

choice should be restricted because “irrational” voters endorse all sorts of harmful nostrums — whether trade protection or farm price supports (he might have added health insurance with low deductibles, drug price controls, and free choice of doctors) — he may be out on a limb.<sup>4</sup> But the tree is one that many policy experts climb.

Ironically, then, the failure of the Clinton administration’s plan was made more, not less, likely by the amount of policy expertise poured into its design. The Clinton advisers sought the ideal policy synthesis. Though aware of political realities, they treated them as problems of policy design, to be managed within the confines of the president’s blueprint rather than incorporated into a political strategy that would make the president’s goals and ideals, not a 1342-page bill, the guiding light of congressional debate. And the advisers designed the proposal knowing full well that many of its elements, such

as greater emphasis on tightly managed health plans, were at odds with what most of the public professed to want. That was a problem for the political consultants, who would try to figure out how to “sell” Americans on what was good for them. The result was a fiasco — and a cautionary tale about the limits of expert presidential advice in an age that demands it.

This time around, health policy advisers — whatever their formal background, and whether two-handed or more Vishnu-like — would do well to take a different tack. We badly need health care experts in the White House who offer advice based on evidence and analysis, not prejudice. But even the best experts need to know when to defer to the political process, to see the purpose of their craft as facilitating democratic debate rather than providing final answers once Americans have decided on the questions.

Winston Churchill once said

that “scientists should be on tap, not on top.”<sup>5</sup> That is a good starting point. But sometimes presidential policy experts should also have the good sense to get out of the way.

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## 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 eth-

ics are and must be the same for civilian and military physicians, “except in the most extreme contingencies.”<sup>1</sup> 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.”<sup>1</sup> 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.

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 Afghan-



istan. 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.<sup>2</sup>

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).<sup>2,3</sup> 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.<sup>3</sup>

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 mil-

itary 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.’”<sup>4</sup> 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

**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 observations 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.”

has appropriately objected to it.<sup>3</sup> 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 mili-

tary 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 box).

Pellegrino has emphasized that “medical ethics begins and ends in the patient-physician relationship” and that there is no military exception to this rule.<sup>1</sup> 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.<sup>1</sup>

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.<sup>5</sup> Basic human-rights violations, including torture, inhumane treatment, and experimen-

tation 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.”

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

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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.”<sup>1</sup> 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.”<sup>2</sup> The opinion defines direct participation as including “monitoring interrogations with the intention of intervening.” Although the AMA and APA conceded that physi-

cians 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.”<sup>3</sup>

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](http://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