

More on: “Doctors Must Be Healers”*

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It is a great privilege to host this session and to welcome such a distinguished panel and guests. I wish to commend Mr. Denbeaux and his staff for organizing this important event and keeping the spotlight on the policies and ethical principles that lie behind our current military engagements. The timely publication of Bob Woodward’s *State of Denial* has inspired a number of side pieces on the culture of the senior military officers and the propriety of their challenge to the direction and guidance of our civilian leadership—either within the corridors of the Pentagon or publicly. There are many examples of the unhappy consequences of the tension between decisions made by the civilian leadership and the difficulty of implementing these changes by those who have made the military a career. But nowhere in the system can the consequences be measured more dramatically in human suffering than in the area of military medicine, and the practices and policies of military health professionals. As a retired Brigadier General, a medical doctor, psychiatrist, and someone who organized military medical support for the first Gulf War, I have sustained a special interest throughout the years, and particularly during our engagement in Iraq.

The publicity surrounding Abu Ghraib in 2004 and Guantánamo, even today, has raised serious questions about the actions or, more to the point, the apparent inaction of medical personnel at both of these facilities. Over time, more reports have been published on the participation of health professionals in interrogations, treatment of detainees in hunger strikes, and deaths during incarcerations. It is becoming apparent that contemporary notions of

* See Robert Jay Lifton & Stephen N. Xenakis, Editorial, *Doctors Must Be Healers, Not Interrogators; The Pentagon Forces Mental Health Professionals to Betray the Hippocratic Oath*, L.A. TIMES, June 8, 2006, at B17.

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national security trumped historic traditions of medical ethics and the overriding responsibilities of the health practitioners in times of war. We have witnessed the insidious proposition that brutalizing a few prisoners is a small price to pay for defending the country. According to this line of reasoning, military medical personnel should put a higher priority on fighting the war against terrorism than on abiding by the recognized ethical and moral principles of their profession.

That is not how military physicians have been trained. Military doctors have long been proud of the privilege of serving their nation and giving care to the soldiers, sailors, and airmen who defend it and its values. As military medical officers, they have taken an oath to the Constitution and the founding principles for which it stands—that we understand that this is a nation of laws and that we have respect for human dignity. Therefore, there has been no conflict for military medics because they have supported the same underlying values and principals that founded this great nation and that have guided them as healers.

Last year, a group of retired senior officers sent letters to the Congress and the President in support of the McCain Amendment and spoke out against torture and unconventional practices in the interrogation of prisoners. They affirmed historic principles that “[t]he abuse of prisoners hurts America’s cause in the war on terror, endangers U.S. service members who might be captured by the enemy, and is anathema to the values Americans have held dear for generations.”¹

Furthermore, these senior leaders emphasized that it is “apparent that the abuse of prisoners in Abu Ghraib, Guantánamo and elsewhere took place in part because our men and women in uniform were given ambiguous instructions, which in some cases authorized treatment that went beyond what was allowed by the Army Field Manual.”²

As one general officer put it, “[i]t is very clear that cruel treatment of detainees became a common Army practice because generals and colonels and majors allowed it to occur, even encouraged it.”³

¹ Public letter from General Joseph Hoar, U.S.M.C. (Ret.) et al., to Senator John McCain (Oct. 3, 2005), available at <http://www.globalsecurity.org/military/library/news/2005/10/051003-letter-to-sen-mccain.htm>.

² *Id.*

³ HINA SHAMSI, COMMAND’S RESPONSIBILITY: DETAINEE DEATHS IN U.S. CUSTODY IN IRAQ AND AFGHANISTAN (Deborah Pearstein ed., Human Rights First, February 2006), available at <http://www.humanrightsfirst.org>

There is a basic rule: the commander is responsible for what the soldiers do and do not do. In other words, commanders are responsible for the ethical and moral climate of their units.

