing sexual health care during deployment including any ethical issues experienced providing care in a command atmosphere that forbids sexual contact. One researcher facilitated discussion and the other observed verbal and non-verbal behavior and operated recording equipment. An independent transcriptionist prepared transcripts of tape recordings from the dialogical engagements.

At the beginning of each engagement an explanation of the study was provided. The researchers communicated the importance of participation. Verbal informed consent was explained and obtained prior to the beginning of the session.

Demographic background data were obtained. This data consisted of theater of deployment, type of unit served, demographics of unit and type of mission (combat, humanitarian, etc.). After this background information was obtained, the researcher encouraged the participant through guiding the dialogue and requesting that the participant give details about the experience. Researchers allowed discussion to guide the engagement.

The Parse research method was employed as a means of conducting this study. Dialogical engagements were conducted with the participants. Before conducting the dialogical engagements, the researcher "dwelt with" the meaning of the experience in order to maximize understanding of the phenomenon.

The researcher opened the dialogue with the statements, "please tell me about your experiences providing sexual health care during your deployment" and "please tell me about any ethical issues you may have experienced providing sexual health care during your deployment." The researcher did not interject questions, but moved the discussion by saying, "go on" or "please say more about your experience of providing sexual health care during your deployment" or "can you think of anything else that may help me understand your experiences of providing sexual health care during your deployment?"

The dialogical engagements lasted approximately 30-60 minutes. The dialogical engagements were transcribed in preparation for the extraction-synthesis process of data analysis. (Parse, 2000)

### Data Analysis

After completion of the dialogical engagements the researchers employed the Parse method to analyze the data. Analysis begins with Step Two of the Parse method.

Step Two. The researchers developed ideas about the phenomenon from the audiotapes and transcripts by extracting the essences of the individuals' dialogue using their own language and conceptualizing the experiences in a scientific manner. The researchers then generated synthesized essences, the interpretation of core ideas using the researchers' own language.

Step Three. The researchers developed a proposition from the participant's descriptions of experiences. The proposition is the researchers' conceptualization of the core ideas expressed by the participants.

Step Four. The researchers used propositions to develop core concepts. The core concepts are representations of ideas expressed by all of the participants. These core concepts represent central themes interpreted by the researchers.

Step Five. Structures were created from the participants' experiences using the core concepts. The structure is the statement synthesized from the core concepts that answers the question of the meaning of the lived experiences.

#### Protection of Human Rights

Approval to conduct this study was obtained through the Uniformed Services University of the Health Sciences' Institutional Review Board prior to data collection. Informed verbal consent was obtained from each individual prior to the beginning of the dialogical engagements. Each participant was informed that all personal information would be kept strictly confidential. There would be no connection between participants and transcripts of the sessions with the researchers. The participants were informed that participation was voluntary and that they had the right to stop the interview at any time for any reason.

The tapes were secured in a locked box. They were not labeled with the name of the participant, but were coded with a number that related to the date and time of the session. The tapes were destroyed upon completion of the transcriptions.

The transcriptionist was instructed in the manner in which to transcribe the dialogical engagements. No names were used. The transcription service was required to return all tapes to the researchers with the transcripts.

## Chapter IV: Study Findings

The findings of this study were analyzed according to the steps described by Parse (2000). Structures were developed from synthesized core concepts. The core concepts are presented with examples of statements from the dialogical engagements.

### Description of the Sample

There were six participants in the study. All were credentialed providers who were on active duty and were assigned to post-Vietnam deployments. One provider is a nurse practitioner and the other five providers are medical doctors.

The deployments included all phases of Operation Desert Shield and Operation Desert Storm, Operation Restore Hope in Somalia, Hurricane Mitch and operations in the Bosnia/Turkey Theater. Four of the providers were assigned as primary care providers as their main responsibility. One of the providers was a preventive medicine officer with additional primary care responsibilities; another of the providers was company commander with additional primary care responsibilities. Two of the providers had been deployed more than once and discussed both deployments. All of the providers were assigned to a field unit in the event of a deployment. None were assigned to their units as a primary care provider prior to deployment.

### Fundamental Structure

Four structures were identified in the synthesis of the core concepts. They are Provider Experiences, Solider Experiences, Command Experiences and Ethical Experiences. These structures represent the experiences of the providers meeting sexual health care needs during post-Vietnam deployments (see Table 2).

Provider Experiences. The providers had various experiences providing sexual health care. Some providers--primarily those assigned to field hospitals--had experiences that

Table 2.

Core Concepts and Structures that represent the experiences of the providers meeting sexual health needs.

<b>Provider Experience</b>	
<b>Core Concepts</b>	<b>Structures</b>
Pregnancy Sexually transmitted infections Contraception issues Difficult patient care issues Masturbation issues No sexual issues Therapeutic relationship issues	Provider Experiences
Dynamics change when women are present Lack of feminine hygiene products Different rules Human nature and relationships Relationship strain due to deployment Inadvertently directly observed sexual relationships Inherent risk-taking behaviors of soldiers	Soldier Experiences
Enforcing “no-sex” policy unrealistic Commanders approaches varied Reporting procedures varied	Command Experiences
Ethical experiences varied Frameworks based on past experiences Greatest good for greatest number Justice and equity	Ethical Experiences

contained the entire spectrum of sexual health issues. Providers who cared for primarily all male combat arms units were more limited in their experiences.

Pregnancy. All of the participants who provided sexual health care for both men and women in the field had experiences with pregnancy. Concern was expressed over the need to take medications due to the deployment environment. Providers felt that some female soldiers became pregnant as means of leaving the theater of operations.

I had at least four pregnancies a week, at least. Then towards the end of the deployment there were less. Some of the pregnancies were from pre-deployment but the majority of them were during the deployment.

I scrubbed in on a rule-out ectopic pregnancy.

