When Doctor Go to War
M. Gregg Bloche, M.D., J.D., and Jonathan H. Marks, M.A., B.C.L.

When military forces go into combat, they are typically accompanied by medical personnel (physicians, physician assistants, nurses, and medics) who serve in noncombat roles. These professionals are bound by international law to treat wounded combatants from all sides and to care for injured civilians. They are also required to care for enemy prisoners and to report any evidence of abuse of detainees. In exchange, the Geneva Conventions protect them from direct attack, so long as they themselves do not become combatants.

Recently, there have been accounts of failure by U.S. medical personnel to report evidence of detainee abuse, even murder, in Iraq and Afghanistan.1 There have also been claims, less well supported, that medics and others neglected the clinical needs of some detainees. The Department of Defense says it is investigating these allegations, though no charges have been brought against caregivers.

But Pentagon officials deny another set of allegations: that physicians and other medical professionals breached their professional ethics and the laws of war by participating in abusive interrogation practices. The International Committee of the Red Cross (ICRC) has concluded that medical personnel at Guantanamo Bay shared health information, including patient records, with army units that planned interrogations.2 The ICRC called this “a flagrant violation of medical ethics” and said some of the interrogation methods used were “tantamount to torture.”2 The Pentagon answered that its detention operations are “safe, humane, and professional” and that “the allegation that detainee medical files were used to harm detainees is false.”2

Our own inquiry into medical involvement in military intelligence gathering in Iraq and Guantanamo Bay has revealed a more troublesome picture. Recently released documents and interviews with military sources point to a pattern of such involvement, including participation in interrogation procedures that violate the laws of war. Not only did caregivers pass health information to military intelligence personnel; physicians assisted in the design of interrogation strategies, including sleep deprivation and other coercive methods tailored to detainees’ medical conditions. Medical personnel also coached interrogators on questioning technique.

Physicians who did such work tend not to see these practices as unethical. On the contrary, a common understanding among those who helped to plan interrogations is that physicians serving in these roles do not act as physicians and are therefore not bound by patient-oriented ethics. In an interview, Dr. David Tornberg, Deputy Assistant Secretary of Defense for Health Affairs, endorsed this view. Physicians assigned to military intelligence, he contended, have no doctor–patient relationship with detainees and, in the absence of life-threatening emergency, have no obligation to offer medical aid.

Most people we interviewed who had served or spent time in detention facilities in Iraq or Guantanamo Bay reported being told not to talk about their experiences and impressions. Dr. David Auch, commander of the medical unit that staffed Abu Ghraib during the time of the abuses made notorious by soldiers’ photographs, said military intelligence personnel told his medics and physician assistants not to discuss deaths that occurred in detention. Physicians who cared for so-called high-value detainees were especially hesitant to share their observations.

Yet available documents, the consistency of multiple confidential accounts, and confirmation of key facts by persons who spoke on the record make possible an understanding of the medical role in military intelligence in Iraq and Guantanamo. They also shed light on how those involved tried to justify this role in ethical terms.

In testimony taken in February 2004, as part of an inquiry into abuses at Abu Ghraib (and recently made public under the Freedom of Information Act,
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and posted on the Web site of the American Civil Liberties Union (ACLU at www.aclu.org), Colonel Thomas M. Pappas, chief of military intelligence at the prison, described physicians’ systematic role in developing and executing interrogation strategies. Military intelligence teams, Pappas said, prepared individualized “interrogation plans” for detainees that included a “sleep plan” and medical standards. “A physician and a psychiatrist,” he added, “are on hand to monitor what we are doing.”

What was in these interrogation plans? None have become public, though Pappas’s testimony indicates that he showed army investigators a sample, including a sleep deprivation schedule. However, a January 2004 “Memorandum for Record” (also available on the ACLU Web site) lays out an “Interrogation and Counter-Resistance Policy” calling for aggressive measures. Among these approaches are “dietary manipulation — minimum bread and water, monitored by medics”; “environmental manipulation — i.e., reducing A.C. [air conditioning] in summer, lowering heat in winter”; “sleep management — for 72-hour time period maximum, monitored by medics”; “sensory deprivation — for 72-hour time period maximum, monitored by medics”; “isolation — for longer than 30 days”; “stress positions”; and “presence of working dogs.”

