American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet www.psych.org

September 12, 2008

Dr. Robert M. Gates
Secretary of Defense
Department of Defense
1400 Defense Pentagon
Washington, DC 20301-1400

Dear Secretary Gates,

We were dismayed to read in the articles by Jonathan H. Marks, M. Gregg Bloche and George J. Annas in the current issue of the *New England Journal of Medicine*, that the military is training or has trained psychiatrists in methods of interrogation. Both the American Psychiatric Association and the American Medical Association have taken official positions opposing the participation of physicians in interrogation. We understood that the U.S. military had acknowledged those policies. Has the military's position changed?

To quote the article by Marks and Bloche, "The Ethics of Interrogation—The U.S. Military's Ongoing Use of Psychiatrists,"

> An October 2006 [U.S. Army] memo titled "Behavioral Science Consultation Policy" ...fails to mention the APA statement and provides a permissive gloss on the AMA's policy, at some points contradicting it outright. The memo appears to claim that psychiatrists should be able to provide advice regarding the interrogation of individual detainees if they are not providing medical care to detainees, their advice is not based on medical information they originally obtained for medical purposes, and their input is "warranted by compelling national security interests." The advice envisaged by the memo includes "evaluat[ing] the psychological strengths and vulnerabilities of detainees" and "assist[ing] in integrating these factors into a successful interrogation."

Furthermore, in the article "Military Medical Ethics—Physician First, Last, Always," George J. Annas writes that the war on terror has initiated a fundamental change in the way that the U.S. military has operated at least since the time of the Nuremburg trials. He notes that in the textbook *Military Medical Ethics*, "...The medical-ethics rule ...is clear and is reinforced by international h

uman rights standards: no physician can take part in any action involving torture or cruel or inhumane treatment or use medical knowledge or skills for punishment." He goes on to say that "The DOD's new position that its physicians not follow nationally and internationally accepted medical ethics represents a major policy change."

The American Psychiatric Association opposes the use of psychiatrists in interrogating prisoners. The proper role of psychiatrists is to provide humane and compassionate care for those suffering from mental illnesses. We believe that the use of psychiatrists to aid in interrogations is a serious violation of medical ethics and should be discontinued. We await your reply as to current Defense Department policy.

Sincerely,

Nada L. Stotland, M.D., M.P.H.
President
American Psychiatric Association

Psychiatric Participation in Interrogation* of Detainees

POSITION STATEMENT

Approved by the Board of Trustees, May 2006
Approved by the Assembly of District Branches, May 2006

"Policy documents are approved by the APA Assembly and Board of Trustees... These are ...position statements that define APA official policy on specific subjects..." -- *APA Operations Manual.*

1. The American Psychiatric Association reiterates its position that psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action.

2. a) Every person in military or civilian detention, whether in the United States or elsewhere, is entitled to appropriate medical care under domestic and international humanitarian law. b) Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities. c) Psychiatrists should not disclose any part of the medical records of any patient, or information derived from the treatment relationship, to persons conducting interrogation of the detainee. d) This paragraph is not meant to preclude treating psychiatrists who become aware that the detainee may pose a significant threat of harm to him/herself or to others from ascertaining the nature and the seriousness of the threat or from notifying appropriate authorities of that threat, consistent with the obligations applicable to other treatment relationships.

3. No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.

---

*As used in this statement, "interrogation" refers to a deliberate attempt to elicit information from a detainee for the purposes of incriminating the detainee, identifying other persons who have committed or may be planning to commit acts of violence or other crimes, or otherwise obtaining information that is believed to be of value for criminal justice or national security purposes. It does not include interviews or other interactions with a detainee that have been appropriately authorized by a court or by counsel for the detainee or that are conducted by or on behalf of correctional authorities with a prisoner serving a criminal sentence.