The other common thing we saw was the incidence of pregnancy.

Most of the troops were on Mefloquine, which is not recommended in pregnancy. That spawned a registry of women who became pregnant, or were pregnant, and were on Mefloquine.

Some of the pregnancies didn't surface until they were forced to take pyridostigmine bromide tablets. Then all of a sudden there was that fear of "what's that going to do to my baby?" and those kinds of issues.

I lost probably eight soldiers to pregnancies. We lost some before we left; we lost some after we got there. Whether they got pregnant before they left or after they got there, I'm not sure. All my losses were fairly early in the first four to six weeks, so most of them probably got pregnant just about the time they left. Of the ones that were in theater, some of them were deliberate for sure to get out of the deployment. There was no question about that.

I do recall that the leading cause of medical evacuation out of country was pregnancy. And it was a concern--because the environment was so austere--that pregnancy was seen as a very acceptable ticket home.

Sexually Transmitted Infections (STIs). Providers had a variety of experiences with STIs. Populations treated included multinationals and American service members. Soldiers acquired infections after periods of rest and relaxation out of theater as well as inside of the deployment environment. Providers who cared for all male combat units had no experience with STIs in theater.

Now as far as the U.S. forces, there were a fair number of STIs, a fair number. Not as high as the other forces, though.

I'd say weekly I would probably treat five or six people for an STI and the distribution was probably equal between males and females. Most of the females I treated were U.S. Most of the males I treated were the multinational forces--just because there were very few females.

I did have a couple of cases of PID, one of which we admitted for IV antibiotics.

There were some men who came in with rectal pain or had discharge and erythema and also had dysuria that I was concerned about. And they got better on treatment for gonorrhea.

We had scenarios where there were STDs, sexually transmitted diseases... routine STDs with regards to chlamydia and gonorrhea.

I didn't really see our own troops for sexually transmitted diseases that much. I can recall one specific instance that a soldier--and this was on the peacekeeping mission in Bosnia--had gonococcal arthritis. He was kind of well known within the hospital for having sexual intercourse with all takers. He ended up coming in with

inflammatory arthritis and we discovered by tapping the joint that it was gonococcal arthritis. He was the only one that really stood out as a confirmed case.

My experience with male and female genitourinary complaints was that multinational forces were very active.

The multinationals saw it as an opportunity to go to downtown Tuslow or to go to Sarajevo and have a good time and then come back and get their shot.

We also focused very specifically on sexually transmitted diseases since we knew people not only were exposed with sexual intercourse while they were deployed, but also on return travel on leave at home, and also on R&R travel up into usually either Germany, or Hungary, or places of that nature. And it was not uncommon that they came back to get checked. So we counseled them about symptoms--what to look for upon return. We talked to them about common sexually transmitted diseases as well as blood borne pathogens like HIV

A lot of the service members on extended deployments got to go to Turkey--where there was not a no sex in theater order... They acquired an STI and they came back in theater for treatment.

I had no clear STDs during my time. If there were, people made sure that I didn't know about it. Even if the other docs were hiding it from me, I didn't run into it on my own with the volume I was seeing.

We had other people that had come in presenting the symptoms potentially as sexually transmitted diseases. We had the availability of cultures and no one ever became positive on any of those. We did go ahead and treat them empirically as if they had them.

Contraception issues. Providers who served both male and female populations had experiences providing contraception. Contraception was provided in both an active and passive manner. Oral contraception for female soldiers was seen primarily as being for hygienic reasons. Some providers had no experience with contraception in theater.

We had condoms and I had a drawer full of them. I didn't really keep track of who was taking them and who wasn't.

I guess probably the most visible thing that you see in terms of sexual health is just kind of the very passive offering of condoms. Very commonly in the Clinic setting and outside the Clinic--in not really an open area but some place where people had access--there would usually be a bowl of condoms that was put out for general use. No one had to see a provider for that or even check in at the Clinic. Basically as time went on, you would notice that the level of condoms was slowly dropping and it would have to be refilled. So that was kind of the first level of treatment that we saw and probably the most common.

Prior to leaving theater, there were the issues that were largely at least sold as hygienic. A lot of the women liked to get Depo-Provera, which is a double-edged sword because when it doesn't work you're screwed. But a lot of the women liked to get Depo.

Certainly in the Company there were some women who went on, or continued on birth control for cycle related reasons. Again, cycle related as opposed to contraception... So when we would occasionally have to get those products for people it would be for health reasons as opposed to contraceptive. Now that may not have been the truth but that was the official reason given to me.

We were set up to do contraceptive counseling--most of that ended up being refills. And to tell you the truth we really didn't delve into why they were on birth control or why they wanted them to be filled.

Condoms were not available and not passed out. We didn't have those supplies, and we certainly didn't administer them. If people had them, they got them themselves. There was nowhere to get them locally.

We didn't have condoms to distribute and really there wasn't any need for what we were doing.

Nobody came to me and asked for condoms.

Difficult patient care issues. Several of the providers experienced patient situations related to sexual health that were complicated by the deployment.

I did have one female patient who I'll never forget. It was one of our medics, who was married and she became pregnant over there. One of the troops was the father and I have no idea who that troop was. But she became pregnant and discussed the case with me as her physician. She needed to have an abortion. She didn't want to go back. While we tried to negotiate that and figure out what we were going to do, get her home or whatever, she lost the baby. We had to send her to a Kuwaiti hospital because she needed to have a D&C. It was very awkward because their customs are quite different over there. You need to be completely shaven, which was very, very difficult for her.

I actually had several individuals that came up positive for pre-cancerous changes on their pap smears. As we now understand, the human papilloma virus is sexually transmitted. We had to send them out to Germany to get evaluated with colposcopy.

Actually one gal had pre-cancerous--actually early cancerous--changes in her cervix. She actually went to Germany and had a hysterectomy.