Physicians collaborated with prison guards and military interrogators to put such approaches into practice. “Typically,” said Pappas, military intelligence personnel gave guards “a copy of the interrogation plan and a written note as to how to execute [it]. . . . The doctor and psychiatrist also look at the files to see what the interrogation plan recommends; they have the final say as to what is implemented.” The psychiatrist would accompany interrogators to the prison and “review all those people under a management plan and provide feedback as to whether they were being medically and physically taken care of,” said Pappas. These practices, he conceded, were without precedent. “The execution of this type of operation . . . is not codified in doctrine,” he said. “Except for Guantanamo Bay, this sort of thing was a first.”

At both Abu Ghraib and Guantanamo, “behavioral science consultation teams” advised military intelligence personnel on interrogation tactics. These teams, each of which included psychologists and a psychiatrist, functioned more formally at Guantanamo; staff shortages and other administrative difficulties reduced their role at Abu Ghraib.

A slide presentation prepared by medical ethics advisors to the military as a starting point for internal discussion poses a hypothetical case that, we were told, is a “thinly veiled” account of actual events. A physician newly deployed to “Iraqistan” must decide whether to post physician assistants and medics behind a one-way mirror during interrogations. A military police commander tells the doctor that “the way this worked with the unit here before you was: We’d capture a guy; the medic would screen him and ensure he was fit for interrogation. If he had questions he’d check with the supervising doctor. The medic would get his screening signed by the doc. After that, the medic would watch over the interrogation from behind the glass.”

Interrogation facilities at Abu Ghraib included a one-way mirror, according to internal FBI documents obtained and made public by the ACLU in December. Draft rules of conduct, now under review, would permit army medical personnel to attend interrogations but would give them a right to refuse on ethical grounds.

Military intelligence interrogation units also had access to detainees’ medical records and to clinical caregivers in both Iraq and Guantanamo Bay. “They couldn’t conduct their job without that info,” Tornberg told us. Caregivers, he said, have only a limited doctor–patient relationship with detainees and “make it very clear to the individuals that their medical information will not be protected . . . To the extent it is military-relevant . . ., that information can be used.”

In helping to plan and execute interrogation strategies, did doctors breach medical ethics? Military physicians and Pentagon officials make a case to the contrary. Doctors, they argue, act as combatants, not physicians, when they put their knowledge to use for military ends. A medical degree, Tornberg said, is not a “sacramental vow” — it is a certification of skill. When a doctor participates in interrogation, “he’s not functioning as a physician,” and the Hippocratic ethic of commitment to patient welfare does not apply. According to this view, as long as the military maintains a separation of roles between clinical caregivers and physicians with intelligence-gathering responsibilities, assisting interrogators is legitimate.

Military physicians point to civilian parallels, including forensic psychiatry and occupational health, in arguing that the medical profession sometimes serves purposes at odds with patient welfare. They argue, persuasively in our view, that the Hippocratic ideal of undivided loyalty to patients fails to capture...
the breadth of the profession’s social role. This role encompasses the legitimate needs of the criminal and civil justice systems, employers’ concerns about workers’ fitness for duty, allocation of limited medical resources, and protection of the public’s health. But the proposition that doctors who serve these social purposes don’t act as physicians is self-contradictory. Their “physicianhood” — encompassing technical skill, scientific understanding, a caring ethos, and cultural authority — is the reason they are called on to assume these roles. The forensic psychiatrist’s judgments about personal responsibility and competence rest on his or her moral sensibility and grasp of mental illness. And the military physician’s contributions to interrogation — to its effectiveness, lawfulness, and social acceptability in a rights-respecting society — arise from his or her psychological insight, clinical knowledge, and perceived humanistic commitment.

In denying their status as physicians, military doctors divert attention from an urgent moral challenge — the need to manage conflict between the medical profession’s therapeutic and social purposes. The Hippocratic ethical tradition offers no road map for resolving this conflict, but it provides a starting point. The therapeutic mission is the profession’s primary role and the core of physicians’ professional identity. If this mission and identity are to be preserved, there are some things doctors must not do. Consensus holds, for example, that physicians should not administer the death penalty, even in countries where capital punishment is lawful. Similarly, when physicians are involved in war, some simple rules should apply.

Physicians should not use drugs or other biologic means to subdue enemy combatants or extract information from detainees, nor should they aid others in doing so. They should not be party to interrogation practices contrary to human rights law or the laws of war, and their role in legitimate interrogation should not extend beyond limit setting, as guardians of detainees’ health. This role does not carry patient care responsibilities, but it requires physicians to tell detainees about health problems they find and to make treatment available. It also demands that physicians document abuses and report them to chains of command. By these standards, military medicine has fallen short.