The American Psychiatric Association • 1000 Wilson Blvd., Suite 1925 • Arlington, VA 22209-3901
Telephone: (703) 907-7300 • Fax: (703) 907-1085 • Email: apa@psych.org

The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE

◂ Previous Volume 359:1090-1092 September 11, 2008 Number 11 Next ▸

The Ethics of Interrogation — The U.S. Military's Ongoing Use of Psychiatrists

Jonathan H. Marks, M.A., B.C.L., and M. Gregg Bloche, M.D., J.D.

In May 2006, the American Psychiatric Association (APA) adopted a position statement prohibiting psychiatrists from "direct participation" in the interrogation of any person in military or civilian detention — including "being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees."[1] A few weeks later, the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) issued a similar opinion, stating that "physicians must neither conduct nor directly participate in an interrogation, because a role as physician–interrogator undermines the physician's role as healer."[2] The opinion defines direct participation as including "monitoring interrogations with the intention of intervening." Although the AMA and APA conceded that physicians could participate in general training of interrogation personnel, both organizations firmly opposed physicians' helping to devise interrogation plans for individual detainees. The World Medical Association also revised its Declaration of Tokyo in May 2006 in firm terms, asserting that "the physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals."[3]

Yet documents recently provided to us by the U.S. Army in response to requests under the Freedom of Information Act (FOIA) make clear that the Department of Defense still wants doctors to be involved and continues to resist the positions taken by medicine's professional associations. An October 2006 memo entitled "Behavioral Science Consultation Policy" (see the Supplementary Appendix, available with the full text of this article at www.nejm.org) fails to mention the APA statement and provides a permissive gloss on the AMA's policy, at some points contradicting it outright. The memo appears to claim that psychiatrists should be able to provide advice regarding the interrogation of individual detainees if they are not providing medical care to detainees, their advice is not based on medical information they originally obtained for medical purposes, and their input is "warranted by compelling national security interests." The advice envisaged by the memo includes "evaluat[ing] the psychological strengths and vulnerabilities of detainees" and "assist[ing] in integrating these factors into a successful interrogation."

The new Army field manual issued in September 2006 allayed some concerns about the use of coercive interrogation tactics by the military (though not by the Central Intelligence Agency [CIA]). The manual prohibits some aggressive techniques, such as waterboarding, hooding, and the use of military dogs. However, it still permits "physical separation" for an initial period of up to 30 days, which may be renewed. Given that prolonged isolation has serious psychological consequences and can cause post-traumatic stress, the prospect that physicians might still be advising interrogators on its effective use for "conditioning" detainees should be cause for concern.

The policy memo also states that a "behavioral science consultant" may not be a "medical monitor during interrogation" and suggests that this is a "healthcare function." However, it appears to authorize monitoring as part of consultants' intelligence functions, since "physicians may protect interrogatees if, by monitoring, they prevent coercive interrogations." It asserts, more specifically, that "the presence of a physician at an interrogation, particularly an appropriately trained psychiatrist, may benefit the interrogatees because of the belief held by many psychiatrists that kind and compassionate treatment of detainees can establish rapport that may result in eliciting more useful information."

This statement is troubling. First, it seeks to undermine the positions taken by the AMA and APA concerning physicians' monitoring of interrogations. Second, it suggests that the officials who signed off on this memo (the Army's former surgeon general and former assistant surgeon general for force protection) were skeptical about the merits of rapport-building detainee interviews. It also hints at the rationale that the military may be using to encourage psychiatrists to reject the positions of their professional associations.

To their credit, the memo's authors instruct physicians to report coercive interrogations to "the appropriate authorities" and, if necessary, to "independent authorities that have the power to investigate or adjudicate such allegations." But physicians' reporting obligations do not in themselves require that they adopt a direct monitoring function, and this role creates the potential moral hazard that interrogators will "push the envelope" while waiting for the physician to intervene.