Masturbation issues. One of the providers was approached by an officer in his unit with concerns of masturbation. The provider educated the officer that this behavior was normal.

I remember an S-3 coming to us and he was a really good guy, but he was worried. He came to me really as his friend. He had gone to one of the platoons in the company, and these guys were all around in a circle and they were masturbating, you know, a circle jerk thing. And he was saying, "I don't know, is that normal, should we be worried about this?" And my comment was that these guys are a long way from home and this is probably just a normal component.

No issues providing sexual health care. The providers who served exclusively male units had no issues with sexual health during their deployment.

There just wasn't that much opportunity for sexual contact where we were.

I do not recall any significant issues having to do with sexual health care problems.

Reintegration issues. One of the providers recalled the counseling the unit received on how to reintegrate with one's significant other when reunited.

As we were preparing to come home, the chaplain and some people from the Psychology Supporting Unit came by and gave either printed materials or talks and maybe both to the soldiers about how to reintegrate with their lives when they got home. Part of that had to do with sexual matters. Essentially the message was, don't force yourself on you wife. You may be eager to get back into sexual activity but go slowly and realize your wife has feelings.

Trusting therapeutic relationships with patients. Some of the providers felt that the PROFIS system--that which assigns personnel to a field unit in the event of a deployment--prevented them from establishing a therapeutic relationship with their populations prior to deployment. The providers had varied opinions on how this affected sexual health care.

We had one service member who was having marital problems... As I didn't spend every day with these enlisted guys, I didn't really know he was having marital problems.

As a PROFIS officer I was unknown and not trusted because I was not originally part of the unit. I was concerned with lack of trust. Because I went on leave and returned to my normal job after the deployment, I was not able to take part in follow-ups.

I had no previous contact with my unit at all up until the point where I was deployed. It makes it very difficult since you're really not dealing with these people every day. You are unfamiliar with not only those soldiers that are being taken care of by the hospital unit, but also those individuals within the hospital that are helping you provide care. So it made it difficult, specifically in regard to these sexual issues.

I didn't feel that way. Maybe I'm naïve. I didn't feel that way as a physician, because they were really happy to have instead of a GMO a fully trained family physician with more experience and more rank come in. I felt like people came forward pretty freely for physician issues... The other thing was realistically they had nowhere else to go, at least not in theater. They really didn't have a lot of options.

Soldier Experiences. The providers experienced sexual issues outside of their provider role. The providers experienced sexual health issues simply as members of deployed units and watching those around them.

Behavior dynamics change when women are present. The providers noted that human behavior changed when men and women associated with each other.

I joked when I put concertina wire along my Med Company that I put it there to keep the GIs out not the Iraqis. I had 40 women and there are 8,000 men. Our Med Company was a very popular location for people to find an excuse to visit. If somebody were hurt, you'd have ten guys wanting to bring him in to help him out.

Even though those are forward positions and are considered male only, they're full of nothing but women. The ambulance companies were probably 60, 70 percent female. So I'm sending two females in a tracked ambulance out with an infantry company, and they're off by themselves. And they're on their own for a protracted period of time... I can say none of them got pregnant over the four to six months we were in theater so something worked in terms of contraception. Whether they were not having intercourse, whether they had contraception, I couldn't tell you. That was an issue that again didn't meet doctrine--and it didn't meet any common sense principles--but I had no options. I couldn't say I'm only sending males out

because I couldn't have met three quarters of my obligations. There was no choice at all.

I found the most striking thing to be that there were only a few women there, and the men who were talking with the women were assumed to be sleeping with them... There was a lot of pressure on those few women who were there to be involved with the men.

There is a lot of pressure on the women in settings where there are a lot of men--when you're there for a year with nobody to go out and date.

Lack of feminine hygiene products. The provider who was also a company commander had multiple issues supporting his female soldiers' feminine hygiene supply needs. Supplies were limited, difficult to acquire and often came from the soldiers' families.

If you were a woman, you were in trouble. We really had to fight to get stuff to supply our women for support for periods. Everybody comes with a 30-day supply or whatever and when that ran out, it was hard... We were blessed once established with such a huge and generally good flow of packages. A lot of those needs were met from home, not through our supply system. They were met by "send me four boxes of tampons" and that was not uncommon. We did have some and we hit up the log bases and informal channels. The Air Force started bringing some in country, but they were never what a woman would want. They'd have the heavy pads and nobody wants heavy pads. So it was pretty broken and it took some creative work. Once we were established we managed to get some discretionary funds. During the port stays, we were able to go downtown and buy stuff to augment our supplies.

Different rules when perceived as equals. The providers noted that multinationals had different rules regarding sexual relationships and leaving their areas of operations. The multinationals were not prohibited from having sexual relationships with U.S. troops.

The U.S. Army soldiers, however, were forbidden from engaging in sexual activity with anyone.

You have the multinationals who are able to go downtown. They don't have the same rules--no sex in theater. That becomes a challenge because they're having sexual relationships and U.S. forces are to have no sex in theater.

You're working side by side with these multinational forces, but yet their rules are different. And that becomes a challenge because they're having relationships and U.S. forces can have no sex in theater.

Their policies for their troops are different from ours and sexual contact was somewhat expected.

Human nature and relationships. The providers felt that the development of intimate relationships while deployed is human nature. These observed relationships varied in the level of commitment. The providers felt that some soldiers engaged in sexual activity without emotional commitment.

People are very close together and they develop a lot of intimate relationships.

The Command had come out and offered this blanket statement that fraternization was not allowed... People who really understand human nature know that if people were seeking sexual intimacy that they were going to find it no matter where they are.

People are just having sex for the sake of having sex and not really getting emotionally involved... there was no doubt that they were just having physical act.

