An Ethical Analysis of Treatment of an Active-Duty Service Member With Limited Follow-up

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PRACTICE **POINTS**

- Dermatologic conditions are among the most common concerns reported by active-duty service members.
- The unique considerations of deployments are important for dermatologists to consider in the treatment of skin disease.

For active-duty service members, dermatologic conditions are among the most common presenting concerns, comprising 15% to 75% of wartime outpatient visits.[1] In general, there are unique considerations when caring for active-duty service members, including meeting designated active-duty retention and hierarchical standards.[2] We present a hypothetical case: An active-duty military patient presents to a new dermatologist for cosmetic enhancement of facial skin dyspigmentation. The patient will be leaving soon for deployment and will not be able to follow up for 9 months. How should the dermatologist treat a patient who cannot follow up for so long?

The therapeutic modalities offered can be impacted by forthcoming deployments[3] that may result in delayed time to administer repeat treatments or follow-up. The patient may have high expectations for a single appointment for a condition that requires prolonged treatment courses. Because there often is no reliable mechanism for patients to obtain refills during deployment, any medications prescribed would need to be provided in advance for the entire deployment duration, which often is 6 to 9 months. Additionally, treatment monitoring or modifications are severely limited, especially in the context of treatment nonresponse or adverse reactions. Considering the unique limitations of this patient population, both military and civilian physicians are faced with a need to maximize beneficence and autonomy while balancing nonmaleficence and justice.

One possible option is to decline to treat until the patient can follow up after returning from deployment. However, denying a request for an active treatable indication for which the patient desires treatment compromises patient autonomy and beneficence. Further, treatment should be provided to patients equitably to maintain justice. Although there may be a role for discussing active monitoring with nonintervention with the patient, denying treatment can negatively impact their physical and mental health and may be harmful. However, the patient should know and fully understand the risks and benefits of nonintervention with limited follow-up, including suboptimal outcomes or adverse events.

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The authors report no conflict of interest.

The views expressed in this article are those of the authors and do not reflect the official policy or position of the Department of Navy, Department of Defense, or the US Government.

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doi:10.12788/cutis.0960

Another possibility for the management of this case may be conducting a one-time laser or light-based therapy or a one-time superficial- to medium-depth chemical peel before the patient leaves on deployment. Often, a series of laser- or light-based treatments is required to maximize outcomes for dyspigmentation. Without follow-up and with possible deployment to an environment with high UV exposure, the patient may experience disease exacerbation or other adverse effects. Treatment of those adverse effects may be delayed, as further intervention is not possible during deployment. Lower initial laser settings may be safer but may not be highly effective initially. More rigorous treatment upon return from deployment may be considered. Similar to laser therapies, chemical peels usually require several treatments for optimal outcomes. Without follow-up and with potential deployment to remote environments, there is a risk for adverse events that outweighs the minimal benefit of a single treatment. Therefore, either intervention may violate the principle of nonmaleficence.

A more reasonable approach may be initiating topical therapy and following up via telemedicine evaluation. Topical therapy often is the least-invasive approach and carries a reduced risk for adverse effects. Triple-combination therapy with topical retinoids, hydroquinone, and topical steroids is a common first-line approach.[4] Because this approach is patient dependent, therapy can be more easily modulated or halted in the context of undesired results. Additionally, if internet connectivity is available, an asynchronous telemedicine approach could be utilized during deployment to monitor and advise changes as necessary, provided the regulatory framework allows for it.[5]

Although there is no uniformly correct approach in a scenario of limited patient follow-up, the last solution may be most ethically favorable: to begin therapy with milder and safer therapies (topical) and defer higher-intensity regimens until the patient returns from deployment. This allows some treatment initiation to preserve justice, beneficence, and patient autonomy. Associated virtual follow-up via telemedicine also allows avoidance of nonmaleficence in this context.

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