There is no escaping that the responsibility for the conduct of the medics at Guantánamo Bay and Abu Ghraib rests with the senior leadership of the medical departments. Since the onset of combat in both Afghanistan and Iraq, the leadership has faced difficult challenges regarding the appropriate conduct of medical personnel in the treatment of detainees, the way medics handle casualties and deaths of prisoners, and the response to hunger strikes and other medical emergencies in the detention facilities. Historically, detention facilities have fully staffed clinics with primary care physicians, nurses, and a host of other support personnel who are supposed to treat American soldiers as well as detainees. The rule has been that soldiers, POWs, and detainees are entitled to the same standard of care. The common duty—from corpsmen with basic medical skills training to the most experienced surgeon—has been to provide care according to the highest standards of medical practice to all who need it and, of course, to report any signs of physical or psychological abuse. Medical officers have enjoyed special privileges and status and have been expected to abide by, and stand up for, their professional principles at all times and in all situations.

The responsibility and authority for the policies and practices guiding healthcare delivery rest with the military medical leadership, and this ultimate responsibility can be neither deferred nor side-stepped. Each military service—Army, Air Force, and Navy⁴—has a separate medical department that is headed by its own Surgeon General, a three-star officer. All health professionals belong to those medical departments and wear the respective insignia of their branch—either medical corps, medical service corps, or medical specialist corps. It is difficult to underestimate the importance of these branch insignia; even as general officers, most health professional officers wear their branch insignia unlike general officers in the combat arms or combat support branches. All physicians—M.D.s and D.O.s—who are licensed to practice medicine must belong to the medical branch. To find an exception to this, one must go back to the nineteenth century and the story of General Leonard Wood, awarded the Congressional Medal of Honor for valor while commanding an infantry detachment, and the only medical officer to

⁴ The Navy medical department provides medical support to the Marines. DEPARTMENT OF THE NAVY, BUREAU OF MEDICINE AND SURGERY, MANUAL OF THE MEDICAL DEPARTMENT, NAVMED P-117, 3 (1994) (Change 109).

have served as the Chief of Staff of the Army. Similar rules govern chaplains, but not necessarily lawyers.

The regulations for psychologists and other doctoral-level health professionals are different. For example, if an officer with a doctorate in psychology wishes to practice as a clinician, then the officer is “branched” in the medical department and abides by the ethics and policies of the health professions. Other officers—such as infantryman, military police, or interrogators—may earn psychology doctorates but not practice as clinicians. These officers serve in their respective branches and roles and are expected to conform to the regulations of their professional colleagues. All officers assigned to the medical departments of the military services are expected to fulfill the guidelines and codes that come with being a healing practitioner and wearing the insignia of a health professional.

While these differences may appear to be small bureaucratic distinctions, the singular identity of the medical corps goes to the heart of the treatment and handling of detainees, and the serious lapses that have followed. First, consider the grim record of these lapses. Human Rights First reported in February 2006 that ninety-eight detainees died in American custody and proposed that there had been eight to twelve deaths that followed acts of torture.⁵ A recent report by the Physicians for Human Rights (“PHR”) confirmed 105 deaths in Iraq and Afghanistan from 2002 to 2005.⁶ Homicide accounted for forty-three enemy deaths followed by thirty-six deaths attributed to mortar attacks.⁷ PHR found that autopsies were not required for deaths in custody, in a departure from usual policy, and there were no “full and adequate records” of treatment or documentation of the incidents.⁸

The timeliness and delivery of emergency resuscitation are unclear from the available records. Aggressive techniques, including dietary manipulation, stress positions, isolation, and environmental factors such as extremes of heat and cold used in the interrogation of detainees, imposed further burdens on the medical departments and obfuscated the comprehensive reviews and investigations they have conducted. Each fatality should have been handled with special at-

⁵ SHAMSI, *supra* note 3, at 5 n.2.