You'd noticed things that you'd blow off initially. Out in the gym you'd noticed couples kind of pairing up. You'd notice some individuals that maybe over the course of several weeks were pairing up with other individuals.

There was a place outside of the area in Hungary that was set up just for MWR. It was sponsored by MWR and there was a lot of wild crap going on there--because there was alcohol allowed in that section too. Once you left the theater, you were allowed to drink

Relationship strain due to deployment. The deployments required that soldiers would be away from significant others. The stress of separation manifested itself both for the families at home and the deployed soldiers.

You have service members' significant others back home. Rumors about relationships that their soldiers have formed during the deployment get back to them. They're not even able to question their spouse face to face, and they're getting hearsay from garrison.

Now there were people over there who of course were frustrated because they were a long way from family and friends and people with whom they might cohabit.

There were psych problems just from people under stress of deployment. After a month or so, they weren't sure that they could deal with it anymore and some of that had a sexual component to it. You know, "I can't be with my fiancée, or with my wife, or with my girlfriend." I think there was a sexual component to some of the psychological distress that some of these people felt during the deployment.

We actually had two suicides in the area when I was there. Nobody from my Battalion but somebody apparently shot himself in one of the showers. I'm not sure whether that had to do with his being away from his girlfriend or maybe his girlfriend sending him a "Dear John" letter. I don't know. But that's kind of marginally sexual. That's more of a relationship problem than a frankly sexual one.

Directly observed sexual relationships. Providers inadvertently directly observed soldiers engaged in sex as part of their deployment experiences. Fluency in the local language made contact with the civilian population easier.

I had physically found people together in my command position.

There was a mill-van or something. A couple of people just went in there and everybody else turned their head.

Most of the sexual activity seemed to be U.S. soldier to U.S. soldier in the tents within our compound.

There was a great deal of mixing between the military and the local nationals because there was a selection pressure to take folks who had Spanish language skills. We were near towns where there was a lot of sneaking in and out under the fence and a lot of sneaking in of women from the towns. So I'm quite sure there was a lot of sexual interaction between local nationals and U.S. soldiers

There were some couples deployed within Companies, or Cross Battalion, or Cross Brigade within the same Divisions. They were proximate enough to occasionally be able to be near each other's company. I knew of a few, so there obviously were a number of them. Of those that were married, there was a general consensus that if we can accommodate them and look the other way, and its not going to happen very often, why not?

There were the established relationships and the newly established relationships in theater, i.e. not officially married for whatever reason. Certainly a certain amount of that went on. It was certainly not encouraged. There were people caught doing that.

I had a physician whose wife was in another Company, another Forward Support Medical Company. And so if I had the opportunity, I would do what I could to support him "hooking up." If we needed to borrow supplies or in any way interact, if I could, I'd let him jump on the jeep and go visit her. So I didn't see that as a dilemma.

I discovered that once by myself because I happened to walk in on them.

They basically called it “bunker love” because people would run around to these dirty, nasty air raid bunkers in the middle of wintertime. I can see how the guys would do that but I don’t know about the women.

Inherent risk-taking behaviors of the military. One of the providers felt that risk-taking behaviors are an inherent quality in soldiers. He felt that it should not be surprising that soldiers take sexual risks.

We select for the military people that basically are risk takers. We want people that want to jump out of planes. We want people that want to run up hills. We select the people that are risk takers and we get them. That’s why you can’t have risk-taking behaviors in only the areas that you want and not get them in other areas. We selected for people who have sexual risk-taking behaviors also. Certainly the militaries of the world are always at the forefront of sexually transmitted disease.

Command Experiences. Providers interacted with commands regarding sexual issues. They had experiences dealing with their own commands and those of the soldiers for whom they provided care.

Enforcing no-sex rules is unrealistic. The providers questioned the reality of expecting soldiers to refrain from sexual activity during a deployment. Guidance was vague and lacked reinforcement.

I can tell you that often leadership has unrealistic expectations that everyone’s going to obey the General Order #1, which is No Sex in Theater. Particularly when you start talking about a six or nine month deployment.

Command will come in and say, no sex in theater and that’s all. It’s kind of like, “say no to drugs.” It doesn’t really work.

Sexual contact was forbidden, there really wasn’t any other guidance until it came to the point of disciplinary action.

Commanders had various approaches to sexual issues. Providers observed various disciplinary actions administered to soldiers who were found engaged in sexual activity. The position of the individual caught and the effect on the unit complicated disciplinary actions. Commanders' interest in sexual issues varied overall.

I had multiple pregnancies, multiple STIs, and I never had any issues regarding UCMJ action on someone for not conforming with General Order #1, which is No Sex in Theater.

I know of no one that was formally disciplined and we certainly heard plenty of stories of people doing watch at night and getting caught in trenches and things like that. You heard about those kinds of things.

Some people had disciplinary action for fraternization. One incident was an enlisted soldier and a female nurse who was an officer. They got brought up on charges. I don't know what the ultimate outcome was. They had arranged basically to go on an R&R together and I know at least the female nurse was married. I don't know about the enlisted soldier.

I was left with two lieutenants and myself as the officers of this organization. One of the lieutenants was the XO and one was the other officer. They hooked up and I discovered that once by myself because I happened to walk in on them... I chose to read them both the riot act and I didn't do anything else about it. The survival of the Company was at stake. I mean you weren't getting replacements at that point. I literally could have court-martialed them and that would have been easy to do.

It was clear that I was treating them for STIs if anybody really wanted to know.

What was interesting about that case was that we labeled it. Nobody from the Command came down and said, "oh, she's got PID, she obviously had sex, you have to UCMJ." There was not one UCMJ paperwork initiated from my medical records.

I don't think there was a lot of discipline meted out when people were caught

having sex--at least not if it happened once and stopped after that. Clearly it was going on. There's no question in my mind because I'm sure.