Other documents obtained under FOIA indicate that between July 2006 and October 2007, five Army psychiatrists were put through the "behavioral science consultation" training course. The policy memo raises critical questions about that course, among them, Why are consultants receiving training in "learned helplessness" — a term that invokes the work of psychologist Martin Seligman, who used electric shocks to induce passive behavior in dogs and destroy their will to escape? As Jane Mayer has revealed, Seligman was invited by the CIA to give a lecture in learned helplessness at the Navy's Survival, Evasion, Resistance, and Escape school in 2002, purportedly to help U.S. soldiers to resist torture rather than enable them to inflict it.[4] According to Mayer, at least one

experienced interrogator has claimed that learned helplessness was the paradigm for some of the most aggressive interrogations in the war on terror. If coercive interrogations are supposed to be off the table, why teach this theory to behavioral science consultants?

Although the authors of the 2006 policy memo should be credited for requiring behavioral science consultants not to "perform any duties they believe are illegal, immoral or unethical," the value of such a mandate is undermined by the confusion the memo introduces regarding the ethical obligations of health professionals who serve as consultants. The memo is set to expire this October 20. The Army should take this opportunity to clarify the guidance and to embrace the positions of the AMA and the APA. In a high-pressure interrogation environment, unnecessary uncertainty about ethical constraints can only lead to mischief.

No potential conflict of interest relevant to this article was reported.

Source Information

Mr. Marks is an associate professor of bioethics, humanities, and law at the Pennsylvania State University at University Park and at the College of Medicine in Hershey, and a barrister and academic member of Matrix Chambers, London. Dr. Bloche is a professor of law at Georgetown University and a Nonresident Senior Fellow at the Brookings Institution, Washington, DC, and an adjunct professor at the Bloomberg School of Public Health, Johns Hopkins University, Baltimore.

References

1. American Psychiatric Association. Psychiatric participation in interrogation of detainees: position statement. May 2006. (Accessed August 22, 2008, at http://archive.psych.org/edu/other_res/lib_archives/archives/200601.pdf.)
2. American Medical Association. Physician participation in interrogation: report 10-A-06 of the Council on Ethical and Judicial Affairs. (Accessed August 22, 2008, at http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja_recs_10a06.pdf.)
3. World Medical Association. Declaration of Tokyo (as amended, May 2006). (Accessed August 22, 2008, at http://www.wma.net/e/policy/c18.htm.)
4. Mayer J. The dark side: the inside story of how the war on terror turned into a war on American ideals. New York: Doubleday, 2008.

The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE

◄ Previous Volume 359:1087-1090 September 11, 2008 Number 11 Next ►

Military Medical Ethics — Physician First, Last, Always

George J. Annas, J.D., M.P.H.

The global war on terror has brought renewed attention to the question of whether physicians in the U.S. military are physicians first, soldiers first, or physician–soldiers, or whether some other formulation best describes their medical–ethical obligations. The chair of the President's Council on Bioethics, Edmund Pellegrino, has insisted that medical ethics are and must be the same for civilian and military physicians, "except in the most extreme contingencies."[1] There is no special medical ethics for active-duty military physicians any more than there is for Veterans Affairs physicians, National Guard physicians, public health physicians, prison physicians, or managed care physicians. The only question is whether there are "extreme contingencies" that justify physicians' suspension of their medical–ethical obligations.

It is not surprising that wars have produced battlefield situations in which suspending patient-centered medical ethics has seemed reasonable, at least to military commanders. Perhaps the best-known example from World War II is the decision during the North African campaign to provide penicillin first to troops with sexually transmitted diseases, rather than to seriously wounded troops, because the former could be quickly returned to combat. In the first Gulf War, the primary medical–ethical problem was whether military necessity justified physicians in prescribing investigational drugs without the informed consent of troops. In the war on terror, controversy has centered on the participation of physicians in prisoner interrogations and hunger strikes and, most recently, on the use of psychotropic medications to retain soldiers in combat areas or return them for another tour of duty. What role can ethical military physicians play in each of these situations?