The conclusion that doctors participated in torture is premature, but there is probable cause for suspecting it. Follow-up investigation is essential to determine whether they helped to craft and carry out the counter-resistance strategies — e.g., prolonged isolation and exposure to temperature extremes — that rise to the level of torture. But, clearly, the medical personnel who helped to develop and execute aggressive counter-resistance plans thereby breached the laws of war. The Third Geneva Convention states that “[n]o physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever.” It adds that “prisoners of war who refuse to answer [questions] may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind.” The tactics used at Abu Ghraib and Guantanamo were transparently coercive, threatening, unpleasant, and disadvantageous. Although the Bush administration took the position (rejected by the ICRC) that none of the Guantanamo detainees were “prisoners of war,” entitled to the full protections of the Third Geneva Convention, it has acknowledged that combatants detained in Iraq are indeed prisoners of war, fully protected under this Convention.

The Surgeon General of the U.S. Army has begun a confidential effort to develop rules for health care professionals who work with detainees. Such an initiative is much needed, but it ought not to happen behind a veil of secrecy. Ethicists, legal scholars, and civilian professional leaders should participate, and the process should address role conflict in medicine more generally. An Institute of Medicine study committee, broadly representative of competing concerns (including the military’s),
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would be a more suitable venue. To their credit, some military physicians in leadership roles have tried to involve outside ethicists in discussion of duties toward detainees. The Pentagon’s civilian leadership has blocked these efforts.

Military physicians, nurses, and other health care professionals have served with courage in Iraq and other theatres of war since September 11, 2001. Some have received serious wounds, and some have died in the line of duty. By most accounts, they have delivered superb care to U.S. soldiers, enemy combatants, and wounded civilians alike. We owe them our gratitude and respect. We would affirm their honor, not besmirch it, by acknowledging the tensions between their Hippocratic and national service commitments and by working with them to map a course between the two.


DOCTORS AND PATIENTS

Shifting Sands
Perri Klass, M.D.

For drama’s sake, this story should start, “It was the coldest night of the year in Boston.” Poetic license aside, it was a frigid January night, and I decided to splurge on the overpriced parking right near Symphony Hall. Now, I am not usually the symphony-goer in my family; I am the parent who stays home with the kids so their father can enjoy his single Boston Symphony Orchestra subscription. This was a special treat: we had a babysitter, and Larry and I were meeting at Symphony Hall.

But my mind was not on music. I was in the middle of what we used to call a “social service code.” Two evenings earlier, I had seen one of my regular patients, a three-month-old boy, for a checkup. I had treated his rather severe diaper rash, weighed and measured him — and worried. Because his mother seemed kind of stressed, kind of marginal, kind of over the edge. I knew some of her story: housing problems and homeless shelters, money problems, and legal problems. I had already invoked domestic violence services, family support services, patient advocate services, the emergency clothing pantry. And, of course, the Department of Social Services. There was an open DSS case on the baby, and I had spoken many times with the DSS worker.

At the end of that visit, I told the mother that I was worried. She had run out of money and supplies from the Women, Infants, and Children program and was feeding the baby out of a big can of powdered elemental formula — nothing that would harm him, but something that must have been prescribed for some other baby with a digestive problem and come her way through her mysterious network of shadowy friends. The baby, who was usually dressed immaculately in outfits with matching socks and coordinated caps, looked scruffy and bedraggled. And the mother seemed... off somehow, all over the place, overwhelmed and disoriented. It’s hard to put into words the feeling she gave me — that’s why I reach for these vague expressions of dislocation and discomfort. Or I could express it in jargon — she seemed “inappropriate,” she was showing “poor judgment.” Whatever was going on in this family’s life, I knew it wasn’t good. When I asked about it, she shook her head and hinted darkly at disasters and betrayals. “But I’ve been praying a lot,” she said.

So I told her I would call DSS in the morning, and she flinched. She felt judged and found guilty, and perhaps betrayed yet again. “So they can help you,” I said. “So they can make sure you have food

Dr. Klass is associate professor of pediatrics at Boston University School of Medicine and Boston Medical Center, Boston, and the medical director of Reach Out and Read.