⁶ SCOTT A. ALLEN, JOSIAH D. RICH, MPH, ROBERT C. BUX, BASSINA FARBENBLUM, MATT BERNS & LEONARD RUBENSTEIN, DEATHS OF DETAINEES IN THE CUSTODY OF U.S. FORCES IN IRAQ AND AFGHANISTAN FROM 2002 TO 2005 (Dec. 5, 2006), <http://www.medscape.com/viewarticle/547787> (registration webpage only).

⁷ *Id.*

⁸ *Id.*

tention. The absence of evidence is astonishing, including missing body parts of deceased prisoners needed for autopsies in some cases. Special effort should have been exercised to ensure the highest quality care for detainees, and any indication of problems in delivering that care or suspicion of maltreatment should have been investigated in depth.

Adding to the problems, the Department of Defense introduced Behavior Science Consultation Teams (“BSCTs”) in Guantánamo and Abu Ghraib, starting in 2002, to support interrogations. Military health care personnel, including psychiatrists and psychologists, assisted in questioning detainees. Doctors were asked to approve, and even monitor, interrogation plans at Abu Ghraib relying on sleep deprivation. A report issued by The Surgeon General of the U.S. Army in 2005 acknowledged that military psychiatrists and psychologists on BSCTs were involved in the design, approval, and monitoring of interrogations.⁹ Army interrogators, The Surgeon General reported, were instructed to consult regularly with the BSCTs regarding detainees’ medical histories, and to focus on vulnerabilities such as depression, delusional behaviors, manifestations of stress, and determining “what are their buttons.”¹⁰ Interrogators were advised to rely on BSCT personnel’s knowledge of “when to push or not push harder in the pursuit of intelligence information.”¹¹

Recognizing that any interrogation is inherently coercive, participation by mental health professionals directly conflicts with acceptable ethical roles and should be forbidden altogether. Even in the mildest interrogation, the subject is deliberately put under stress, anxiety is intentionally heightened, fears and concerns are exploited, and facts are manipulated. A person is put on edge, perhaps confused, and is often lied to. There is no circumstance for healers to become involved in interrogations, except to treat and support subjects who are suffering from disease and injury. In all respects, there is a bright line between “healing” and “interrogating.”

It should be noted, though, that psychologists who are branched as military intelligence officers, police, or infantryman, can find legitimate ways to participate in interrogations. Often, the public does not distinguish between psychiatrists (M.D.s) and psychologists (Ph.D.s or Psy.D.s) and lumps them all together as mental health

⁹ DEPT. OF ARMY, OFFICE OF THE SURGEON GENERAL, FINAL REPORT, ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO AND OIF (Apr. 13, 2005), *available at* <http://www.armymedicine.army.mil/news/detmedopsrprt/detmedopsrpt.pdf>.

¹⁰ *Id.*

¹¹ *Id.*

specialists. There are, however, significant differences in training and responsibilities in the military and the private sector. Psychiatrists are physicians who hold a medical degree and live by the ethical principles and regulations that govern all doctors, without exception. In the military, psychiatrists are often expected to act as primary care physicians as well—stop the bleeding and do C.P.R. before, for instance, asking about the patient's mother.

On the other hand, psychologists hold either Ph.D.s in psychology, education, or counseling, or they hold Psy.D.s, doctorates of psychology. They are governed by different rules and regulations from physicians and some have earned graduate degrees as part of their professional training as interrogators or infantryman. These psychologists, who are not assigned to medical branches, are not authorized to perform any healthcare functions nor to act in any way that could be construed as having a clinician-patient relationship. They wear the insignia of their parent branch and follow career paths that are different from traditional healthcare providers. They have their own professional rules and guidelines—those of the combat arms and combat support branches. Even so, they do not have the license to be freewheeling cowboys. They are obligated to be cognizant of, and abide by, all accepted practices, conventions, and laws in carrying out their duties, including the Geneva Conventions. There is no room for harsh, inhuman, or degrading treatment. The experience of working interrogators (military intelligence officers), some with training and background in psychology, bears this out. A number have reported to me that they find harsh and punitive tactics abhorrent and counterproductive, and damaging to their professional identity and state of mind. These officers speak forthrightly and confirm that witnessing such tactics harms them and degrades the effectiveness of the interrogations.