The editors of the textbook *Military Medical Ethics* conclude that a military physician is a "Physician First, Officer Second" and that "instances of significant conflict" between civilian and military medical ethics are "very rare."[1] This formulation states the problem rather than the solution, since it is only these "rare" cases involving "military necessity" that could require military physicians to betray medical ethics in favor of military or national security concerns. The use of the investigational drug pyridostigmine bromide as a chemical warfare "pretreatment" during the first Gulf War is an example. In seeking a Food and Drug Administration (FDA) "waiver of informed consent" for use of the drug, the Department of Defense (DOD) confused military necessity with medical ethics.

View larger version (12K):
[in this window]
[in a new window]
Get PowerPoint Slide ►

In the war on terror, military physicians have faced at least three major challenges to medical ethics: orders that they help to interrogate terrorist suspects, force-feed prisoner hunger strikers, and certify soldiers as fit to be redeployed to Iraq or Afghanistan. The medical-ethics rule in the first two instances is clear and is reinforced by international human rights standards: no physician can take part in any action involving torture or cruel or inhumane treatment or use medical knowledge or skills for punishment. Nonetheless, the DOD's post-9/11 interrogation policy required physicians to certify prisoners as fit for interrogation, and instructions issued in 2006 explicitly authorize physicians to certify prisoners as fit for "punishment" and even administer the punishment if it is "in accordance with applicable law," as interpreted by the DOD's civilian lawyers.[2]

Force-feeding hunger strikers at Guantanamo has been justified on the basis of military necessity, and military physicians have been ordered to force-feed prisoners "for the good of the country." Additional rationales are that the prison is an extension of the battlefield, that hunger strikers are engaged in asymmetric warfare, that allowing them to die by starvation would be widely viewed as a military failure in the war on terror that could force the closure of Guantanamo, that physicians should not allow their patients to die by starvation, and that the prisoners are incapable of making either an informed refusal (because they are incompetent) or a voluntary refusal (because of peer pressure). Current DOD instructions on force-feeding directly contradict the explicit

ethical positions of both the American Medical Association (AMA) and the World Medical Association (WMA).[2,3] Yet supporters of the practice have argued that force-feeding, even with restraint chairs, is consistent with civilian medical ethics as applied in the U.S. federal prison system — a justification that recognizes that there are no special medical ethics for the military but fails to acknowledge that many aspects of medical care in prison in the United States may also violate basic standards of medical care and ethics.[3]

A third example of such an ethical conflict is provided by military psychiatry. The durations of the wars in Iraq and Afghanistan and the shortage of troops have required that more troops receive mental health treatment for serious mental disorders than in previous wars. Increasingly, soldiers' depression, post-traumatic stress disorder, and anxiety are being treated with newer psychotropic medications, especially selective serotonin-reuptake inhibitors (SSRIs). There is no military doctrine on the use of SSRIs in combat situations, but some military psychiatrists have recommended that their colleagues in Iraq "should consider having one SSRI in large quantities, to be used for both depressive disorders and anxiety disorders . . . to [in the words of the motto of the Army medical corps] `conserve the fighting strength.'"[4] This strategy is consistent with medical ethics only if the treatment is part of an overall treatment plan, is medically indicated, and is provided with the voluntary and informed consent of the soldier–patient.

At a press conference called to announce the DOD's new policies regarding the treatment of prisoners on June 7, 2006, the then assistant secretary of defense for health affairs, William Winkenwerder, said: "We operate under principles of medical ethics. There is no conflict medically, ethically speaking, in our view, between what we are doing and what's laid out in a variety of ethical documents in the medical world. . . . [As for hunger strikes,] we view what we are doing as largely consistent with that [Malta] declaration." Of course, "largely consistent" means that there must be parts that are inconsistent. As Winkenwerder went on to say, the new policy specifically authorizes physicians to violate the WMA's Malta Declaration on torture and hunger strikes when ordered to do so. It may be understandable that the DOD does not want an international organization to set standards for the U.S. military. But because medical-ethics standards are universal, the DOD position should not be acceptable to the medical profession, and the AMA has appropriately objected to it.[3] The Army surgeon general's memorandum on the policy for behavioral science consultation referred to by Marks in this issue of the *Journal* (pages 1090–1092) also gives guidance that is inconsistent with specific medical–ethical rules of the AMA. Nonetheless, the guidance is correct in instructing all physicians to "regularly monitor their behavior and remain within professional ethical boundaries as established by their professional associations, by the licensing State, and by the military."