I supposedly had the only female forward support commander. It may or may not be true--but that's what I was told. I had a female in a command position, Battalion Commander, so you would think that that would help the problem. I don't think it did. I don't think awareness was raised at all except for her own awareness.

It's an issue nobody's going to want to really look at because everybody just assumes it's not happening because everybody's so professional, which is a bunch of crap.

Well, when I was in the field in Kuwait, the only command attitude that was clear to me was that if there was going to be dating, it would be officer/officer, or enlisted/enlisted. In a big deployment those were really the only issues I had to face.

I actually ran the Well Women Clinic. We were mandated by the Command to have a clinic that provided pap smears and contraceptive counseling for women who were deployed in Bosnia.

I think it was well known to everybody that fraternization was not allowed. That was a very firm policy that was made clear by the Command when we had our pre-deployment briefings, as well as when we came into country. It was something that was more passively enforced because the longer that you were there, you would notice that things that were happening around you.

His general attitude towards sexual issues was, "okay, here are the rules, and let's obey them to the best of our ability." It wasn't a repressive environment.

I think the priority of the Command was very simple. It wasn't happening. I mean there was no priority. It's not something that should be happening now. I think that throughout the Commands there was the knowledge that there were some couples, some married couples around. I don't think anybody cared about that. Although even that stresses morale because just because you're married doesn't mean that other people don't wish they could have the same kind of arrangement. So even that was not necessarily considered okay at the Command level because it threatened morale.

Reporting procedures varied. Due to limited time with commanders, providers often had to prioritize their concern to health issues that were operational and affected the overall health of the command. Directives to report those who were pregnant or had sexually transmitted infections varied.

For a line commander sexual issues are not the most important things that he's worried about. Medical is not the most important stuff. We think it is because that's our world but we're just one of 20 or 25 people that are going to be briefing the command. We get our two minutes to brief them twice a day during Command and staff, and it is in my opinion not that important to the command... If it's malaria or diarrhea disease--safe water and things like that, that's going to be more important. I'm going to have to prioritize. I'm not saying the other things aren't important but if we don't get clean water, 70 percent of our division could be having diarrhea and not even be able to defend ourselves much less accomplish the mission. So, that's what I'm going to talk about in my minute.

The only thing we had to report was pregnancies because you couldn't be pregnant and be in the field.

We weren't given any strict guidance on that. It wasn't like the command came down and said, you will report every STI to us.

There was that one incident of people masturbating in a circle and there was no conflict there really. I'm sure I didn't report that to the Battalion Commander. That was just between the S-3 and me.

We were required to report to the Preventative Medicine Officer who is the Deputy Commander for the Medical Affairs on post... Those were never reported by name at all.

Ethical Experiences. Providers dealt with ethical issues providing sexual health care in the field. Providers' approaches were based on past experience and concern for the group as a whole. They were concerned with the equity of disciplinary actions.

Ethical experiences varied. Providers encountered few ethical dilemmas in providing sexual health care. There were no ethical issues for some participants due to the limited amount of sexual health care they provided. Some providers felt it was their duty to provide care without consideration of command attitudes.

I think its a constant struggle because as a provider you want to get the information and be able to do what's right.

No, no, we didn't actually really have any conflict. There were conflicts as far as policy went, but the sexual things just didn't come up.

I wouldn't call it a dilemma. I had a physician whose wife was in another Company, another Forward Support Medical Company. And so if I had the opportunity, I would do what I could to support him hooking up. If we needed to borrow supplies or in any way interact, you know, if I could, I'd let him jump on the jeep and go visit her. So I didn't see that as a dilemma.

Command had come out with this blanket statement but everyone knew people were going to do what they wanted to do. So even when we saw people in the Clinic, I didn't feel it was my role to make a judgment even though they were presenting for a sexual complaint unless I had seen something that was grossly interfering with the Command's directive. I didn't report anybody for sexual activity. Were we all going against the Command's directive? I suppose if you looked at the letter of the law, yes. But I think if you looked at the spirit of what they were saying, that basically we were holding people to that.

I didn't have any ethical dilemmas. If a patient came in and they wanted contraceptives, they wanted condoms, or they wanted treatment, I was just the physician. I made no ethical judgments. I just treated the patients.

Ethical frameworks were based on past experiences. One of the providers felt that ethical dilemmas with sexual issues are experienced early in one's career. Ethics was part of the providers' residency training and provided a framework to deal with future situations.

You generally come up with that ethical dilemma early in your training. You're an occupational medicine physician no matter what your specialty, and the occupation is soldier and you have a responsibility to the organization and a responsibility to the patient.

It became pretty clear to me early in my training that I was taking care of quite a few active duty military that were homosexual and that that was an important piece of information for me to know. I made a decision that when I took a sexual history from my patients--which I did during physicals for both male and females--that I'm not going to write it down and it doesn't matter to me at all but, for your health care because it means different things in terms of what I have to be worried about. I need to know your sexual orientation, are you straight, are you gay, are you bi? And that was pretty well received... That was just a decision I made knowing that I could receive a legal order in a court martial to say what I knew. At that time I would like to think that I would have stood my ground but I don't know because I never was faced with that situation.

I will say I'm not completely consistent. For example, I have had people who I thought had alcohol problems and I would confront them against their will. I would go to their commander against their will because I felt an obligation to the military, to the organization of the military that this person was of a high enough position or was a PRP or there was something where this person could not continue what they were doing with their alcohol problem.

I think for most people--especially if they've been through a clinical residency--these things come up either indirectly or directly in the curriculum. You go through scenarios and talk with people who are medical ethicists. These situations are not unique to deployments... What are you going to do if you're a family practitioner and a husband has an STD and the wife may or may not? Or their daughter wants birth control pills and you know the parents are devout Catholics, and they're a two star general--in my case one time. How are you going to handle that situation?