The stories about the treatment and handling of detainees on hunger strikes are particularly disturbing. In the nearly five years since the first detainee arrived at Guantánamo, several hundred have participated in hunger strikes at one time or another and three have committed suicide. The policies of the commanding authorities are generally stern and punitive. A year ago, the military introduced “the chair” to “break the hunger strike[s].”¹² The “specifically designed chair” has been used to strap prisoners down and feed them by na-

¹² George J. Annas, *Hunger Strikes at Guantanamo—Medical Ethics and Human Rights in a “Legal Black Hole,”* 355 *NEW ENG. J. MED.* 1377 (2006).

sogastric tubes.¹³ The prisoners are bound for two to three hours after feeding to prevent them from vomiting or otherwise expelling their stomach contents.¹⁴ It has been also reported that the prisoners are subjected to forced ingestion of laxatives and diuretics, as well as other stresses.¹⁵ The U.S. Department of Defense (“DoD”) argues that the “individuals in this situation do not meet the ethical criteria for self-determination” and so can be fed against their will.¹⁶ On the other hand, the medical leadership has not implemented procedures for ascertaining if the detainees are competent to decide whether they wish to be fed, if they suffer from illnesses or circumstances that unduly influence their decisions, or if they have been given the right to have a second opinion of outside examiners who review their cases. These detainees are not all simply engaging in “asymmetrical warfare,” as command authorities have asserted,¹⁷ and there is no one story that explains each detainee’s decision to embark upon a hunger strike. The conditions of incarceration at the detention facilities illustrate that our military healthcare system has not taken all possible measures to prevent a downward spiral into a hopeless and helpless state for those men held captive—to the point that self-starvation seems like a reasonable alternative to the suffering. Each detainee deserves individual attention, in the interest of protecting their lives and health, in the best traditions of excellent medical care.

One senior general, while still on active duty, remarked in a private discussion that the military had to scramble and adjust to personnel shortfalls with the multiple demands of the wars in Afghanistan and Iraq, and took actions that may seem ill-advised or questionable in retrospect. Perhaps, but the policies and practice guidance of the DoD have started our military down a slippery slope. We should not endorse the notion that our leadership, military or civilian, can change the rules just because this is “a state of war.” Military medics, especially, must abide by the American Medical Association’s Code of Medical Ethics, and apply the highest standards of medical practice to all who need it, including prisoners, and report

¹³ See Tim Golden, *Tough U.S. Steps on Hunger Strike at Camp in Cuba*, N.Y. TIMES, Feb. 9, 2006, at A1.

¹⁴ *Id.*

¹⁵ Andrew Sullivan, *How Doctors Got into the Torture Business*, TIME, June 23, 2006, available at <http://www.time.com/time/nation/article/0,8599,1207633,00.html>.

¹⁶ Letter from John S. Edmondson, M.D., Captain, U.S. Navy, Force Surgeon JTF GTMO, to Dr. D.J. Nicholl, Dec. 12, 2005 (on file with author).

¹⁷ Josh White, *Three Detainees Commit Suicide at Guantanamo*, WASH. POST, June 11, 2006, at A1.

any signs of physical or psychological abuse. Surely senior military medics faced tough decisions and determined leadership when preparing for war and in the ensuing conflicts. Nonetheless, they should have first asked the hard questions about the ethical parameters guiding the conduct of medics, and focused on the policies that governed that conduct: what is the historical precedent; what are the best ideas about the role of medics in this war; and what are the long-term consequences of their actions? Now they confront even more of a burden—returning to some of the old and important values of the past, while repairing the recent damage to morale and reputation that the military has suffered.