The DOD's new position that its physicians need not follow nationally and internationally accepted medical ethics represents a major policy change. Until now, and at least since Nuremberg, the U.S. military has consistently operated under the assumption that its physicians are required to follow not only U.S. medical ethics but also internationally recognized medical ethics. And at Nuremberg the U.S. military went even further, asking the AMA to select an expert witness to explain the standards of medical ethics to the judges at the Nazi doctors' trial. Under existing military practice, ethics enforcement seems to have been left primarily to state medical licensing boards, which have tried to avoid investigating ethics complaints against active-duty military physicians. Unless and until there is a special federal medical license for the military (not, I believe, a good idea), state licensing boards should take their responsibility to uphold ethical principles much more seriously, as the California legislature has recently urged (see From California State Senate Joint Resolution No. 19, Adopted August 14, 2008).

Pellegrino has emphasized that "medical ethics begins and ends in the patient–physician relationship" and that there is no military exception to this rule.[1] Thus, in the case of using SSRIs to prepare troops for redeployment, the military psychiatrist's loyalty must be to the patient–soldier's mental health and the prevention of further psychological injury. This conclusion doesn't mean that physicians can purposely undermine the military mission by always recommending that their patients not be returned to combat. Rather, it is based on another judgment: that the U.S. military is likely to be healthier, both physically and ethically, when its physicians can consistently follow medical ethics by treating their soldier–patients with dignity and honor.[1]

There are battlefield and prison conflicts that military physicians must resolve, but these conflicts are not captured by oversimplified expressions such as "mixed agency" or "dual loyalty." These frames set up a false choice.[5] Basic human-rights violations, including torture, inhumane treatment, and experimentation without consent, can never be justified. Other conflicts should be analyzed as possible exceptions in extremis to the rule that medical ethics are universal. The "physician first" guidance is only half the story; the other half should be "last and always."

> **From California State Senate Joint Resolution No. 19, Adopted August 14, 2008.**
>
> "The Legislature hereby requests that when California licensed health professionals have reason to believe that Interrogations are coercive or `enhanced' or involve torture or cruel, inhuman, or degrading treatment or punishment, they shall report their observatins to the appropriate authorities [and if no action is taken] . . . those health professionals are ethically obligated to report those practices to independent authorities that have the power to investigate and adjudicate those allegations."
>
> "No law, regulation, order, or exceptional circumstance, whether induced by state of war or threat of war, internal political instability, or any other public emergency, may be invoked as justification for torture or cruel, inhuman, or degrading treatment or punishment."

No potential conflict of interest relevant to this article was reported.

Source Information

Mr. Annas is chair of the Department of Health Law, Bioethics, and Human Rights, Boston University School of Public Health, Boston.

References

1. Beam TE, Howe EG, eds. Military medical ethics. Falls Church, VA: Office of the Surgeon General, 2003.
2. Instruction: medical program support for detainee operations. No. 2310.08E. Washington, DC: Department of Defense, June 6, 2006.
3. Crosby SS, Apovian CM, Grodin MA. Hunger strikes, force-feeding, and physicians' responsibilities. JAMA 2007;298:563-566. [Free Full Text]

4. Benedek DM, Schneider BJ, Bradley JC. Psychiatric medications for deployment: an update. Mil Med 2007;172:681-685. [ISI][Medline]
5. London L, Rubenstein LS, Baldwin-Ragaven L, Van Es A. Dual loyalty among military health professionals: human rights and ethics in times of armed conflict. Camb Q Healthc Ethics 2006;15:381-91. [ISI][Medline]