I think the people who have gone through a reasonable training program and have had a little more time, have sort of faced those types of decisions before deployment.

Greatest good for the greatest number. Several of the providers stated that they would discuss soldier behavior with the command if they felt the health of the command was threatened.

The ones that I would traditionally report are the ones who I felt were a threat to the group. Someone who I felt was unstable, psychologically unstable.

I've gone the other way in not respecting the confidentiality of the patient at all if I felt the greater responsibility was to the organization.

I will say I'm not completely consistent. For example, I have had people who I thought had alcohol problems and I would confront them against their will. I would go to their commander against their will because I felt an obligation to the military, to the organization of the military that this person was of a high enough position or was a PRP or there was something where this person could not continue what they were doing with their alcohol problem.

Justice and equity of disciplinary actions. Providers questioned the justice and equity of disciplinary actions. Partners were difficult to identify due to fear of UCMJ. Women experienced varied disciplinary actions for pregnancy.

That became somewhat of a difficult challenge to generate the partner. Was the partner in the same unit, was the partner in one of the infantry units that happened to come strolling through just for a short period of time, was the person redeployed back to CONAS or to UCOM? It becomes somewhat of a challenge to do the follow-ups.

You have to find out who the partner is and it is very difficult to get that information because of the General Order. They're afraid that you're going to UCMJ their partner.

The women who were pregnant, no UCMJ was initiated, they were just sent back home to their units.

We would see the pregnant women. They were given a same day appointment for chapter physicals, to be returned to the U.S. and discharged from service. All that we were there to do was to complete their physical exam paperwork and clear them to return to the United States... that was fairly cut and dried. If they came up with a positive pregnancy test within days if not a day or two, they were out of sector, home, you know, discharged.

I don't know that there were any ramifications for the males that were involved. We never sought them out and I'm sure that the Command never did so really the ramifications fell on the pregnant women only.

There was an issue with a gal who had actually gotten pregnant while she was deployed but it was not diagnosed. She came back to the United States on leave and subsequently found out she was pregnant. She had an abortion while she was home and came back... But it just gave me kind of an uncomfortable feeling because here all these other women on the previous deployment were sent back immediately, no questions asked, you're going home. It seemed that just because the luck of the draw that she wasn't diagnosed until she was at home on leave, and had everything taken care of kind of neatly. She was not held to the same rules as someone who might have found out otherwise.

I really had no ethical dilemma taking care of her because that's, you know-- basically my job is to take care of the health needs of the Command, but really more on a personal level, I felt like there was a double standard.

She became pregnant and discussed the case with me as her physician. She needed to have an abortion. She didn't want to go back. And while we tried to negotiate that and figure out what we were going to do, get her home or whatever, she lost the baby.

## Chapter V: Conclusions and Recommendations

Summary of the Study

The purpose of this research was to describe the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments. The study was undertaken because there is little research that explores sexual health care needs and sexuality in the field setting during these deployments. As the Army has sought to add the role of advanced practice nurses to deployments, they will potentially find themselves faced with the issues of sexual health care in the field. An understanding of this phenomenon would enhance nursing and the ability to care for soldiers during deployments.

In this time of increased operational tempo, health care continues to be delivered in the deployment setting. This study is significant because it has explored the experiences of primary care providers and has identified sexual health care issues and needs for further research.

Research approach

A phenomenological methodology was used in this study for the purpose of understanding, interpreting, and describing the experiences of United States Army primary care providers while meeting sexual health care needs during deployment. Phenomenology was the best approach for this study because it seeks to examine the phenomenon of the deployments as it was lived by the primary care provider.

A review of the literature was conducted as part of this study. The literature review prepared the reader and the investigator for this study by exploring existing information

on the phenomena and establishing the need for further research.

Purposeful sampling was used for this study, and 6 primary care providers participated. All were credentialed providers who were on active duty and were assigned to post-Vietnam deployments. The deployments included all phases of Operation Desert Shield and Operation Desert Storm, Operation Restore Hope in Somalia, Hurricane Mitch and operations in the Bosnia/Turkey Theater.

The dialogical engagements were conducted in quiet, private settings using open-ended questions. Audiotapes of the dialogical engagements were transcribed and analyzed using approaches adapted from Parse (2000) and Colaizzi (1978).

#### Research Conclusions/Implications

After reflecting on the audiotapes and transcripts, 21 core concepts were developed from the dialogical engagements. Four structures were developed from these synthesized core concepts: provider experiences, soldier experiences, command experiences, and ethical experiences. These structures enabled the researchers to describe the experiences of the providers.

This study described the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments. The providers dealt with a multitude of issues that they were able to identify during dialogical engagements.

The providers who were assigned to mixed-gendered units dealt with contraceptive issues that were both hygienic and preventative. They experienced a wide range of sexually transmitted infections and genitourinary complaints. Pregnancy was prevalent and presented unique challenges in evacuating women out of the theater. The providers who cared for male only units had no direct sexual issues, but dealt with masturbation

issues and reintegration issues.

As soldiers, the providers inadvertently directly visualized other service members engaged in sexual activity. They noticed that there were dynamic behavior changes when women were present. They noted multinational soldiers have different rules and behaviors compared to U.S. soldiers. They saw the strain in relationships when the soldier is separated from family. Feminine hygiene products were difficult to obtain over the course of a long deployment.

The providers dealt with commands in regards to sexual health issues. The commands had various approaches to sexual health care that were not uniform. The reporting procedures required of the providers varied as well.

The providers made ethical decisions that were based on past experience. They felt their training prepared them to make difficult ethical decisions in the field environment. At times the decision to report or discipline a soldier was based on the desire to do the greatest amount of good for the unit. The providers felt there were problems with justice and equity in dealing with UCMJ issues.

#### Recommendations

There has been little research recently on U.S. Army sexual health issues in the deployment setting. No published studies were found that addressed the sexual risk behavior, or rates of STDs and unplanned pregnancies during post-Vietnam U.S. Army deployments. Further research that could benefit advanced practice nurses includes areas of provider issues, soldier issues, command issues and ethical issues.

Provider issues identified in this study would benefit from clinical research. Further studies could explore sexually transmitted infection and pregnancy rates during

deployments and identify preventive strategies and plans of care.

Soldier issues identified in this study would benefit from administrative review. Studies could be designed to explore contraceptive and feminine hygiene needs during deployments. This would enhance the Army's ability to plan what supplies would be required to meet soldiers' needs during long deployments.

Issues with soldier stress were recognized. The development and enhancement of educational interventions designed to decrease soldiers' stress during deployment should be continued.

Expression of sexuality is a human need. Studies could be designed that explore the feelings and effects of soldiers being unable to express sexuality for prolonged periods of time. Soldier populations could be compared and contrasted with other populations that are forced to abstain from sexual contact such as inmates, clergy and deep-sea oil platform workers.

Command issues were identified that included variance in administrative policies regarding enforcement of no-sex orders. These policies could be reviewed for consistency and evaluation of soldier expectations.

Ethical issues during deployment were identified as part of this study. As commissioned officers, military providers have ethical dilemmas that are unique to military medicine. Further studies could be done to explore the ethical decision making of providers--both in garrison and the field.

### Conclusion

The purpose of this study was to explore the experiences of U.S. Army primary care providers meeting sexual health care needs during post-Vietnam deployments and associated ethical issues providing care in an atmosphere that forbids sexual contact. This study is significant because it has explored the experiences of primary care providers and has identified sexual health care issues and needs for further research. As the Army has sought to add the role of advanced practice nurses to deployments, they will potentially find themselves faced with providing sexual health care in the field. A phenomenological approach was used in this study for the purpose of understanding, interpreting, and describing provider experiences during deployment. Purposeful sampling was used and dialogical engagements were conducted with six U.S. Army primary care providers who had served in post-Vietnam deployments. The Parse method (1987; 2000) was adapted to synthesize 21 core concepts and four structures that enabled the researchers to describe the experiences of the providers. The four structures are: provider experiences, soldier experiences, command experiences, and ethical experiences. Recommendations for further areas of research include rates of STI and pregnancy, feminine hygiene needs in the field, suppression of sexuality in the field, and ethical decision making among military providers.

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# UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

4301 JONES BRIDGE ROAD  
BETHESDA, MARYLAND 20814-4799



August 28, 2001

MEMORANDUM FOR CPT (P) RICHARD M. PRIOR, AN, USA & LCDR DOMINIC T. WESKAMP, NC, USN, GRADUATE SCHOOL OF NURSING

SUBJECT: IRB Approval for Protocol T061CV-01 Involving Human Research Participants

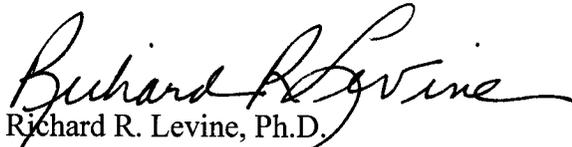
The protocol entitled "*The Experiences of U.S. Army Primary Care Providers Meeting Sexual Health Care Needs During Post-Vietnam Deployments*" received an expedited review and was **APPROVED** by Edmund G. Howe, M.D., J.D., Chairperson, Institutional Review Board on 8/28/2001. This protocol, with the stipulations listed below, is considered to be no greater than minimal risk in accordance with 45 CFR 46.110(a)(1)Suppl.(F)(7). Signed informed consent is waived in accordance with 45 CFR 46.117(c)(1). This approval will be reported to the full IRB scheduled to meet on 13 September 2001. *Please note that while this approval letter allows you to begin your study, the IRB can, at its next meeting, decide to hold the study in abeyance if it feels that additional information is required.*

The purpose of this study is to explore the experiences and associated ethical dilemmas of U.S. Army health care providers in meeting sexual health care needs during post-Vietnam deployments in actual combat environments or in missions other than war. The IRB understands that this study involves interviewing up to 6 primary care providers (physicians, nurse practitioners, or physician assistants) about their experiences in providing sexual health care deployments in a command atmosphere that forbids sexual contact. The IRB further understands that no personal identifying information will be collected. The IRB stipulates the following:

- ***Your study is approved through 31 March 2002.***
- To avoid a breach in confidentiality, ***signed informed consent is waived*** in accordance with 45 CFR 46.117(c)(1), since the only record linking the subject and the research would be the consent form. However informed consent must be obtained as indicated below.
- You are required to provide participants with a written statement regarding the research in accordance with 45 CFR 46.117(c)(2). This statement should contain the basic elements of informed consent in accordance with 45 CFR 46.116(a), to include the following: Purposes of the research; description of any reasonable risks/discomforts; description of any expected benefits; alternatives to participating in the research; confidentiality of data; points of contact and their phone numbers for answers to questions; and a statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the volunteer is otherwise entitled, and that the volunteer may discontinue participation at any time without penalty or loss of benefits.
- You may not collect or record, on paper or recording tape, any personally identifying information, e.g., name, full or partial service or social security numbers, initials, etc., of your study volunteers. You may record gender, professional specialty and branch of service. You may refer to your volunteers by a code on paper or recording tape, but if a code key is maintained, it must be destroyed at the end of the study.

- You may not seek to identify by name or rank, or record such information on paper or recording tape, any members of the volunteer's deployed unit.
- Other than the type of unit assigned to, you may not collect or record any demographic information relating to the dates/location of deployment or identify the unit deployed. You may specify the type of unit served (Armor, Infantry, etc.).
- You must destroy recording tapes at the end of the study.
- You are required to complete a USUHS Form 3204a between 30 and 60 days before the end of your approval date (or sooner if you've completed your research) in order to obtain continuing review and approval of your protocol. Failure to comply with this stipulation could result in suspension of your study and rescission of your study data. An electronic version of USUHS Form 3204a may be found on the REA website; a hard copy may be found in our office.

Please notify this office of any amendments you wish to propose and of any adverse events that occur during the conduct of this project. If you have any questions regarding human volunteers, please call me at 301-295-3303 or contact me at [rlevine@usuhs.mil](mailto:rlevine@usuhs.mil).



Richard R. Levine, Ph.D.  
LTC, MS, USA  
Director, Research Programs and  
Executive Secretary, IRB

cc: Director, Research Administration  
COL Martha Turner, GSN



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

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January 31, 2002

MEMORANDUM FOR CPT(P) RICHARD M. PRIOR, AN, USA & LCDR DOMINIC T.  
WESKAMP, NC, USN, GRADUATE SCHOOL OF NURSING

SUBJECT: Continuing IRB Approval for Protocol TO61CV Involving Human Subject Use

The protocol entitled "*The Experiences of US Army Health Care Providers Meeting Sexual Health Care Needs During Post-Vietnam Deployments*" received an *expedited annual review* and was **APPROVED** by Edmund G. Howe, M.D., J.D., Chairperson, Institutional Review Board on 1/31/02. This protocol is considered to be not greater than minimal risk in accordance with 45 CFR 46.110 (b)(2) Supplement (F)(8)(c), and this approval will be reported to the full IRB scheduled to meet on 14 February 2002. *Please note that while this approval letter allows you to continue your study, the IRB can, at its next meeting, decide to hold the study in abeyance if it feels that additional information is required.*

The purpose of this study is to explore the experiences and associated ethical dilemmas of US Army health care providers in meeting sexual health care needs during post-Vietnam deployments in actual combat environments or in missions other than war. Data collection was completed for 6 participants. Recording tapes have been destroyed (per IRB stipulation). The study is open for data analysis only.

Please notify this office of any amendments you wish to propose and of any adverse events that occur in the conduct of this project. If you have any questions regarding human volunteers, please call me at 301-295-3303.

Kathryn H. Knudson, Ph.D.  
LTC, MS, USA  
Human Research Protections Program  
Administrator and Executive Secretary, IRB

cc: Director, Research Administration





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## INFORMED CONSENT

“The Experiences of U.S. Army Health Care Providers Meeting Sexual Health Care Needs During Post-Vietnam Deployments”

CPT (P) Richard M. Prior. Email: Rprior@usuhs.mil Phone: 301-963-3364  
LCDR Dominic T. Weskamp Email: [Dweskamp@usuhs.mil](mailto:Dweskamp@usuhs.mil) Phone: 301-540-3851  
Graduate School of Nursing  
Uniformed Services University of the Health Sciences  
Bethesda, MD 20814-4799  
(301)-295-1001

### Purpose of Study

The Purpose of this study is to explore the experiences of U.S. Army health care providers meeting sexual health care needs during post Vietnam deployments and associated ethical dilemmas while providing these services in a command atmosphere that may forbid sexual contact.

### Description of the study

A Phenomenological methodology will be used in this study for the purpose of understanding, interpreting, and describing the experiences of United States Army primary care providers while providing sexual health care during deployment. Data will be obtained through oral dialogue sessions. The sessions will be audio taped. Participants will be asked to describe their experiences providing sexual health care during deployment - to include any ethical issues experienced providing care in a command atmosphere prohibiting sexual contact. One researcher will facilitate dialogue and the other will observe verbal and non-verbal behavior and generate written notes. An independent transcriptionist will prepare transcriptions of tape recordings from the sessions.

### Amount of time for you to complete this study

Your participation will involve a one-time dialogue session taking 30-60 minutes of your time. The dialogue session will be scheduled to occur at a time and place convenient for you.

### Possible discomfort from being in this study

There are no expected risks associated with your participation in this study. However, reflecting on your experiences could make you feel uncomfortable and you are free to stop the dialogue sessions at any time. The only inconvenience will be the time needed to take part in the dialogue session.

USUHS IRB APPROVED  
*RM* 28 April 01  
Expires: 31 May 2002





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BETHESDA, MARYLAND 20814-4799



### Possible benefits to being in the study

You may not benefit directly from this study, but the information we gain may be helpful in providing guidance and active interventions to military personnel that will foster good health, military retention and promote wellness.

### Confidentiality (Privacy) of your identity and your research records

To avoid a breach in confidentiality, **signed informed consent is waived**, since the only record linking the subject and the research would be the consent form. However informed consent will be obtained with this document. Researchers will not collect or record, on paper or recording tape, any personally identifying information, e.g., name, full or partial service or social security number, initials, etc., of the study participants. The researchers will record gender, professional specialty, type of unit (Armor, infantry, etc.).

The principle investigators will maintain research records of your participation in this study until completion of the study. Participant's confidentiality will be maintained at all times. Your name will not appear in any published paper or presentation related to this study. The audio tapes will be labeled with only the number of the dialogue session. The audio tapes, transcripts and any other notes generated during the study will be destroyed at completion of the study.

### Conditions under which participation may be stopped

Participation in this study is voluntary. You have the right to refuse participation. The decision to participate is non-binding. You may withdraw your participation at any time, for any reason, without negative consequences. You are encouraged to ask any questions at any time about the nature of the study and the methods that we are using. The investigators may also stop your participation if they feel the dialogue is causing undue stress or discomfort to the participant.

I have read the above terms and understand the information stated above. I understand that I may ask questions or withdraw at any time.

USUHS IRB APPROVED  
RM 28 AUG 01  
Expires: 31 Mar 2002

